INDIVIDUALS AND FAMILIES WITH CHRONIC PAIN: THE USE OF HYPNOTIC TECHNIQUES WITH INDIVIDUALS AND PROBLEM CENTERED SYSTEMS FAMILY THERAPY WITH FAMILIES AS TOOLS TO MEDIATE THE EFFECTS OF CHRONIC PAIN

BY

LINDSAY REYNOLDS

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difficult for me to easily sum up all my thoughts and feelings. What I can say is that I know I would not be at this point of completion, were it not for you. Thank-you.

Introduction

The Buddha said that of all the unknowns and inconsistencies in life, one thing that man can count on is the continued existence of pain (Rahula, 1972). Pain is an unavoidable element in the fabric which comprises our lives. Hurtful and unpleasant as it certainly may be, pain often serves an integral function for our lives. Pain is what alerts us to life's dangers so that we may immediately steer away from what threatens us. Pain also serves us well as a teacher. Though I like to forget the panicked feeling of freezing my tongue on a cold iron gate, it only took one maligned incident to teach me to avoid such an encounter.

However, what of the nature of pain which persists much longer than common sense indicates is necessary? What of pain which far exceeds the original injury in duration and intensity? What of pain which at casual glance no longer provides a life enhancing warning, but rather is a life inhibition which creates disability and dysfunction? This is the nature of **Chronic Pain** and the effects on it's sufferer's (Chapman, 1977; Melzack, 1979; Sternback, 1974; Violon, 1982).

The intention of this practicum will be to explore this human issue from a social work perspective with a dual focus on individual treatment and family based treatment approaches. This report shall begin with a substantial literature review covering a general overview of the medical and psycho-social approaches to chronic pain. This will be followed with a more specific review of hypnotic interventions for individual treatment and family based treatments for families. Problem Centered Systems Family Therapy will be highlighted as this was the treatment of choice for this practicum. Within the respective sections on hypnosis and family based treatment, a rationale will be developed for the use of each intervention. Following the literature review, the report shall turn to a description and discussion of the practicum experience which involved the use of hypnosis as an adjunct therapy for individuals, and Problem Centered Systems Family Therapy as treatment with the families of a chronic pain patient.

CHRONIC PAIN: Theory, Research and Treatment Considerations

This discussion will start with a brief overview of the conventional medical approach to chronic pain. This will begin with a description of the operative pain theory in conventional medicine, and the interventions which naturally came of this theory. The reasons for why the conventional approach is not appropriate for the complexities of chronic pain shall be raised. This will lead into a discussion of a new way to look at chronic pain in theory and intervention practice. The conventional approach to the interpretation and intervention of chronic pain largely focused on the purely physiological aspects while ignoring or discrediting the psychological and social contribution to the pain experience (Elton et. al., 1983; Melzack & Wall, 1984; Merskey, 1982). The new way of looking provides an allowance for the consideration of the psycho-social aspects.

The psycho-dynamic, Behavioral/Cognitive and Interactional interpretations of this new perspective will be considered separately from each other as will be their accompanying interventions.

What is Pain?

Pain remains a nebulous question for mankind as a whole. In many respects it seems as though much of life is spent trying to evade pain's grasp, or at best, minimize it's influence. The philosophy of Existentialism emphasized that pain is an unavoidable aspect of life. Our personal mission is to attach meaning and understanding to it (Frankl, 1962). But what exactly is pain? The question still remains. As Ronald Melzack and Patrick Wall stated, " *Despite the importance of pain in medicine and biology, it is astonishing to discover that the word pain has never been defined satisfactorily* " (Melzack & Wall, 1982). According to Merskey, pain is a very subjective experience. Often it is associated with

organic tissue damage but it is also an issue of the mind. One's psychological and perceptive state can influence the degree and experience of pain (Merskey, 1973).

Is pain, as Mountcastle contends, a "*sensory experience evoked by stimuli that injure or threaten to destroy tissue, defined introspectively by every man as that which hurts* " (Mountcastle, 1980). Sternbach views pain as:

1). *a personal, private sensation of hurt*;

2). *a harmful stimulus which signals current or impending tissue damage*;

3). *a pattern of responses which operate to protect the organism from harm.* (Sternbach 1968)

Merskey simply defines pain as "*an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage* " (Merskey, 1979).

There is a wide range of definitions implicit in these statements. These definitions are not necessarily compatible. Mountcastle implies a view that pain may only exist where organic tissue damage has occurred. There is no mention of, or allowance for, psychological and social contributions to the experience. Melzack and Wall point out that this perspective is incompatible with much of the clinical and psychological evidence produced which notes the impact of emotion, motivation and individual perception on pain. Although Sternbach's expansion on the definition puts pain into a more abstract light, Melzack and Wall argue that this does not advance our understanding any further, and may in fact be misleading. They believe this definition confuses the stimuli with the experience and makes a statement on the protective nature of pain which by clinical examples is frequently not the case. Of the three general definitions, Melzack and Wall are most closely in agreement of Merskey's seemingly simple statement of pain being an unpleasant experience which may or may not be associated with actual physical injury, but is non the less described in like terms. They agree with Merskey's flexible association between injury and pain, but more so they

affiliate with the inclusion of the emotional element in relation to the sensory experience. However, this definition is incomplete as the multi-dimensional qualities of "unpleasant" has yet to be specified. This is necessary as there is too wide a range of experiences associated with pain to fuse categorically under one heading. Melzack and Wall admit that such an undertaking would be extremely complex, but view it as necessary if a truly specific definition of pain is to be developed (Melzack & Wall 1982).

The purpose of briefly relating the three interpretations of pain was certainly not to portray the "correct" one. A complete definition of pain does not exist yet. Melzack and Wall infer the question of whether it is possible for one definition to exist, as it would have to account for all the variations and complexities of the human experience of pain. Though the task may seem impossible, they compare this task to a similar one in sub-atomic or quantum physics. Even within the physical sciences the definitions of the basic concepts of energy and matter are being argued and redefined. Amidst the din of discussion, an increasing sense of certainty is developing. Though not in completely absolute terms, an increased probabilistic understanding is unfolding (Melzack & Wall, 1982). Within the field of Chronic Pain Intervention, increased understanding is emerging on the relationship between the physical and psycho-social aspects of pain (Elton et. al., 1983; Melzack & Wall, 1982; Merskey, 1982).

As could be expected from the above discussion regarding the definition of pain, a concise, agreed upon definition of ***Chronic Pain*** is problematic. Liebeskind and Paul make a distinction between acute and chronic pain. They describe acute pain as pain associated with the sensation of specific physical tissue injury, while chronic pain is psychogenic or "motivational-affective" in nature (Liebeskind & Paul, 1977). Bonica (1953) described chronic pain as pain that persists past the normal time of healing. As a contingent of this definition, the length of time has varied amongst practitioners and researchers from less than a month to six months. For the purpose of this practicum, the operant definition of

chronic pain will be that as described in agreement by the subcommittee on taxonomy for the International Association for the Study of Pain: Chronic pain is pain which exceeds the normal length of healing by three months or more (Merskey, 1986).

The Conventional Theory of Pain

The conventional theory of pain was very much the approach which bio-medicine took towards the explanation and treatment of pain (Melzack and Wall 1982). This theory is called the ***Specificity Theory*** and has it's roots in the philosophy of Rene Descartes in the seventeenth century. It states that one senses only what is real within the physical world. In essence the theory states that pain is a message which travels along specific pathways from the pain receptors in the tissue, to the pain center in the brain (Boring, 1942; Melzack & Wall, 1982). The perception of pain was seen as the message obtained from an occurring injury. The assumption of the theory, as it was developed by Max von Frey, was that there was a specific one to one connection between stimuli and sensation. In other words a specific stimulus would illicit a specific sensation representing a linear relationship between a physical stimulus and what is perceived (Boring, 1942; Melzack & Wall, 1982). The psychological process was not viewed as being a contributing part of this system. The psychological component was seen as merely a reaction which would not compound on the reception, transmission, and sensation of pain.

Goldscheider in 1894 proposed that it was not a specific stimuli which caused pain, but rather was the cumulative summation of the stimuli. It was in his ***Pattern Theory*** of pain that he stated when the sensory receptors were excessively stimulated and passed a critical level, pain would be experienced. Below this level other sensations, such as warm and cold, would be experienced (Melzack & Wall, 1982).

These two theories, briefly outlined here, were the two major contributing bodies of understanding utilized by bio-medicine. They focused primarily on the physiological

aspects of pain, and though while much increased understanding was developed in the area of physiology and pain, they could not explain several persistent varieties of pain; namely phantom limb pain, neuralgia, or causalgia (Elton et. al., 1983; Melzack & Wall, 1982].

The interventions which grew out of the conventional pain theories were largely pharmacological and neuro-surgical. Melzack and Wall point out that until recently (or specifically until the Gate Control Theory was formulated), only "*two medical procedures had the stamp of approval of conventional medical wisdom for the control of severe, intractable pain: the use of drugs, and, if they failed, the destruction of pathways in the spinal cord or brain that were believed to carry pain signals*" (Melzack & Wall, 1982).

A surprise is that 99% of pharmacological prescriptions are derivatives of only two compounds: aspirin and opium. Aspirin is often used to minimize inflammation in joints and fever. The opiates are used in imitation of the bodies own endorphin and enkephalin system of pain control. Used for their effectiveness with acute pain and terminal illness, they produce analgesia, mood changes and drowsiness. Though Melzack and Wall believe the concern of addiction with pharmacological intervention is highly over stated, they do acknowledge that there are side effects to the drugs which may make their extended use problematic. The aspirin related drugs may generate extreme gastric hemorrhaging and the opiates will produce constipation and possibly nausea so severe it may have to be treated with other drugs (Melzack & Wall, 1982).

There is a wide array of neuro-surgical techniques employed to produce a permanent blockage of pain transmission within the nervous system. This constitutes the destruction of nerves. Depending on the nature and location of the pain, a manual separation of the nerves may be performed by cutting, the use of toxic substance injections, or a localized burning of the nerves by passing an electric current through a needle. If the pain is contained in a specific locale, the intervention may performed upon the peripheral nerves. If

the pain covers a large diffuse area, the technique may be applied to a more central nervous structure. Neuro-surgical operations of this nature may occur anywhere from the peripheral sensory roots to spinal cord roots, and in extreme situations, the brain. Melzack and Wall state that while the neuro-surgical techniques are effective in providing short-term control of pain, and thus are justified for use with terminally ill patients, "*acceptable long-term control of pain is rarely achieved by surgery. Not only does the pain eventually recur but additional unpleasant sensations appear as a result of the denervation*" and in fact may produce a "*disaster* ." This may include paralysis, disability, and prolonged pathological pain as a result of these extreme interventions (Melzack & Wall, 1982).

Aside from the possible iatrogenic consequences of conventional medicine's approach to pain, theoretically it could not account for:

- **conditions of pain with out injury;**
- **pain in excess of the severity of injury;**
- **continued pain after healing of injury; or**
- **clinical evidence of psychological impact on the pain**

A new way of understanding was necessary which could account for these unresolved physiological issues, but more so for the purpose of this discussion, the influence of psychological aspects on the experience of pain. The Gate Control Theory of pain provides an alternative understanding of these issues (Melzack & Wall, 1965, 1982).

A New Way of Looking

Ronald Melzack and Patrick Wall proposed their **Gate Control Theory** in 1965 and were taken back by the extreme controversy surrounding the new theory (Melzack & Wall, 1965; Melzack & Wall, 1982). Some expressed the theory as being "*undoubtedly one of*

the major revolutions in our concept of pain in the last 100 years." Others argued that the theory was an incomplete challenge to the conventional wisdom of the Specificity theory (Cherry 1977; Schmidt 1972). The paper which proposed the theory was the eighth most cited neuroscience paper in the 1960s (Garfield 1980). The Gate Control Theory must be put into the context of being a hypothetical and non-definitive theory subject to change. However, today it is considered to be one of the most comprehensive and influential pain theories (Elton et. al., 1983).

The Gate Control Theory states that within the dorsal horns of the spinal cord, there is a neural mechanism which acts like a gate. This gate may increase or decrease nerve transmission from the peripheral fibers to the central nervous system. Pain is experienced when (as in the Pattern Theory) the transmission of impulses is equal to, or exceeds a critical level. The degree of transmission is moderated by the relative activity of large diameter and small diameter neural fibers and the descending influences of the brain. The large fibers restrict the gate and minimize pain. The small fibers open the neural gate and intensify the experience of pain. The pain stimulus enters the active central nervous system which is subject to the the psychological processes in the individual. All the past experiences, learnings, and current attitudes may impact on the transmission and experience of pain. The small diameter fibers, which are responsible for increasing the transmission of pain, are activated by negative emotions and perceptions such as fear, anxiety, and anger. The large diameter neural fibers reduce the transmission of pain and are activated by positive emotions and perceptions which includes states of relaxation, acceptance pleasure (Melzack & Wall, 1965, 1982).

Previously, no pain theory model made provision for the psychological influences on the experience of pain. Now the gate-control theory had a conceptual framework which explained that:

> *"psychological processes such as past experience, attention, and emotion may influence pain perception and response by acting on the spinal gating mechanism. Some of these psychological activities may open the gate while others may close it. "* (Melzack & Wall, 1982).

Very clearly, a theoretical mandate was developed for the exploration, and delivery of psychological interventions to assist the existing treatment of chronic pain.

Psychological Interpretations of Pain

There are two basic approaches to the interpretation of the relationship between psychological aspects and pain . These approaches are the ***psycho-dynamic*** (Engel, 1959; Szasz, 1955), and ***Behavioral//Cognitive*** (Block, 1980; Block et. al., 1980; Ellis and Harper, 1975; Fordyce, 1976; Meichenbaum, 1977; Miller, 1978; Sternbach, 1974)..

Engel (1959) and Szasz(1955) are the main writers on the ***psycho-dynamic*** aspect of pain. Szasz looked at the experience of pain in terms of it's unconscious meaning to the patient and it's quality as an emotion. Taking Freud's concept of conversion, he suggested that prolonged physical pain was an unconscious expression of emotional pain. Engel proposed that childhood experiences of aggression, abuse, neglect and suffering could render an individual susceptible to pain-prone behavior as an adult. Engel based his belief on his clinical observation. A number of other practitioners and researchers have echoed the possibility of a relationship between negative childhood experiences and adult chronic pain (Gross et. al., 1980, 1981; Hudgens, 1979; Mersky & Boyd, 1978; Roy, 1982; Violon, 1985). Though this certainly makes sense on a clinical level, there is a shortage of knowledge on the process of how such experiences become translated into chronic pain.

Some therapy modalities are based on the psycho-dynamic approach. A form of intervention may include a brief number of therapeutic sessions held with the patient. The therapist, while being aware of transference, resistance and avoidance, will encourage the patient to slowly raise and become aware of the issues and feelings associated with the pain. The therapist provides clear, supportive, clarifying feedback to enable the patient to develop an increased awareness of the connection between their emotional issues and the development of pain chronicity. As the patient deals with these issues, self-control techniques are taught (Pilowsky & Bassett, 1982).

There are few empirical data on the efficacy of such techniques. However, a study by Bassett and Pilowsky suggests that there may be therapeutic value to a psycho-dynamic approach (Bassett & Pilowsky, 1985). In the study 26 pain clinic patients were randomly assigned to two different therapeutic interventions: cognitively oriented supportive psychotherapy (6 sessions); psycho-dynamic psychotherapy (12 sessions). Questionnaires were administered before and after the interventions to gain a measure of illness behavior, depression and anxiety. Both groups reported comparable improvement. The measures were administered six and twelve months later. They indicateded that the psycho-dynamic group had a greater percentage of maintained improvement and reported a significant increase in activity. Suggestive though this may be, the conclusion of the study was that more research is warranted.

The ***behavioral/cognitive*** approach to pain is represented by the writings of Block (1980), Block et. al. (1980), Ellis and Harper (1975), Fordyce (1976), Meichenbaum (1977), Miller (1978), and Sternbach (1974). Though related, the behavioral and cognitive approachs will be separated in presentation.

Fordyce developed the proposition that all pain behavior is acquired through learning and having behaviors reinforced. Behavior which is followed with a positive consequence will

be reinforced and maintained. Likewise, behavior which is ignored, or given a neutral response will not be reinforced and will be eliminated. Within a chronic pain scenario, a patient who exhibits typical pain behavior such as complaining or moaning may actually have this behavior supported by a spouse or family member who does extra activities on behalf of the person with pain. Over time the individual may develop the behavior as a means to avoid their normal responsibilities and control the behavior of others. Sternbach (1974) used the term, "*home tyrant*" to describe an individual who uses the excuse of debilitating pain to control a vast spectrum of behaviors in the family members. In this way the other family members must carry the task responsibilities the patient would normally perform. The pain behavior may also quell any direct questioning or confrontation of the patient by the family as there may be a fear of upsetting the patient. The family members may feel that they are walking on eggs and can not honestly express their true feelings of anger, frustration and hopelessness about the patient and home situation (Sternbach 1974).

There is a considerable amount of empirical support for this behavioral approach more commonly known as Operant Conditioning (Block et. al., 1980). The research performed by Block (1980) and Block's et. al. (1980) displayed the relationship between spouse support and higher degrees of reported pain. Block (1980) performed a study measuring the skin conductance of spouses as they observed their spouses in pain. Block found the spouses who reported the higher levels of marriage satisfaction also recorded higher levels of galvanic skin response in response to their spouses' pain. This suggests that spouses who are satisfied with the marriage may display more empathic responses to the pain cues of their spouse. Block et. al. (1980) found that patients who viewed their spouses as being highly supportive rated their pain higher when in the presence of their spouse than when they were in the presence of a neutral observer. Taken together this research suggests the response of the spouse is important for the patient's adjustment to chronic pain.

The principle of operant conditioning may be utilized by a therapist in working with a patient in treatment. It also may be taught to a spouse or family for at-home treatment of the pain behavior (Lieberman, 1979). With this approach an atmosphere of normalcy is encouraged as the patient is urged to function in as healthy a manner as possible. Regressive or undesirable behaviors are not rewarded with sympathy or reallocation of responsibilities; they are ignored. On the other hand wellness behavior is purposely acknowledged and supported.

The Cognitive approach is similar to the Operant Conditioning in that they both work on the change of undesirable behavior. However, there is a difference. Where operant conditioning alters overt external behavior, the cognitive therapies work to change covert or internal cognitive behavior (Ellis & Harper, 1975; Meichenbaum, 1977). Proponents of Cognitive therapy state that by altering the way one thinks, one can change the way one feels (Ellis & Harper, 1975). The process involves the therapist exploring the patient's perceptions, beliefs, assumptions and attitudes, and becoming aware of the impact they have on the way the patient feels and behaves externally. This approach acknowledges the close relationship between reason, emotion and behavior. The therapeutic process would include becoming aware of the cognitive behavior and realizing that it is a perception or belief which may be false and produce an unduly negative impact. The next step would be to adopt a new set of beliefs or perceptions which are more desired and health producing. It may be defined as making conscious decisions on how to perceive and feel about the world (Ellis & Harper, 1975).

There is a very wide range of approaches to cognitive therapy which may reflect the many ways cognition may be applied to alter existing patterns (Elton et. al., 1983). There are cognitive therapies which focus entirely on thinking processes such as Rational-Emotive

Therapy (Ellis & Harper, 1978). There are also cognitive therapies which teach people to use their awareness to reduce tension and anxiety on a joint cognitive/physical level such as biofeedback and relaxation training. Briefly, some of the therapies include:

Rational-Emotive Therapy (Ellis & Harper, 1975). In this therapy the patient is helped to gain awareness of their negative and dysfunctional beliefs which add to their suffering. The patient is supported in adopting a new belief system which acknowledges the world is not a perfect place where all of one's needs will always be met, but neither is it a bad place as one can live a satisfying and happy life. This approach is for the most part optimistic as it recognizes the importance of feelings while focusing on the positive over the negative.

Elton et. al. (1983) comments on the possible use of Rational Emotive Therapy as a treatment for chronic pain. By improving mood and altering dysfunctional perceptions it may be possible to improve the coping behavior of a chronic pain patient. There is no existing research literature which explores or tests this treatment's efficacy or applcation with chronic pain. This renders Rational Emotive Therapy as an interesting yet unproven treatment for chronic pain.

Meichenbaum's Approach (Meichenbaum, 1977). Meichenbaum's approach to cognitive therapy is similar to Rational-Emotive therapy as they both work with internal belief systems. Along with this aspect, Meichenbaum teaches copingskills so that individuals will be able to recognize when they are under the stress of pain and maintain control and a state of relaxation. This is established through the conscious use of stress recognition, patterned identifying statements, breathing and body awareness, and positive imagery techniques.

There is no research evidence which provides a strong representation of the effectiveness of Meichenbaum's *stress-inoculation* approach for chronic pain. Elton et. al. (1983) commented that Meichenbaum's contribution was that he pointed out the importance of the cognitive process in medical treatment and further suggested that patients may teach themselves to deal more effectively with stress and pain.

Relaxation Techniques (Jacobson, 1938; Kleinsborge & Klumbies, 1964). There is a wide range of relaxation techniques available. Jacobson's Progressive Relaxation and Kleinsborge and Klumbies Autogenic Training are well known examples. With progressive relaxation, the individual consciously tenses and then relaxes body parts in a progressive building manner starting with the extremities and moving to the center. This is continued till the entire body is participating. Attention is focused on the before and after sensations. With autogenic training the participants make verbal suggestions to themselves of increasing relaxation. Again the body parts are given attention in a progressive manner. There are many variations on these techniques utilizing visual imagery, verbal programming and gentle movement (Bresler, 1984).

Elton and Stanley (1976) demonstrated that subjects utilizing relaxation techniques had higher thresholds for pain. Forty-two subjects were divided into two groups (experimental and control) and were tested for pain threshold, pain tolerance and anxiety. The experimental group was provided with a session on relaxation and taught to let go of any pain. The two groups were then exposed to a pain source, namely a clinical sphygmanometer which projected the subjects with a sharp but non lacerating pain. The experimental group displayed a significantly higher tolerance for pain and pain threshold over the control group. The anxiety state was also markedly lower in the experimental group.

Biofeedback . With the use of biofeedback an external sensor is attached to an individual to relay information on muscle tension. Using this device the patient is able to learn how to reduce muscle tension and receive ongoing feedback on their progress. Physical cues may be taught to the patient along with relaxing imagery or phrases.

Biofeedback has generally been shown to be effective in giving the subjects a sense of control over stress and pain (Budzynski et. al., 1973; Cameron, 1982; McKee, 1981). Budzynski et. al. found biofeedback effective for the reduction of tension headaches. Biofeedback has also produced positive effects for chronic migraine sufferers (Cameron, 1982). In a comparative study, 20 chronic pain patients were divided into four groups (Imagery with biofeedback; biofeedback; regular day treatment; control waiting group). McKee demonstrated the effective use of biofeedback to induce relaxation and decrease pain. The biofeedback group reported decreased pain, decreased depression, and an increase in leisure activity over the group receiving conventional day treatment and the waiting list group receiving no treatment. What is interesting is the fourth group, which received a biofeedback and imagery program, and displayed the best outcome (McKee, 1981).

Summary

This chapter of the practicum write up was intended as a general overview to the issue of chronic pain. Certainly, many questions remain on the nature of pain and chronic pain. The issue was raised that the definition of pain is far from complete. Merskey (1979) described pain as an unpleasant experience which may occure on both the physical or psychological plain. Many experiences may be described as painful. However, what are the gradient differences between physical and emotional pain? Perhaps a more pertinent question is what are their similarities? Another is what are their relationships to each other?

The Gate Control Theory of pain has attempted to join the somatic and psychological aspects of pain together into a comprehensible understanding of the possible causal relationship between the two. Aside from this theory, there is an absence of actual understanding into the process by which the physical and mental components may influence each other to alter pain. There is also a need for understanding into what occures to turn an acute pain situation into an extended chronic one. What interplay is there, if any, between the physical and emotional variables which supports chronicity? The answers to these questions would provide valuable information on the understanding of this process.

A number of psychological interpretations and interventions for working with individual pain sufferers were reviewed briefly. The psychodynamic approach suggested the interesting possibility that an individual's early life experience may influence their proneness to chronic pain . Some evidence was discussed which supported this perspective. Although there is some research and clinical examples, the process of such influences translating into pain is far from understood. The behavioral approach emphasized the role of reinforcing behavior on pain. Evidence was discussed which supported the concept that manipulating external behavior may alter the effects of pain.

The cognitive approaches also worked to alter pain through altering behavior, yet in this instance it was the interior behavior of perception and cognition. The efficacy of a number of specific techniques were discussed. A number of the techniques, though interesting, had not been tested to demonstrate their efficacy in the context of chronic pain. Relaxation training and biofeedback have been tested for their utility with chronic pain. They both have demonstrated a useful potential for mediating the effects of pain. .

The literature review shall now turn it's focus to a specific psychological treatment for chronic pain, hypnosis.

Hypnosis for use with Chronic Pain

Introduction

Hypnosis, as a valid phenomenon and clinical tool, has gained a considerable amount of scientific and professional acceptance within the last few decades (Baker, 1987; Fromm, 1987). As Hilgard points out, this is because hypnosis has been subjected to a growing amount of quantitative, controlled research which has enabled hypnosis to leave behind the unscrupulous associations of the past (Hilgard, 1987). There has been a burgeoning growth of hypnotic applications and techniques during this period of time spanning a wide range of settings and fields (Frankel, 1987). However, despite this growth, in many respects understanding has not kept abreast (Baker, 1987). Many of the rudimentary questions surrounding the nature, definition and theory of hypnosis still persist.

The emphasis of the treatment and client/therapist relationship has also experienced considerable amount of change over the last decade. At present the emphasis has shifted from a prescriptive use of hypnosis in which the therapist is omnipotently in control to a more naturalistic approach where much of the control and direction is transferred to the client (Baker, 1987; Frankel, 1987). This shift partially reflects a value change, but also reflects the perceived gain of empowering clients and encouraging therapeutic development beyond the doors of the clinic.

This section of the report will explore the phenomenon of hypnosis. The attempt will be made to present the primary issues and perspectives on hypnosis as they are relevant to the present and the focus of this practicum, which is chronic pain. This will involve discussing the history, experience, theory and definitions, indications and contra-indications, techniques and applications of hypnosis, at first in general and then followed with special reference to chronic pain.

History of Hypnosis

The history of hypnosis is a varied and interesting one. For pragmatic reasons this history will be kept as concise as possible. As many of the authors state, the history of hypnosis is a long one which certainly predates recorded history (Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983; Stam & Spanos, 1982). Many religious and healing practices through out history most likely included the use of hypnotic techniques. During prehistory, the visions or dreams obtained during such trance induced ceremonies or activities may have been interpreted as having descended to man from deities (Udolf, 1987).

The road to the modern use and understanding of hypnosis took a more naturalistic approach when a Swiss physician named Paracelsus (1493-1541) began to speak of the phenomenon, we now call hypnosis, as being caused by the magnetic influences of the stars and planets on people. This concept was developed into what became known as "animal magnetism" by a man named Van Helmont. By influencing magnetic fields through the use of magnets or actual touch, it was believed healing could take place (Udolf, 1987). The conceptual understanding of this healing process was that a healthy magnetic balance was being established in the treated individuals where before there had been a magnetic imbalance. It was conceptualized that this imbalance led to illness.

Franz Anton Mesmer (1734-1815) is the name which most associate with the beginning of modern hypnosis. He was an Austrian physician who received his medical degree in 1776. He picked up on the concept of "animal magnetism" and wrote his doctoral dissertation entitled, "The Influence of the Stars and Planets on Curative Powers" (Udolf, 1987). Mesmer believed, as did Paracelsus and Van Helmont, that curative powers emanated from the stars and planets. He used very flamboyant techniques with his patients; often dressing in sorcerer type garb, utilizing magnets and a wand, and at times immersing people in large baths (Rosen, 1959).

These provocative techniques became very controversial due to the often sexually suggestive nature of the healings (Udolf, 1987). Despite the many cures,.Mesmer was called before a special commission of the French Academy of Science and pronounced a fraud (McConkey & Perry, 1985). This commission consisted of some of the outstanding scientists of the day (Benjamin Franklin, Lavoisier, and Guillotine) who took a very dim view of Mesmer's claims. They explained Mesmer's phenomenon, not as "animal magnetism", but rather as workings of the imagination. Therefore it was not a physical reality and did not exist. Mesmer, who had been living and working in France, left for Switzerland with a tarnished reputation where he died, destitute, in 1815.

Due to the waxing influence of scientific philosophy during the "Age of Enlightenment", hypnosis became stigmatized as a sham. This caused a cyclical struggle for hypnosis to be accepted through out modern history (Udolf, 1987; Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983).

John Elliotson (1791-1868), a British Physician, began to use mesmerism for surgery in Britain. Despite his apparent success he was asked to stop using the technique by his medical society. When he refused to abandon mesmerism he was eventually forced to leave his hospital position (Marmer, 1959). However, another physician by the name of James Esdaile (1808-1859) read Elliotson's work and used hypnosis for minor and major surgery in India. He documented over 300 operations in which hypnosis was used successfully to eliminate pain and greatly reduce post surgical shock. The operations involved amputating tumors and limbs. Esdaile found that not only did hypnosis reduce pain, but mortality rates also dropped. He reported the mortality rate dropped from 50% - 5%) (Pulos, 1980).

Hypnosis did not receive support from the medical community as it was still held with much suspicion. Timing was also against hypnosis as nitrous oxide was discovered in 1844 as was ether in 1846. Chloroform was discovered shortly after. With the advent of

these powerful (though dangerous) anesthetics, the use of hypnosis for surgery rapidly declined as the drugs were easily administered and reliable in their effects (Hilgard and Hilgard, 1983; Marmer, 1959).

Hypnotism gained much credibility due to the work of James Braid (1795-1860) (Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983: Udolf, 1987). Braid was a British physician who rebutted the "animal magnetism" explanation of mesmerism. Rather, he stated that the phenomenon had a naturalistic root. He was responsible for naming the phenomenon "hypnosis" (from Greek for "sleep"). As the name suggests, he believed hypnosis was related to the process of sleep and was typified by increased suggestibility and a narrowed focus of attention. He remained within the main stream of the medical community of his day and was able to promote serious consideration of hypnosis by his profession.

One of the scientists who contributed greatly to the acceptance of hypnosis was a renowned and respected French neurologist named Jean Charcot (Crasilneck & Hall, 1975). He initially believed that hypnosis was a pathological condition which could be used to add or remove symptoms exclusively in hysterical patients. However, after reviewing the work and research of Ambroise-August Liebeault (1823-1904) and Hippolyte Bernheim (1837-1919), he changed his view to hypnosis being a normal phenomenon caused by suggestion (Chertok, 1984).

Liebeault (a doctor) and Bernheim (a neurologist) had worked with over 12,000 patients using hypnosis. They emphasized the role of suggestibility in hypnosis. With the approval of their ideas by the eminent Charcot, hypnosis gained much acceptance. More so than ever before the medical profession was seriously considering hypnosis as a reality and tool (Crasilneck & Hall, 1975; Udolf, 1987).

A student of Charcot, and a contemporary of Sigmund Freud, Pierre Janet (1859-1947) contributed to the conceptual understanding of Hypnosis. Janet theorized on the dissociative aspects of hypnosis and believed that hypnosis was highly concentrated awareness on the part of the subject (Hilgard & Hilgard, 1983; Udolf, 1987).

Sigmund Freud (1856-1939) studied hypnosis under both Charcot and Bernheim. Up until he developed his psychoanalytic approach he used hypnosis quite extensively with patients. Orne (1982) points out that even though Freud was exceptionally well versed in the knowledge and use of hypnosis, he moved away from his use of it (Udolf, 1987).* Udolf states that there were six primary reasons for Freud's abandonment of hypnosis:

"1. He found that not all patients could be hypnotized.

"2. Often the patient would not be benefited when informed, after awakening, of material uncovered. The patient had to participate actively in the discovery process, and the method of free association was much better suited to this than hypnosis.

"3. Hypnosis stripped patients of their defenses while they still needed them.

"4. Even when symptoms were relieved, the cure was often not permanent.

"5. Hypnosis was too time-consuming.

"6. Hypnosis had an objectionable seductive quality about it."**

After Freud's dismissal of hypnosis, it's use and research largely lay dormant until the first world war at which time it began to be used as an abreactive treatment for war trauma. This included work done by J. A. Hadfield and William McDougall during the first world war and J. Watkins following the second world war (Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983; Watkins, 1949).

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* Udolf cites M.T. Orne from a January 1982 Seminar on the use of hypnosis in treatment at the institute of the Pennsylvania Hospital.

** Udolf, pg. 8.

During and since the second world war an increased emphasis was placed on the role of researching hypnosis. Clark Hull (1844-1952) was a part of this push for stringent research requesting that sound research methodology be honored (Crasilneck & Hall, 1975; Udolf, 1987). One of the most cited researchers and theoreticians since this time has been Ernest Hilgard. He has produced a great deal of qualitative literature and quantitative research on the nature and conceptualization of hypnosis. Some of his specific research interests are that of hypnotic susceptibility (Hilgard, 1965) and hypnosis and pain control (Hilgard & Hilgard, 1983).

With the increased documentation and research of hypnosis, it has been increasingly accepted as a valid phenomenon and medical tool. In 1949 the Society for Clinical and Experimental Hypnosis was formed in the U.S.A. and later expanded to become the International Society of Clinical and Experimental Hypnosis in 1959. The American Society of Clinical Hypnosis was created in 1957. In 1955 the British Medical Association accepted hypnosis as a valid tool as did the American Medical association in 1958 and the American Psychological Association the same year. In 1960 certifying boards were set up for the use and research of hypnosis (Crasilneck & Hall, 1975; Mutter, 1985).

The Experience of Hypnosis

What is the experience of hypnosis like? There are many descriptions of the experience. A common description is that the subject may experience feelings of deep relaxation, focused or narrowed attention, and a distorted or confused sense of time (Benson et. al., 1981; Fromm et. al. 1981; Hilgard 1965; Hilgard & Hilgard,1983). Often a dissociated body sense and awareness of surroundings may occure when the subject becomes aware of only the directing voice of the hypnotist (Tart, 1970). Tart points out that at such hypnotic

depths it is not uncommon for subjects to describe the sensations in terms of expansive mystical experiences (Tart, 1969b).

There appears to be a range of experiences under hypnosis; some that focus awareness on ones self, and others that provide an expansive awareness of the surrounding environment (Sacerdote, 1977). Sacerdote (1977) refers to these different consciousness states as Introverted and Extraverted hypnotic awareness. With Introverted awareness, one may have a highly specific sensation of ones body and ego state. There may be a heightened sense of connection and control between the mind and body. An Extraverted experience would be typified by an expansive awareness and association with ones surroundings, increased imagery, and transcendence. Sacerdote states that often the experience is beyond casual verbal description and thus may be difficult to express and measure.

Udolf (1987) comments that there are behavioural or overt signs of hypnosis which can be objectively observed and measured as there are covert or subjective experiences of hypnosis which can be recorded only through self-reports. The overt signs include:*

1). Fluttering eye lids when eyes are closed.

2). Deep observable relaxation typified by decreased muscle tone, limp limbs, slow responses to questions.

3). Demonstrated literalness in the understanding and following of suggestions.

4). Excessive salivation,swallowing or tearing.

5). Observable increase in measured galvanic skin response.

6). Often there is decreased respiration (slower and deeper), heart rate, blood pressure.

7). Increased suggestibility.

8). An increased ability to tolerate altered perceptions and inconsistencies.

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* Taken from Udolf (1987), pg. 80.

The covert signs of hypnosis include:**

1. Feelings of deep relaxation and disinclination to expend any kind of effort.

2. Feelings of bodily heaviness, particularly in the limbs.

3. Feelings of numbness, tingling, or dullness in the limbs or hands.

4. Feelings of floating or lightness.

5. Feelings of detachment and being out of touch with the environment, which appears to be distant.

6. Noticing of commonly ignored distracting stimuli, such as development of itching sensations."

It appears as though the experience of hypnosis varies subjectively and with the depth of hypnosis. Crasilneck and Hall (1974) have broken down hypnotic depth to four levels. They contend that each level has associated observable phenomenon that is indicative of the hypnotic depth. The four levels and associated phenomenon include:

"Hypnoidal
- Fluttering of the eyelids
- Physical relaxation
- Closing of the eyes
- Feelings of muscular lethargy

Light trance
- Inability to open the eyes
- Deep and slow breathing
- Progressive deepening of lethargy

Medium trance
- Glove anesthesia
- Partial anesthesia
- Hallucinations

** Taken from Udolf (1987), pg. 81-82.

Deep trance (Somnambulism)
Ability to open the eyes without affecting the trance
virtually complete anaesthesia
Extensive anesthesia
Posthypnotic anesthesia and analgesia
Age regression
Posthypnotic positive and negative hallucinations
Lip pallor." *

Tart (1970) maintains that hypnotic depth is best measured on the subjective level. Shor (1962) theorized that hypnotic depth was the combination of the subjects hypnotic role taking involvement, along with the degree to which the subjects general sense of reality has been replaced with the hypnotic reality, and the depth to which the subjects' personality has become involved in the hypnosis.

Definitions and Theory

As many researchers of hypnosis will attest, there is presently no completely satisfactory theory or definition of hypnosis (Crasilneck & Hall, 1975; Udolf, 1987). There are however a number of different approaches to describing and explaining hypnosis.

One such approach defines hypnosis as one of a variety of **altered states** of consciousness (Crasilneck & Hall, 1975; Fromm, 1977; Johnson, 1981; Shor, 1959; Tart, 1969b). Shor (1959) states that most people share a societally sanctioned and reinforced reality which he calls the *General Reality Orientation* (GRO). Though there may be variance from person to person, and from time to time, it largely remains constant. Through hypnosis, or other mind-altering techniques, the GRO fades (though never completely) and is gradually replaced with another reality orientation. This new reality may provide different perspectives and meanings for the subject which may be used therapeutically.

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* Crasilneck and Hall (1975), pg 53.

Another definition is that hypnosis is a **narrowed focus of attention** (Udolf, 1987). This is reminiscent of Braids' "monodeism" concept. He used the term to describe the phenomenon of hypnosis as a highly concentrative state where the amount of stimuli within the plain of conscious awareness is limited. There is literature which is suggestive that this inner concentrative state is very similar to (if not identical to) certain meditative states (Aaronson, 1968; Benson, 1981; Hariman, 1981; Naranjo & Ornstein, 1971). Frankel (1975) noted that many techniques, along with hypnosis, often share the use of a fixed point of attention (internal or external), a passive attitude with limited awareness span, decreased muscle tone, and a non-distracting practice environment.

Deep relaxation is another referred definition of hypnosis (Benson, 1983; Benson et. al., 1981; Frankel, 1975). These authors note that hypnosis often share the same techniques and physiological responses with other relaxation approaches. Benson et. al. (1981) states that the physiological similarities are decreased respiration, (decreased O_2 consumption and CO_2 elimination), along with decreased heart-rate and blood pressure. Along with this there may be increased stimulation of the non-dominant brain hemisphere (Crawford, 1982; Gruzelier et. al., 1984). This may illicit slowed alpha brain wave activity (Hilgard, 1975) and vivid visual imagery. In fact, Tellegen and Atkinson (1974) draw the ability to imagine as the discerning quality of hypnosis.

Braid initially had defined hypnosis as a "**sleep-like state**." He believed that hypnosis was similar to the experience of just about falling asleep. He called this "neurohypnology", which literally means "nervous sleep." He later changed his understanding and definition when he began to hypnotize people with out the suggestions of drowsiness or sleep (Crasilneck & Hall, 1975; Udolf, 1987). Braid then began to attribute suggestibility as a primary factor in hypnosis.

Some literature, in particular by Schwartz et. al. (1955), Horvai (1959), and Crasilneck and Hall (1960) pointed to the key role of **suggestion** in hypnosis. Crasilneck and Hall (1960) found there was no difference (pulse, blood pressure, respiratory rate) between normal awake subjects and those who were neutrally hypnotized (no suggestions). Schwartz and his colleagues found that hypnotized and normal awake subjects had "identical" EEG patterns. They found though that the EEG patterns could become similar to sleeping patterns when the appropriate suggestions were applied. Horvai (1959) stated that often the experience of hypnosis may be sleep-like but this is dependent on the suggestions provided. The research cited strongly indicates the key role suggestion plays in the nature of hypnosis.

Liebeault and Bernheim defined hypnosis as a very **suggestive mental state** during which subjects were increasingly receptive to exterior suggestions (Crasilneck & Hall, 1975; Udolf, 1987). This is one of the more commonly used definitions of hypnosis.

There are those who hold that the phenomenon called hypnosis is not an altered state of consciousness at all, but rather is more so a function of a **conditioned response** or **role playing behavior** (Barber, 1972; Sarbin, 1950, 1984; Smyth, 1981). This perspective states that what is perceived as hypnotic phenomenon is a result of past exposure and learning of the behavior (Smyth, 1981). The subjects behave according to how they believe, are instructed, or are willing to act; not out of reaction to an altered state of any sort (Barber, 1972). Sarbin (1950, 1984) added to this stating that social role, such as performance or compliance expectations have an influence for people to act hypnotized. The person acts hypnotized because of the instructions or orders given to them by an authority figure (Doctor, Therapist, Stage Performer).

Many clinicians and researchers believe that all hypnosis is a form of **self-hypnosis** (Cheek & LeCron, 1968; Ruch, 1975). According to this theory, all hypnotic phenomenon

(externally directed or otherwise) is the result of a internal process. Therapist directed hypnosis, or heterohypnosis, is actually externally guided self-hypnosis (Ruch, 1975). Some have argued the other way around, that all self-hypnosis is heterohypnosis (Udolf, 1987). However related, it appears as though the subjective experience may be different between the two (Fromm, 1975; Fromm et. al., 1981; Johnson, 1979; Johnson, 1981). On a overt behavioral level (which includes physiological measures) there are many more similarities than differences (Fromm et. al. 1981; Johnson, 1979, 1981; Sacerdote, 1981). However, on a subjective level consistent differences are revealed between the two.

Fromm and her associates (1975; 1981) and Johnson (1979, 1981) found that self-hypnosis produced feelings of autonomy and control, rich imagery, expansive free-floating attention, and a receptivity to internal stimuli. Heterohypnosis produced feelings of surrender, concentrated attention, receptivity to a single external source, and various suggested phenomenon such as positive or negative hallucinations, regression and role playing. Sacerdote (1981) commented that the line between heterohypnosis and self-hypnosis has become increasingly vague with new research and clinical perspectives. Johnson (1981) commented that it is the the research design which will emphasize the commonalties or differences. A behavioral design will emphasize the similarities while an experiential or subjective design will highlight the differences.

At present hypnosis has not been reduced down to purely physical correlates. The current state of knowledge suggests the centrality of the roles of suggestibility and focused attention. There are definitions that incorporate some of the perspectives mentioned. Milton Erickson (1958) defined hypnosis as a state of focused attention with a receptiveness and responsiveness to suggestions. Zimbaro and his associates (1972) defined hypnosis as a state where the relationship between the cognitive process and the body is focused and amplified. This state is further indicated by increased imagery and focused concentration which buffers outside distraction. Marmer (1959) stated that hypnosis was an altered state

of consciousness typified by increased suggestibility, narrowed awareness, selective wakefulness, and restrictive attentiveness.

As is evident, a complete theory of hypnosis does not yet exist. If it did exist it would combine the measurable physical and structural variables with the subjective, psychological components (Crasilneck & Hall, 1975).

Susceptibility and Hypnotizability

It was felt important that the concepts of hypnotic susceptibility and hypnotizability be addressed in this report. It has been observed experimentally and clinically that the ability to reduce or modify pain through hypnosis is directly related to the subject's susceptibility and depth of hypnosis (Hilgard, 1987; Hilgard & Morgan, 1975; Stam et al., 1986).

Susceptibility is defined by Hilgard (1963, 1987) as a stable or long term ability of a subject to be hypnotized. Hilgard believes, and has demonstrated, that an individual's susceptibility to hypnosis largely remains the same over long periods of time. In a ten year longitudinal study Morgan, Johnson and Hilgard (1974) compared the susceptibility scores of 801 subjects and found the scores remained relatively stable (.6) over the ten year time period.

Hilgard (1965) commented that research on up to 20,000 subjects during the nineteenth century suggested that 10% of the population displayed no ability to be hypnotized, 30% could achieve a light state of hypnosis, 30% could achieve moderate hypnotic depth, and 30% could achieve a deep hypnotic state. The research of Morgan, Johnson and Hilgard (1974) already cited, indicated similar ranges of susceptibility. They found that approximately 5% exhibited no susceptibility at all, 35% could achieve a light hypnotic state, 35% could achieve a moderate hypnotic state, and 25% could achieve a deep state of hypnosis.

Udolf (1987) makes the distinction between susceptibility and hypnotizability. Where as susceptibility refers to the stable, and largely unchanging talent of an individual to be hypnotized, hypnotizability is defined as the net effect of the individual's susceptibility and situational variables. These situational variables include past experience with hypnosis, motivations, beliefs or cognitions, feelings, therapeutic setting, and the relationship with the therapist. Udolf (1987) and Hilgard (1975) stress that while a subject's overall susceptibility remains constant the hypnotizability of the individual can change as these variables change. This has led Udolf (1987) to speculate that whenever the susceptibility of an individual appears to change it is more accurately a measure of the subject's changing hypnotizability.

Hilgard (1965) comments that personality traits largely correlate poorly with susceptibility. There appears to be no significant difference between sex and susceptibility , though there may be a slight advantage for females (Gravitz & Kramer, 1967). It does appear as though susceptibility for hypnosis is highest between ages 7 to 14 and decreases with age.

Spiegel (1977) spoke of the three cognitive types: Apollonian (rational thinker), Dionysian (emotional and artistic), and Odyssean (in between Appolonian and Dionysian). Spiegel believes that highly rational and reasoning subjects make the worst subjects while subjects whom are able to easily imagine make the best. Those who are between make average subjects. This mirrors Hilgard (1974) and Tellegen and Atkinson (1974) who found the importance of the ability to imagine and be absorbed in their imaginings as being central to susceptibility.

While it may be important to recognize the evidence which suggests the relatively stable susceptibility of one to be hypnotized, it is also important to be cognizant of the situational variables which can have a profound effect on the depth of hypnosis achieved. As Hilgard and Hilgard (1983) point out, a valid measure of susceptibility is possible only if the

individual is in a hypnotizable state. This directs to the need of a therapist using hypnosis to be proficient in developing a therapeutic relationship and flexible with the use of hypnotic skills.

Indications and Contra-indications for Hypnosis

Which clients and situations are best indicated for hypnosis? The literature reviewed suggests that there is a wide range of indication for the use of hypnosis. It is best indicated for subjects who are sufficiently motivated, mentally stable and intellectually able to participate in the design of hypnotic treatment (Crasilneck and Hall, 1975; Udolf, 1987).

Hypnosis has been indicated for behavior control, reinforcing new behaviors, pain control , phobias, encouraging empowerment and sense of control, and self-esteem building (Baker, 1987; Gardner, 1981; Kline and Guze, 1955).

Hypnosis is generally contraindicated for individuals who are mentally unstable, exhibit distorted or poor judgement, and have limited impulse control (Gardner, 1981). Udolf (1987) comments that while adverse reactions have occurred and are documented they are very rare and usually the result of recovered unconscious material or unscrupulous use of hypnosis. Hypnosis is not readily suggested for clients whom are of limited intelligence, unmotivated, depressed, suicidal or psychotic (Baker, 1987; Crasilneck & Hall, 1975; Frankel, 1987; Fromm et. al. 1981; Udolf, 1987). Crasilneck and Hall (1975) also point out that hypnosis is not indicated as a technique to simply remove symptoms which serve an important function for the client. Examples include psycho-dynamically charged symptoms or the pain of an organic illness.

Most of the research reviewed on this topic suggested that the indications far outweighed the contra-indications. There was even some suggestion that hypnosis' application could be extended; in particular for use with psychotics as a tool to encourage the growth of ego or

object relations (Baker, 1981; Baker,1983). However, it was stressed that sound clinical and common sense judgement is required for the appropriate application of hypnosis in any situation.

Induction techniques

The hypnotic procedure may be generalized as having a number of components. These include, Screening, Rapport Building, Induction, and Suggestion provision(from self or guide) (Crasilneck & Hall, 1975; Margolis, 1985). After screening the subject for appropriateness, rapport is established by discussing, answering questions and allaying fears or misconceptions about hypnosis (Udolf, 1987; Crasilneck & Hall, 1975).

When the client and therapist feels prepared and comfortable to initiate the procedure there are a wide range of inductions from which to choose. The commonalty of the inductions are that they often (though not always) involve focusing of the client's attention, eye fixation, deep rhythmic breathing, monotonous repetition of a sound or phrase, stressed attitude of passivity to internal thoughts or external stimuli, use of a quiet environment and clear accurate suggestions (often of comfort and relaxation) (Benson et al. 1981; Crasilneck & Hall, 1975; Hartland, 1967; Udolf, 1987). However as Erickson points out, the contents and range of inductions are limited only by the therapist's flexibility and imagination (Erickson, 1977; Erickson et. al. 1976).

There are a number of common induction techniques which are frequently used prior to the provision of suggestions. The role of the inductions are to prepare the client for receptiveness to the suggestions. Some of these common induction techniques include:

Arm levitation: The suggestion is given that as the client comfortably sits in a chair they will become aware of a slight tingling in their dominant hand. This tingling will turn to a feeling of lightness, and soon the hand and attached arm will begin to lift and gently float

up towards the face. Often the client will be asked to imagine helium balloons attached to the wrist, progressively lifting the arm towards the face. The client is told that when the arm reaches their face they will be comfortable, relaxed and very hypnotized (Crasilneck & Hall, 1975; Sacerdote, 1981; Udolf, 1987).

Braidism: This technique was developed by James Braid, mentioned earlier in the brief history. This is an induction which many may recognize and associate with stereotyped hypnotism. The client is asked to focus their attention on an object just above their normal vision plain. It may be a spot on the wall or a small object which the therapist may hold. The fixation of the eyes in this position will naturally begin to fatigue the eye muscles. Suggestions are provided that the clients will begin to feel their eyes become heavy, tire, and wish to close. The client is told that this is the feeling of becoming hypnotized and that when their eyes close they will feel relaxed, somewhat drowsy, and hypnotized (Crasilneck & Hall, 1975; Udolf, 1987).

Flower's method: This is another well recognized induction technique. The subject is asked to look, with out any particular focus, at a facing wall. The therapist begins to count up or down to a certain number. With each number counted the client is asked to slowly and momentarily close their eyes and reopen them. They are told that with each number counted their eyes will become progressively heavier, and more difficult to open. As the difficulty increases they are told they will feel more relaxed and hypnotized. When the eyes do not open any more the counting may continue or additional suggestions of relaxation may be given to deepen the hypnosis (Udolf, 1987).

Progressive relaxation: The client may be sitting or lying down. Then by using a choice from a variety of relaxation techniques, the client's body parts are methodically focused upon and relaxed. The techniques may be autogenic in nature (imagining feelings of warmth and heaviness in the limbs), Jackobsonian (alternately tensing and relaxing

muscles), or make use of relaxing visual imagery. The client is provided the suggestion that as they feel more relaxed, they will become more hypnotized (Crasilneck & Hall, 1975; Udolf, 1987).

Imagery Inductions: With this induction the clients are asked to lie down and imagine some arbitrary objects such as an apple or baseball. They are asked to imagine what the object looks, feels, smells, and if appropriate, tastes like. After the client has experienced success with the warm up images, they are asked to imagine themselves in a certain scene. Examples may be a beach or a park. Where ever it is it is a pleasant, comforting, and relaxing scene. Again the client is asked to experience the image as fully as possible, accessing each of the senses. When the client has successfully imagined the scene they may then be given suggestions of deepening relaxation and hypnotism (Kroger & Fezler; 1976)

Theater technique: This technique may begin with some general suggestions of relaxation. Then the client is asked to imagine entering a theater and walking down the aisle and sitting down before a large screen. The client may be asked to imagine different sensory aspects of the theater such as the color of the curtain, or the pressure of their body against the imagined chair. They then may be asked to imagine that the curtain rises. The therapist may then provide suggestions of images that the client may see. An alternative of this may be to use the image of a television (Crasilneck & Hall, 1975).

Glove anesthesia: Though often part of a treatment suggestion, it is sometimes used as an induction on it's own. Sitting comfortably, the client is instructed to be aware of a particular hand. They are then given suggestions that the hand is at first beginning to tingle and soon becomes numb as if a thick leather glove has been placed over it. A simple pain tolerance test, such as pricking the numbed hand and comparing it to the hand when it is normally sensitive, may be performed to demonstrate the client's ability to control their sensations (Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983).

Confusion technique: Udolf (1987) comments that sometimes a chosen induction may not have the desired effect of hypnotizing someone. He suggests that rather than immediately changing techniques the problem be explored and subtle shifts in strategy be taken. If induction does not occur a different technique may be attempted as if it was to be used anyway. This is to minimize the feeling of failure a client may experience as a result of not being hypnotized the first attempt. If the client does not become hypnotized the Confusion technique may be attempted. As it's name hints, the client is given confusing and contradictory suggestions such as being aware of two separate body parts simultaneously or experiencing two different stimuli on a limb. The confusing messages may stimulate the client to enter hypnosis as an escape from the confusion (Udolf, 1987). As can easily be discerned, prudence and discretion are necessary for use of this last resort induction.

These are some of the more common inductions used by practitioners of hypnosis. These are by no means the only techniques used. There are many other techniques used and many variations on the inductions presented. With experience a practitioner will develop a repertoire of inductions with which they are comfortable. Within a chosen repertoire, flexibility is necessary to match the needs of the client.

Clinical Use of Hypnosis for Chronic Pain

This report shall now turn to a consideration of hypnosis' application for chronic pain. This will include exploring strategies for use directly with pain, and strategies which focus on the psychological issues as a result of pain in the individuals life.

Pain Focused Strategies

It is important that at this point a short word on the removal of symptoms through hypnosis be given. While working hypnotically with symptoms, whether it be pain or other wise, one must be sensitive to the possibility of their being psycho-dynamically charged with meanings important to the individual's maintenance. When this is the case, symptoms should not be simply removed as this might lead to the formation of a new substitute symptom to express the conflict which is less functional than the existing symptom (Meldman, 1960). As Crasilneck and Hall (1975) point out, in such cases it is important that the client receive insight of the symptoms' meaning during the process. It is for this reason that they recommend that practitioners of hypnosis also be therapeutically equipped to work with the client's psycho-dynamic issues. There is a caution for attempting to use hypnosis with unmotivated clients. Hypnosis will be most effective if the clients are motivated to receive the payoff and least effective when they are not.

For the reasons discussed, practitioners of hypnosis have largely moved away from the therapeutic emphasis of simply removing symptoms. Now the greater emphasis is to provide symptom alteration which provides the client with a more constructive approach to coping (Spiegel, 1967; Udolf, 1987). This includes altering symptoms in a manner which will render them more innocuous or functional. There are still suggestions provided for direct pain reduction, but generally not for complete elimination; especially if the pain is related to an organic lesion or psycho-dynamic conflict. The pain is viewed as serving an important function which must be respected (Meldman, 1960; Udolf, 1987).

During the review of the literature, an awareness was gained of three general categories of suggestions for pain. These included suggestions of Direct Pain Reduction, Pain Experience Alteration and Distracting Attention.

Suggestions of **Pain Reduction**, as the name indicates, are designed to directly minimize the sensation of pain (Hilgard & Hilgard, 1983; Udolf, 1987; Williams, 1983). The

intensity of the pain and the degree of suffering may be decreased by a number of methods. This includes simply suggesting the discomfort will diminish to a lower manageable level. Another is to give the suggestion of pain amnesia (Williams, 1983; Hilgard, 1980). By this the client will be given the suggestion that they will forget they are in extreme pain. They will only remember a small portion of the pain.

Another example of a direct pain reduction suggestion is to have the client use imagery. The client may imagine turning off a switch or dial in their body which in turn will turn down the pain (Hilgard, 1980; Udolf, 1987)). An alternative is to imagine a malleable image which represents the level of pain. The level of pain may be diminished by imagining the object becoming smaller in size. An example may be to imagine a red dot or ball. The client is asked to imagine the size of the dot corresponding to the level of present pain. They are then asked to imagine the object becoming smaller. As it decreases in size they may be given the suggestion their pain will decrease.

There are a number of suggestions which do not necessarily remove pain but rather **Alter the Experience**. This may be done by substituting a less bothersome sensation, such as an itch or hot or cold , for the pain (Crasilneck & Hall, 1975; Udolf, 1987; Williams, 1983). Pain may also be transferred to another part of the body which will enable the client to be more functional. The pain of a neck may be transferred to the smaller region of a finger for example.

One of the induction techniques discussed earlier, glove anesthesia, may be used to create the sensation of distinct numbness in a hand. The numbness may be tested by pinching the skin, or pricking it with a sharp object. This will display to the client their ability to control their pain sensations. By suggestion, this numbness may be transferred to specific body parts by touching or rubbing that part with the numb hand (Hilgard & Hilgard, 1983; Udolf, 1987).

Another technique to alter the experience of pain is to analyze or reinterpret the pain in such a way that it will be easier to cope with and seem less overwhelming (Hilgard, 1980; Howard et. al. 1982; Udolf, 1987). As Udolf (1987) states, the experience of pain may be broken down and re-described in non-painful components. This may have an effect of distancing the pain and creating a sense of control over it. Rather than think, "I am in excruciating pain which I can't control," a patient may be given a suggestion that they will perceive the pain as "I am aware of a synaptic response as a message is passed through my body." It is accurate, yet, less pain laden than the initial response.

Time distortion is another method by which the experience of pain may be altered. By use of time distortion the difficult times of pain may be perceptually sped up and the enjoyable pain free times may be altered to feel extended (Udolf, 1987). This is helpful for use with patients who may have to undergo painful treatments or experience fluctuating levels of pain.

Often with long term intractable pain hypnotic techniques are used which **Redirect attention away from the pain** (Hilgard, 1980; Udolf, 1987). This is a helpful strategy when the pain is very severe and the prognosis does not indicate a reduction for some time. It is also useful for periodic or short-term disabling pain. The use of dissociative suggestions are an example (Hilgard, 1980; Udolf, 1987). A patient may be given a suggestion that during times of extreme pain they will have an out-of-body-like experience. They will feel apart from their pained body. They may even imagine that if they leave the room, their body is left behind. Another example of this is to provide the suggestion of a pain killing drug-like high. Specific suggestions such as feeling care free, euphoric, relaxed, and removed can be utilized to mimic the sensation of an ample dose of a pain killing drugs. Some may be concerned that an addiction may be developed for such a set of suggestions. This may be true, but as Crasilneck and Hall state, it "is certainly more

controlled, more appropriate, and less destructive than the true chemical addiction that has been displaced (Crasilneck & Hall,1974).*

Distraction is another strategy to direct attention away from the pain. By using distraction a client may imagine that they are somewhere else in a pleasant, healthy, healing, and pain free setting (Elton et. al. 1980; Udolf, 1987). Examples may be imagining one is at a favorite beach, park, hideaway, or family gathering. As the patient begins to imagine the scene they are asked to recall, as fully as possible, the various sensory components. What do they see, hear, feel, smell and taste? This will help recreate the experience of being in the "special place" with out the association of pain.

In some respects similar to distraction, regression is a technique by which a patient is hypnotically brought back in time to a period before they had pain (Hilgard & Hilgard, 1983; Udolf, 1987). They may be asked to remember what it felt like physically and emotionally at some time of place before the precipitating accident or onset of pain. There are various images the patient may use. It could simply consist of an image of themselves before the pain, with the suggestion that they will presently feel as they did back then.

These techniques and strategies are frequently used directly with the symptom of pain. However, ingenuity and flexibility are needed to meet the needs of the wide range of clients. Hilgard and Hilgard (1983) suggest that the client be invited to participate in the creation of suitable and helpful suggestions. The clients are not passive consumers of treatment but rather are actively involved in controlling their behaviors and have much imaginative creativity to offer.

Other Strategies

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* Crasilneck and Hall (1974). pg. 140.

There is large agreement that people with chronic pain ailments are at greater risk to experience difficulty coping as a result of lowered self-esteem, increased depression, anxiety and other functional difficulties. The presence of long term pain has an increased likelihood of compounding and compromising emotional health (Elton et. al. 1980; Pilowsky, 1969; Pilowsky & Bassett, 1982; Pilowsky et al., 1977 Pilowsky & Spense, 1980; Sternback & Timmermans, 1975; Woodforde & Merskey, 1972). Aside from feelings of self-doubt, Pilowsky and Spense (1980) demonstrated there is often an abundance of suppressed anger.

The impact of chronic pain is much different than that of acute pain. By it's definition, it is pain which has persisted through time (three to six months minimum) and has begun to take on a life of it's own. This means that the pain may begin to dictate the on going and long term course of the sufferer's life. Therefore treatment of chronic pain ailments must also involve other aspects of the individuals life than just the symptom of lasting pain.

Elton, Burrows and Stanley (1980) recommend that as a part of a treatment strategy for chronic pain, which includes pain symptom specific suggestions, there is a need to address the emotional and behavioral coping difficulties of the patient. They state that hypnotic techniques may be a helpful therapeutic adjunct to overall treatment. A complete treatment package, where felt needed, may include: Self-esteem building; Assertiveness training; Improved coping strategies which includes post-hypnotic suggestions for improved coping; Ego strengthening suggestions which include calmness, awareness and confidence; Stress inoculation, phobia desensitization and relaxation training.

Elton and her associates emphasized the importance of building on the client's strengths during the process. Often in association with the chronic pain there may be an overwhelming sense of personal failure. It is important to encourage the client to change the

reinforcing pattern of beliefs and behavior which may exacerbate or contribute to the maintenance of the situation.

Applications of Hypnosis for Chronic Pain Ailments

Hypnotic techniques have demonstrated a wide degree of applicability for the treatment of pain which is either extreme in it's intensity or duration (Anderson, Basker & Dalton, 1975; Cedercreutz, 1967; Crasilneck et. al., 1955; Harding, 1967; Hilgard 1967, 1969, 1971; Hilgard & Hilgard, 1983; Hilgard & Lebaron, 1984; Margolis, 1985, 1986; Margolis & Declement, 1980; Sacerdote, 1982; Stam, McGrath & Brook, 1984).

Hypnosis has been used and found efficacious in acute pain conditions such as dental pain, burns, surgery (major and minor), and obstetrics to name a few. Dentistry has used hypnosis to reduce pain, anxiety and phobias (Hilgard & Hilgard, 1983; Kleinhauz, Eli & Rubinstein, 1985; Moss, 1963). Hypnosis has been used in the treatment of severe burns to reduce pain and inflammation, improve coping, elevate patient spirits, reduce need for drugs and accelerate healing (Crasilneck et. al. 1955; Dabney, 1986; Hammond, Key & Grant, 1983; Margolis, 1986; Margolis & Declement, 1980). Hypnosis has been used during the surgery process to calm and prepare the patient before surgery; as an anesthetic during surgery; and after surgery to reduce pain and the need for drugs and also increase the healing rate (Cheek & LeCron, 1968; Crasilneck & Hall, 1983; Fredericks, 1980; Hilgard & Hilgard, 1975; Nathan et. al. 1987). Hypnosis has also been used in obstetrics as a calming agent and pain reducer, and as seen with surgery, reduces the need for drugs during the birthing process (August, 1961; Cheek & LeCron, 1968; Omer, 1987).

The study of the treatment of acute pain with hypnosis is fascinating on it's own ground. However, it is not the focus of this report and unfortunately will not be given the full attention it is due.

Hypnosis has been utilized with a wide range of chronic pain ailments. This involves migraine and tension headaches, arthritis, back pain, phantom limb pain, temporo-mandibular jaw pain, irritable bowel syndrome and cancer pain.

Migraine headache has often been described as being vascular in cause and rarely occurs in isolation from muscular tension headaches (Ansel, 1977; Crasilneck & Hall, 1975). There is also growing evidence that there may be a bio-chemical correlate between deprived levels of Seratonin and migraine headaches (Muller-Schweinitzer, 1987; Sjaastad, 1975).

A hypnotic technique which is often used with migraine headaches is to provide suggestions of hand warming to the client (Anderson et. al. 1975; Daniels, 1976; Giavouazzo et. al. 1985; Graham, 1975; Largen et. al. 1981). With this technique the client may raise the temperature of their hands by imagining that they are holding their hands by a fire or heat lamp. Cold hands and poor peripheral blood flow are often associated with migraine headaches. This is projected as the result of dilated cerebral blood vessels in the brain which cause pain. The imagining of warmed hands and a cooled, normal forehead (often included as a suggestion) may draw excess blood from the brain to the periphery .

Davidson (1987) reported that in an uncontrolled study of 10 migraine patients, 7 received a significant improvement of symptoms after four hypnotic treatment sessions augmented by audio cassette tapes.

Anderson and his associates (1975) compared the efficacy of hypnosis to the drug prochlorperazine in reducing the frequency and intensity of migraine attacks. In

comparison, the hypnosis group (n=23) experienced a significant drop in frequency and intensity of headaches over the drug group (n=24). The hypnotherapy group experienced a median drop from 4.5 to .5 headaches per month while the drug group experienced a decrease from 3.3 to 2.9. At the end of treatment, ten (43.5%) of the hypnotic group experienced complete remission while only three (12.5%) of the drug group experienced the same.

Olness, MacDonald and Uden (1987) reported on a nine month study they performed in which they compared the efficacy of the drug propranolol with placebo and self-hypnosis on 28 children. The children were first randomly split into two groups; one propranolol and the other placebo. After three months the groups switched over to the other treatment. At the end of another three months all the children were taught self-hypnosis techniques and instructed to use the techniques for three following months. The mean number of headaches for each three month period was 13.3 for placebo, 14.9 for propranolol, and 5.8 for self-hypnosis. This indicated a significant association between decreased migraine headache frequency and the use of self-hypnosis.

Harding (1967) commented on a study involving 90 migraine sufferers who received from four to seven hypnotic sessions. Though there was no control group to compare, the treatment group reported 38% with complete relief, 32% with moderate relief, and 30% who experienced no change or were lost in the follow-up.

Friedman and Taub (1984) compared two groups of highly susceptible migraine sufferers using hand warming techniques with two groups of low susceptible migraine sufferers using hand warming techniques, one biofeedback group, one relaxation group and a control group. They found that all the experimental groups experienced comparable pain reduction while the control group did not. A follow up one year later revealed that the treatment groups still shared lasting improvement over the control group (Friedman and

Taub,1985). They found that 78% of the patients who received treatment had improved, 8% worsened, and 14% experienced no change. They recommended that long lasting benefits of treatment may be extended through yearly reinforcement sessions. They suggested that this may prove a viable alternative or adjunct to pharmacological treatment.

The research reviewed was suggestive of hypnosis' efficacy for treatment with migraine though there was a distinct lack of controlled studies.

Tension headaches are most frequently caused by muscular contraction, often in the shoulders, neck, and head (Crasilneck & Hall, 1975). As stated earlier, they are often associated with migraine headaches but they do occur on their own. The headaches may be physiological in basis, but they may also reflect personal or family conflicts with in the sufferers' lives (Crasilneck & Hall, 1975; Roy, 1984a; Roy, 1986b).

With tension headache, suggestions of evaporating tension, and lessening intensity and frequency of headaches may be helpful to the client. Crasilneck and Hall recommend leaving in a suggestion that the headaches will remain until the client is ready to give them up. This provides the client with an ability to keep the headaches if they are central as defence against an unconscious conflict.

No specific research literature was found exemplifying hypnosis specifically as a treatment for tension headache. However, some controlled research has been performed which is highly suggestive of the efficacy of cognitive approaches (of which hypnosis is one) for the treatment of tension headaches (Holroyd et. al. 1977; Holroyd & Andrasik, 1978). Attanasio and his associates (1987) have commented on the cost effectiveness of self-monitored and self-administered cognitive therapy programs in the treatment of tension headaches. However, outside of selective case examples, there is an absence of specific and controlled research.

Arthritis and back pain have been treated with hypnosis for pain relief and improved coping. There are a number of studies in which patients took part and appeared to receive some relief (Melzack & Perry, 1975). However more conclusive and controlled studies are necessary. Arthritis and back pain sufferers may be provided suggestions of decreased pain, mood elevation, deep relaxation, and improved coping and functioning ability. Sometimes, as an attempt to minimize pain killing drug use, the client may be given a suggestion that will mimic the effects of the drugs (Crasilneck & Hall, 1975).

An interesting study conducted by Domangue et al. (1985) noted the biochemical correlates of hypnoanalgesia in 19 arthritic pain patients. Following hypnotherapy for pain reduction there were significant decreases in reported pain, anxiety and depression. There were also statistically significant increases in beta-endorphins, norepinephrine, and seratonin, often referred to as the "feeling good" chemicals of the body. There was also a decrease in the plasma levels of epinephrine and dopamine which are bodily produced chemicals linked to increased depression and dysphoria.

Phantom limb pain is a baffling condition in which amputees report a continued sense of pain in the limb which was removed. As example, a patient may continue to feel an itching pain in the spot of their foot which was amputated along with their lower leg. Cedercreutz and Uusitalo (1967) utilized hypnosis in the treatment of 37 phantom limb pain patients. Of the 37 cases they found 30 received a noticeable benefit with 20 receiving complete relief and 10 receiving some improvement. In a eight year follow up, they found that 8 had remained symptom free and 10 had retained improvement. They suggested that the patients who had their symptoms return may benefit from on going reinforcement of the hypnotic suggestions.

Temporo-Mandibular Joint (TMJ) pain is a condition typified by oral hypersensitivity and sharp localized pain. It may be accompanied by misalignment of the

teeth and noises as the jaw moves. In some cases there is a physiological etiology which may be remedied by dental intervention. However, TMJ may also be related to psychological stress which creates muscular jaw tension. Hypnosis may demonstrate effectiveness for reducing the pain and symptoms of TMJ (Botto, 1987). Stam and his associates (1984) randomly assigned 61 TMJ patients to three groups (Hypnosis and cognitive coping skills; Relaxation training and cognitive coping skills; No treatment). They found the two treatment groups to be comparably effective in reducing pain. The two treatment groups were more effective than the control group.

Irritable Bowel Syndrome (IBS) is a painful condition identified by extreme diarrhea and intestinal spasms. It is a condition which is often associated with depression, anxiety, neurosis and hysteria. It has been found to be largely unresponsive to pharmacological interventions (Langeluddecke, 1985). It is increasingly being conceptualized as a psychological disorder often precipitated by an extremely stressful situation (Waxman, 1988). A suggested treatment is the use of supportive psychotherapy and hypnotherapy to induce relaxation, calm and a sense of increased control.

Harvey et al. (1989) reported on 33 IBS patients who received four 40 minute sessions of hypnosis to relieve the pain and distressing symptoms. Of the 33 patients, 20 experienced improvement with 11 patients reporting complete symptom alleviation. A follow-up at three months revealed that the improvements were maintained.

Waxman (1988) reported on eight individual case histories of IBS patients. He noted that the IBS appeared to have a severe stress reaction to a overwhelming event which occurred prior to the syndromes onset. Hypnosis was used to instill calm and desensitize the patient to stress. Waxman stated that following treatment all of the eight patients were free of symptoms. A follow-up indicated that six had maintained their freedom from IBS

symptoms. The two patients who experienced a recurrence of symptoms were successfully treated through a follow-up treatment.

Whorwell (1987) described his treatment of 50 IBS patients. He used the induction methods of eye fixation and arm levitation followed by suggestions of well-being, health, and somatic control. Whorwell reported a 100% success rate with patients under the age of 50, while those over 50 had only a 25% success rate.

The research discussed is suggestive of the therapeutic utility of hypnosis for IBS. Despite, there being a paucity of controlled research, there appears to be a high indication of hypnosis' application for IBS. Of course though, further methodologically sound research is needed to confirm hypnosis' efficacy.

Hypnosis has been used as a tool with **Cancer** patients. It has been used for several ends: reducing pain; minimizing the side effects of chemotherapy; reducing the need for drugs; and enabling the patient to remain consciously alert longer (Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983; Hoffman, 1983; Redd et. al. 1983; Sacerdote, 1966). The hypnotic techniques often used may include glove anesthesia, pain substitution, pain displacement, dissociation, time distortion, amnesia, and deep muscle relaxation (Crasilneck & Hall, 1975; Hilgard & Hilgard, 1983; Hoffman, 1983; Redd et. al. 1983).

Research completed over a one year period by Spiegel and Bloom (1983) compared three groups of breast cancer patients (control; support; hypnosis and support). A ten point Visual Analogue Scale of pain was administered every 4 months to the group members. The hypnosis and support group and the support group both registered improvement over the control group. The hypnosis group reported the greatest reductions in pain.

There is very little controlled research available which indicates the utility of hypnosis with cancer patients. However, additional research by Cangello (1961;1962), Hoffman (1983)

and Redd (1983) are suggestive of the efficacy of hypnosis for cancer and support the consideration of further clinical and research exploration.

These were some of the more familiar uses of hypnosis for chronic pain. Not to be mistaken, there are other chronic pain afflictions and situations in which hypnosis has been used. For the sake of practicality they were not all included in this discussion.

Summary

Despite the increase of research and applications in hypnosis, major questions and unknowns still remain about hypnosis. Baker states,

> " *What is the role of the "unconscious" in hypnosis? Is there unconscious learning which occurs and which can be more directly accessed and facilitated during trance? How important is susceptibility or hypnotic talent in clinical work? Is clinical hypnosis the same thing as hypnosis which occurs in the research under research conditions? Is hypnotizability modifiable? If so, how does one go about modifying hypnotic responsiveness and hypnotic talent?"*
>
> " *What kind of suggestions are most effective in hypnosis? Is there a difference between the outcome of indirect and direct suggestion? Does "in-trance" suggestion work better than post-hypnotic suggestion? What contingencies maximize compliance with suggestion, and do these vary across situations or across individuals?"* •

To answer these questions Hilgard (1987) states that carefully controlled and calibrated studies are necessary. He adds that part of this exercise of research is to discover the limits of what science can accomplish and what it cannot accomplish. Hypnosis is not a singular entity of consciousness that has clear boundaries, physiological correlates and is independent of interaction with surrounding processes (Hilgard, 1987). However, Hilgard believes that continued research will inevitably bring increased agreement on the understanding of the complex phenomenon.

• From Baker (1987). pg. 210-211.

As has been indicated there is a growing body of literature and research which is highly suggestive of the usefulness of hypnosis for modifying the experience of chronic pain. This is coinciding with an increase in interest and research linking the vital casual connection between the body and mind. Baker believes that this interest will continue to grow over the next decade with the growth and validation of behavioral medicine (Baker, 1987). Baker states that acceptance and application of hypnosis will continue to expand over this time as it is one of the technologies most suited to the study and treatment of mind-body interactions.

However, for the sake of this report and practicum, this section was designed to provide an introduction and overview of hypnosis and develop a rationale for the use of hypnosis with chronic pain patients. Though research and theoretical questions still abound on hypnosis, there is substantial evidence supporting the premise that hypnosis has application as a tool for use with chronic pain, if not as a direct moderator of the pain experience, then as a life coping enhancement tool. This is despite the lack of concrete understanding of hypnosis' nature. It is this rationale which lends support to the use of hypnosis as a treatment modality in this practicum.

Interactional: The Family

The perspectives and interventions discussed to this point have focused primarily on the individual. The remaining discussion will now turn in the direction of the relationship between pain and the family. As shall be discussed, a strong rationale will be developed which indicates that the family may have a role in the production, exacerbation, and perpetuation of chronic pain (Mohamed, 1982; Turk, Flor & Rudy, 1987; Flor, Turk & Rudy, 1987). Also, the family itself may be negatively impacted by the onset and developing chronic nature of the pain (Ahern et. al. 1985; Roy, 1982; Roy, 1985b).

Turk, Rudy and Flor (1985) point out that the traditional bio-medical model had no room for the inclusion of the family in the intervention and understanding of chronic pain. As the conventional medical model was based on the Specificity model of pain, the psycho-social aspects of the pain were not considered. The pain was perceived as intense stimulation due to some tissue injury or pathology. The accompanying treatment consisted of pharmacological and surgical interventions to block the transmission of the pain. These interventions have a demonstrated use with acute pain, but as discussed earlier, are inappropriate for pro-longed intractable chronic pain (Melzack & Wall, 1982; Turk, Rudy & Flor 1985).

The gate-control theory of pain created a conceptual vehicle which accounted for the psychological influences on pain. This understanding must be extended to include the psycho-social and interactional aspects of the family (Turk, Flor and Rudy 1987).

> " *Although the gate-control model has increased awareness of the psychological as well as sensory parameters, it has given no direct attention to the role that the socio-environmental context may play in the experience of chronic pain. That is, all chronic diseases have an impact on every aspect of life, social, vocational, recreational, and familial as well as physical. By virtue of the fact that that chronic diseases or conditions extend over time, they are likely to have major consequences for the*

> *family of the identified patient and, moreover, are subject to influence by the family and the social environment."* *

Hulka et. al. (1972) and Pratt (1976) state that 70-90% of all illness's are treated outside the auspices of the formal health care system. The family is very much involved in the care and informal treatment of those who are ill. The family often may play a role which is instrumental for the return of the sick individual to optimum health (Ferguson & Boyle, 1979; Payne & Norfleet, 1986; Wooley et. al., 1978).

These are general statements on family's role within health care. What is the family's relation to the consideration of chronic pain? The specific question then remains: Why include or consider the family in relation to chronic pain (Turk, Rudy and Flor 1985) ? This question will be addressed on three accounts. They are:

Do Families create pain?

Do families perpetuate chronic pain?

Does chronic pain have a negative impact on the family?

Does the family have an etiological role in chronic pain? Do families create pain? Violon (1985) comments that the family etiology of migraines has largely been been accepted as valid. This is not so readily the case with other chronic pain ailments. There is some indication that ones early life experience within families may be correlated with chronic pain (Engels, 1959; Frank, 1973; Hudgens, 1979; Merskey & Boyd, 1978; Violon, 1982; Violon, 1985).

Engels (1959) commented that individuals who had negative experiences in their families of origin may be more susceptible to pain in later years. He stated his clinical observations indicated that a "pain prone" person had an unhappy childhood, experienced physical and emotional abuse, had rejecting fathers and punishing mothers. Frank (1973) agreed with

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* Turk, Flor and Rudy (1987). pg. 4.

Engel. He stated that a person's early family experience was very influential on the later lives of those people. Experiences of pain, suffering and fear could create a predisposition for dysphoric negativity and pain proneness. Violon (1985) stated that her research indicated that a significant number of pain patients had experiences of emotional deprivation, physical and sexual abuse. Merskey and Boyd's (1978) research displayed that a larger percentage of patients of a non-organic pain nature had more early family disturbance than a comparable group of patients with pain of an organic genus. Hudgens (1979) said that in a group of chronic pain patients, 10 of 24 patients reported having cold, harsh, and demanding parents.

There is some indication that the death of a family member may contribute to the onset of pain in some individuals (Engels, 1959; Hill & Blendis, 1967; Hodges et. al., 1984; Hughes & Zimms, 1978). Engels (1959) raised the possibility that unexpressed emotions related to the death of a family member could be converted to pain. Hughes and Zimms (1978) observed twenty-three families of children with pain. A significant number of the families were currently experiencing or anticipating the death of a grandparent or family member. They hypothesized that the pain may have been brought on by the lack of maternal attention to the child in the confusion of the death.

Hodges et. al. (1984) did a comparative study of three groups of children, one of which was experiencing recurrent abdominal pain. Within the recurrent abdominal pain group there was the commonalty of the family dealing with issues of serious illness and death, particularly of a grandparent. Also noted about this group was that the families had experienced a decrease in argument occurrence. This may have reflected tension surrounding the death and may have contributed to the expression of emotion through pain. Hill and Blendis (1967) reported that a significant number of adult pain patients, of a non-organic nature, associated the symptoms onset with the death of a parent.

Does pain run within families? Some research indicates that there may be a relationship between chronic pain and a high incidence of familial pain or illness (Apley, 1975; Baranowski and Nader, 1975; Hodges et. al., 1984; Mohamed, 1978; Pollard, 1985; Violon, 1985; Violon and Giurgea, 1984). Baranowski and Nader (1985) noted that many behaviors and lifestyle traits are passed on from parents to children. This is of a positive and negative nature. From this concept of modelling it is possible that children may learn to copy pain behavior. Violon (1985) also speaks of how children may learn to express emotional difficulties through the physical language of pain. They may even express themselves verbally using physical terms.

Apley (1975) found in his study of children with recurrent abdominal pain that the incidence of pain with in the families was 6 times greater than that reported for the control group. Violon and Giurgea (1984) also reported that the families of the chronic pain patients in their groups had a significantly higher incidence of pain in their families than the control groups. This echoed the research observations of Hodges et. al. (1984) and Mohamed (1978). Of interest is the observation of Kreitman et. al. (1965) which indicated a close correspondence of location of pain between the child and mother who was also experiencing pain. Pollard (1985) discussed a study performed on 76 chronic lower back pain patients. Pollard found a significantly positive relationship between the severity of the patient's lower back pain and the reported number of chronic pain conditions in both the patient's family of origin and genesis. Pollard uses this as data to fuel the possibility that chronic pain behavior may be socially learned and passed on within the family. However, he does not rule out the possible influence of genetics.

There seems to be an indication that the family may play an etiological role with chronic pain. The remaining questions relate more to the process of how the influence of the family may be manifested into chronic pain.If there is an etiological link, is it on the genetic,

interactional, or behavioral level? These are difficult questions which may be explored through the use of carefully controlled studies.

Does the family play a role in the maintenance of chronic pain? At first this proposition may sound quite ludicrous. Why would family members want chronic pain to continue for one of their own? The answer may be far removed from the simplicity of this rhetorical question. However, there is evidence to suggest that family dynamics may contribute to the perpetuation of pain (Roy, 1982). The operative question is, if the pain is being perpetuated within a family by the spouse, what function does that chronic pain behavior serve for the marriage and family? What investment is there for maintaining pain behavior (Roy, 1985b)?

Meisner (1974) notes that chronic pain may fulfill a number of roles, one of which is the avoidance of uncomfortable issues or emotions. Families which are involved with overwhelming problems may feel more comfortable with the somatic illness of a child or spouse than be faced with the problem itself. The advent of chronic pain within a family member may possibly be a stabilizing element in a situation that may be otherwise disruptive (Turk, Flor & Rudy, 1987; Waring, 1977) The pain may also be used as a device to avoid unpleasant tasks, communication difficulties and sexual problems (Norfleet et. al., 1982; Payne & Norfleet, 1986; Roy, 1985b).

The contribution of the behaviorists to the understanding of the perpetuation of pain within the family has been enlightening. Fordyce's (1976) concept of reinforced pain behavior between spouses is illustrative of the process of perpetuating pain. As discussed in a previous section, the research performed by Block (1981), Block (1984) and Block et. al.(1980) displayed a significant correlation between marriage satisfaction, empathic behavior, and increased reported pain. The suggestion is that a satisfied spouse of a patient may be more solicitous to the patient's pain behavior. By unduly providing support to the

pained spouse the pain behavior may be reinforced. A study by Flor et. al. (1987) echoed this possibility as they found the reported pain level was higher for patients with satisfied marriages than dissatisfying marriages.

Research by Gil et al. (1987) compared the results of the McGill Pain Questionnaire (MPQ) and exhibited pain behavior between patients who were satisfied and dissatisfied with the social support they receive. The patients who were satisfied with the social support they received, rated higher in exhibited pain behavior but no different on their MPQ scores than the dissatisfied patients. This indicates that well-intended, though misaligned support may encourage pain behavior. Swanson and Maruta (1980) used the term "*undesirable mutuality*" to describe the situation of agreement between patient and spouse on the nature and extent of the pain. This condition is not only associated with higher levels of pain but also decreased outcomes.

There is clinical and anecdotal evidence that some forms of chronic pain may be exacerbated by increased family disruption and tension. Roy (1986a) discusses this possibility in the context of migraine and tension headache and presents four case examples which demonstrated this dynamic. He recommends that family assessment and treatment, if necessary, be offered and delivered as a routine adjunct to overall treatment.

It is largely accepted that the family does contribute to the perpetuation of chronic pain (Turk, Flor & Rudy, 1987). However, very little is known about how this process functions. What characteristics or elements of a family may translate into an exacerbated chronic pain situation, and if so by which means do they encourage continued pain? These are important questions to consider.

Does chronic pain have a negative impact on the family? There is no question that chronic pain will demand many changes within a family. Most of the observation on this question has been with the impact on the spouse (Turk, Flor, Rudy, 1987). Klein et.

al. (1968) reported that the spouses of chronic pain patients had a higher degree of susceptibility for increased symptoms of physical illness and mental stress. Ahern and Follick (1985) found that a significant number of spouses reported high levels of emotional distress. In a study, Mohamed et al. (1978) contrasted 13 spouses of depressed chronic pain patients with 13 spouses of depressed non-pain patients. In this small yet controlled sample, they found that the spouses of the depressed pain patients had more pain symptoms than the spouses of the non-pain patients.

A study performed by Flor et.al. (1987) found that 26% of the 58 spouses of chronic pain patients had significant levels of depression. The spouses of the pain patients also reported a higher number of physical illness symptoms than the control group. There was also accompanying feelings of lack of control over their lives. Shanfield et al. (1979) in a study of 44 chronic pain patients and their spouses found that the spouses were more likely to experience psychiatric distress than the norms used as the control population. Also indicated was that as distress levels increased in the patients, they also increased in the spouses.

Roberts and Reinhardt (1980) in comparing the traits and characteristics of successful and unsuccessful groups in a chronic pain behavioral management program, noted that the spouses of the patients who did not successfully complete the program had significantly higher MMPI scores of hypochondriasis and hysteria than the spouses of the successful patients. Rowat and Knapfl (1985) reported that of a chronic pain population, 83% of the spouses were experiencing health problems of a significant nature that they attributed directly to their spouse's pain. It may be illustrative at this point to remind the reader of Block's (1981) study which displayed that the spouses from satisfied marriages had increased physical responses when observing their spouses in pain. From the same study Rowat and Knapfl also found that a significant percentage of the spouses were

experiencing feelings of hopelessness and a profound sense that they were unable to help their pained spouse.

The roles within the marriage also have been reported to experience a great deal of stress (Ahern et. al., 1985; Maruta & Osborne, 1978; Maruta et. al., 1981; Rowat ,1985). Rowat (1985) noted that the roles and functioning responsibilities within the relationship may be profoundly changed. This is especially true of the sexual component of the relationship. Maruta et. al.(1981) commented that in a study of theirs 65% of the spouses and 25% of the patients reported a negative change in their marriage functioning and satisfaction since the onset of the pain. A significant number of the spouses (84%) and patients (78%) reported a great reduction or elimination of sexual activity. Likewise, they also reported a decrease in sexual satisfaction. Maruta and Osborne's (1978) study also indicated a substantial decrease in marital and sexual satisfaction amongst spouses and patients. Ahern et. al. (1985) also noted significant levels of marital disatisfaction amongst spouses of patients.

There is little information written on the impact of chronic pain on children and siblings. However the reader shall be reminded of the literature cited earlier which noted the correlation between pain or illness in the family and its relation to pain within children (Apley, 1975; Engels, 1959; Hodges et. al., 1984; Hughes & Zimms, 1978; Kreitman et. al., 1965). These authors raise the possibility that, through a number of mechanisms, a child may be more susceptible to the development of illness or pain themselves when they are raised in a like environment. Research completed by Dura (1988) demonstrated that the children of mothers with chronic pain had a significantly increased likelihood of experiencing depression than comparison populations of family's where the mothers had diabetes or no illness.

It is largely accepted that the family is vulnerable to a negative impact as a result of chronic pain in the family. Ahern et. al. (1985) state that more research is warranted, but that there is enough existing evidence to routinely include the spouse and family in the assessment and treatment of the chronic pain. Roy (1982) states that,

> "In spite of these very definite research problems and shortcomings, **from a clinical perspective, there is no question that the family factors constitute a central point of investigation to understand the origin of pain, the maintenance of pain and pain behavior and consequently treatment approaches involving the whole family. The need for well-designed prospective studies in this whole area cannot be overemphasized."** *

Family Therapies and Chronic Pain

This portion of the discussion will be used to outline some approaches of family therapy to chronic pain. There are a number of family therapy techniques which have been proposed for use with families of chronic pain patients. The modalities which will be discussed are: strategic; structural; behavioral; cognitive; and problem-centered.

The Strategic Approach to therapy is represented by Haley as it's main proponent. A search of the literature indicated that this approach has not been used to any acknowledged degree with chronic pain. However, Haley has made reference to pain in his writings (Haley 1963a). Haley (1963) stated that he believed all behavior is communication.whether it is conscious or not. Haley professed that non-organic symptoms of pain may be the nonverbal communication of an interpersonal conflict between family members.

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* Roy (1982). pg. 11.

Madanes (1981) wrote of symptoms in a spouse indicating power inequities between marital partners. A spouse who feels powerless in an unequal relationship may develop a pain which symbolically expresses this conflict. An example may be a wife who, rather than directly express her frustration and anger she feels towards her husband and his complete control over the finances, may somatize the conflict into a recurring headache.The symptom of the headache is the metaphorical acting out of the conflict. Pain in this instance, would be considered in terms of it's symbolic meaning and expression. The goal of the strategic approach would be to uncover this conflict and deal with it directly. In theory as the conflict is brought to consciousness and resolved, the symptom is alleviated.

Roy (1985) has said that the strategic model has been used very little in relation to chronic pain. Part of this reason may be the difficulty in attaching metaphorical meaning to chronic pain when the nature of etiology is not fully understood. Roy also points out that the goal of strategic therapy is the alleviation of symptoms. This is a tall order for chronic pain and has not yet been performed with complete success .

The Structural Approach has largely focused on illness and pain in children and their families. Minuchin et. al. (1978) stated that certain family structures are associated with the development and perpetuation of psychosomatic illness within children. They added that the illness often performed the role of maintaining stability in an otherwise unstable situation. The person who is sick or in pain may act as a scapegoat for all of the family's problems ("Everything would be better if he did not have pain!"). This may fill the function of deflecting attention away from outstanding problems in the family or refocusing the families' attention on a problem which may be perceived as less threatening to the integrity of the family.

Leibman et. al. (1976) described an uncontrolled study involving 10 children experiencing psychogenic abdominal pain and their families. These families demonstrated elements of

enmeshment, over-involvement, rigidity, over-protectiveness, and lack of conflict resolution. In this family system, the child may become the focus of concern or the "scapegoat" for the families problems and thus deflect attention away from integral problems.

Berger et al. (1977) described a number of cases in which behavioral techniques and structural therapy was used with the families of children with abdominal pain. They reported a high success rate of symptom remission following treatment.

Lask (1984) reports on a case in which a young girl's family was treated with structural family therapy as an attempt to alleviate the young girl's abdominal pain. Through the course of treatment it was revealed that there was a considerable amount of tension in the family as a result of unexpressed anger between the parents. As these issues were dealt with the abdominal pain disappeared.

Roy (1985) raises the question of whether the structural approach would have valid application to adults who do not want to change their behaviors. Kunzer (1986) does discuss the use of Structural Family Therapy in the context of an adult spouse with chronic pain. She emphasizes that therapy may be used to challenge dysfunctional marital transaction patterns which reinforce or perpetuate pain. New functional behavior patterns may be taught to replace the old. In this respect Kunzer states that a structural approach may be helpful in the treatment of chronic pain. Again, however, there is a paucity of supportive research.

The Behavioral Approach has been referred to a number of times previously in this report. It is based on Fordyce's (1976) concept of pain behavior being reinforced or rewarded by accommodating behaviors of the well family member or spouse. According to behaviorists this may happen through the direct support of pain behavior, the indirect reinforcement by avoiding negative consequences of the pain behavior, and the failure to

recognize and support well behavior. The research previously cited gives support to this proposition through observation of spousal response to pain patients (Block, 1981; Block, 1984; Block et. al., 1980).

Lieberman (1979) commented on a presenting case of a migraine headache. The husband appeared to demonstrate attention and affection to this wife, yet only when she was experiencing a headache. This was pointed out to the husband and he was coached to pay attention to the positive behavior of his wife. There was a marked improvement in their marital functioning and the individual functioning of the wife.

Hudgens (1979) reported on the use of behavioral treatment and family therapy for 24 families in an uncontrolled study. Hudgens indicated that following treatment, 75% of the patients were able to lead satisfactory lives and 83% of the patients who were away from work returned to work.

Moore and Chaney (1985) described a study in which comparisons were made between a cognitive-behavioral 16 week patient program which looked at three groups (spouses included in treatment; patients only; waiting list of patients not receiving treatment). Both of the treatment groups reported improvement over the control waiting group in respects to decreased pain behavior. However, the treatment did not seem to have any positve impact on the functioning of the marriage and marriage satisfaction.

While the behavioral approach does display success in treating situations of spousal support of chronic pain behavior, Roy (1985) states that it may not be fully cognizant of the extended interactions in a family which may contribute to the pain experience. On this level it may prove to be an incomplete diagnostic and treatment tool

The Cognitive Approach to family therapy is represented by Waring (1982). He stated that his clinical observation of families where chronic pain was present indicated that there

were often problems of marital intimacy. His assumption is that the problem in intimacy is related to the extent of pain. Therefore the function of therapy is to enhance the intimacy between the couple by the use of intimacy raising exercises. Waring theorized that as the level of intimacy increased, the level of pain would decrease.

The treatment begins with an extensive assessment in which all members of the family participate. An assessment would include all the individual members' perceptions of the illness and marriage.The elements of intimacy explored are affection, cohesion, expressiveness, compatibility, conflict resolution, sexuality, autonomy, and identity. At the end of the assessment the couple is invited to enter treatment for ten, one hour sessions in which the goal is to raise the intimacy level of the couple.

There is only one uncontrolled study to date which indicates the effectiveness of cognitive family therapy and this was not in the context of chronic pain (Russell, Russell & Waring, 1980). Waring (1982) does describe the case example of a couple involved cognitive marital therapy where the wife suffered from arthritis. He stated that following treatment there was improved marital adjustment.

Problem Centered Systems Family Therapy for chronic pain draws it's basic tenets from the systems approach to families (Epstein & Bishop, 1981; Epstein et. al., 1982; Roy, 1984; Roy, 1985; Roy, 1986b). These systemic concepts are:

1). The parts of the family are interrelated;

2). One part of the family can not be understood in isolation from the rest of the system;

3). Family functioning can not be understood by understanding each of its parts;

4). The family structure and organization are important factors determining the behavior of family members;

5). Transactional patterns of the family system shape the behavior of the family members

(Epstein & Bishop, 1981; Epstein et. al., 1982).

The working model of Problem Centered Systems Family Therapy (PCSFT) is the McMaster Model of Family Functioning (MMFF). They were developed by the desire to move away from family interventions based solely on clinical judgement and intuition, and move towards an operationalized and structured model of assessment and treatment of families (Epstein & Bishop, 1981; Epstein et. al., 1982). It was intended to aid in the assessment and treatment of families as operationalized changes in family functioning could be tangibly detected.

The PCSFT and MMFF are based on research which was conducted to develop an understanding of how healthy normal families function (Westley & Epstein, 1969). The research project entitled, "*The Silent Majority*" considered psychiatric and sociological variables of over 100 families to determine how they functioned (Westley & Epstein, 1969). The research gave strong indication for the need of a systemic approach to understanding and treating families.The great influencing power of the family was recognized as being more powerful than the intra-psychic factors previously focused on in other family therapy frameworks (Epstein & Bishop, 1981).

The MMFF grew out of this research and has continued to evolve since that time (Epstein & Bishop, 1981). The research indicated that effective family functioning was correlated with certain behaviors displayed in the dimensions of what developed into the MMFF. Having an operationalized understanding of the elements which comprise healthy family functioning was perceived as helpful for standardized assessments and indications of treatment.

The process of therapy with this model includes four macro stages; **Assessment, Contracting, Treatment, and Closure** during which the focus is on six dimensions of family functioning. These six dimensions are:

1). **Problem Solving;**

2). **Communication;**

3). **Roles;**

4). **Affective responsiveness;**

5). **Affective involvement;**

6). **Behavioral control**

(Epstein & Bishop, 1981; Epstein et. al., 1982; Roy, 1984; Roy, 1985; Roy, 1986b).

The first stage of PCSF involvement is **Assessment.** The purpose of the assessment is to orient the family to the treatment process, identify and describe the structure, organization, and interactional patterns of the family, while clarifying the families' problems (Epstein & Bishop, 1981; Epstein et. al., 1982). It is generally comprised of four steps: Orientation; Data gathering; Problem descriptions; and Clarifying and agreeing on a problem list (Bishop, Epstein & Baldwin, 1980; Epstein & Bishop, 1981; Roy, 1986b).

The *orientation* sets the stage for the duration of involvement. The therapist may begin by explaining the rationale for including the entire family in the treatment process. This may be may done by reframing the individual family member's pain into the context of being a family issue. The chronic pain, which is affecting the identified sufferer, will surely make it's presence known through out the entire family by the way it effects the other family members (Roy, 1986b). What effects one person in a family also effects the family as a whole, and how a family operates will also effect a family member.

The family is told prior to starting treatment that the change to expect will not be necessarily less pain, but rather improved family functioning (Roy, 1985). It may occur that pain will

diminish as a result of improved family functioning but that is not the intended purpose. Roy (1985) hypothesized that reduced family tension may be transmitted to reduced muscle tension which may lead to reduced pain levels for some conditions exacerbated by muscle tension.

Each family member is given an opportunity to express their view of the presenting problem which in this case may be the chronic pain. Information is gathered on the presenting problem, which includes each family member's perspective on the problem's nature and history, precipitating event, affective components, and how it effects each family member. The therapist may then provide their own understanding of the problem for clarification purposes (Bishop, Epstein & Baldwin, 1980).

Roy (1986b) makes the comment that an ongoing task of the therapist will be to move the families' preoccupation away from chronic pain. All too often the family members will state that there would be no problems at all if a cure was found to remove the pain. The therapist works to reframe pain in terms of it's effect on functioning of the family.

The discussion of the presenting problem provides an opportunity to begin the *data gathering* to determine the functioning level of the family. Within the context of the problems being discussed, appropriate questions are asked which enable the therapist to assess the families' functioning on the six dimensions mentioned. A brief discussion of each of the dimensions is warranted to help create an understanding of the MMFF.

Problem Solving is defined by Epstein and Bishop (1981) as a families ability to resolve problems to the extent that effective family functioning is maintained. Westley and Epstein (1969) demonstrated that families which functioned effectively or ineffectively did not have a difference in the amount of problems they faced. Rather the difference was how they dealt

with problems. Effective functioning families were more able to solve problems than ineffective families.

Problems are divided into instrumental and affective categories. Instrumental problems are those which relate to the material needs of the family such as the children being fed, finances, and house cleaning. Affective issues are problems which involve family members' feelings (Epstein & Bishop, 1981).

Epstein and Bishop (1981) state that a families ability to resolve both instrumental and affective problems depends on their capacity to.move through seven identified steps of problem solving. The first step is *identifying the problem.* Who recognizes the problem and how? Are they the family member that usually recognizes problems? Is the problem correctly identified?

The next step of problem solving is *communication of the problem.* Who is told of the problem and is that person the appropriate person to be told? The third step is the *development of action alternatives.* What types of plans are considered, and how are ideas brought forth? Do all the family members contribute? Are the action alternatives appropriately solicited from relevant family members? The next step of problem solving is whether the family is able to *decide on one of the alternative plans suggested.* Was a decision made? How was the decision made and considered? Who made the decision? Were the appropriate family members consulted and informed of the decision?

Once a decision was made on what to do, *was the action carried out* ? Was the action carried out completely and in an appropriate manner? The sixth step involves *monitoring the action* ? Who made sure the action was carried out? Was it monitored? The final stage of problem solving is whether the family *evaluates the effectiveness of the action carried out* ? Does the family attempt to learn from their problem solving actions to improve their abilities by recognizing what worked and what did not?

It is suggested that the most effective problem solving families are those which are most able to move through all of the stages (Epstein & Bishop, 1981; Epstein et al., 1982)

The next dimension to be considered in a MMFF assessment is that of **communication**. Communication is defined as how information is verbally exchanged within a family (Epstein & Bishop, 1981). The nature of information may be instrumental or affective. The communication patterns may be assessed on a range of clear vs masked and direct vs indirect. Clarity of communication refers to the clarity with which the information is passed. Is the message clear enough so that it may easily be understood or is it hidden, confused or masked? Directness refers to whether the message is sent to the person intended, or if it is sent to someone else. From these dimensions of communication four patterns may emerge:

1). Clear and direct
"*I'm so angry at you because...*"
2). Clear and indirect
"*I sure get angry when people...*"
3). Masked and direct
"*Bill! I don't want to have tofu tonight* !"
4). Masked and indirect
"*I really hate Chinese food* !"

Epstein et. al. (1982) conceptualize the healthy pattern of communication that will lend it self to effective family functioning is clear and direct communication on both affective and instrumental issues. Masked and indirect is least associated with healthy functioning.

Roles in a family refers to individual family member's patterns of behavior by which the families' function needs are fulfilled (Epstein & Bishop, 1981). The types of role functions can be divided into instrumental and affective. As before, instrumental refers to the material

needs of a family, while affective refers to the emotional needs of the family members. Epstein and Bishop (1981) note that roles are categorized into two additional divisions called *necessary family functions* and *other family functions.*

The necessary role functions include meeting the instrumental, affective, and mixed needs of the family. The instrumental refers to the role of securing and providing adequate material provisions such as food, shelter, clothing and money. The affective roles which need to be fulfilled in a family includes the provision of adequate emotional nurturance and support to each of the members (parents and children) and the sexual gratification of the marital relationship.

The mixed needs of the family include meeting the challenges of life skills development. This refers to how the family functions to enable the members to develop through life stages. How are the family members enabled and prepared for school, relationships with the opposite sex, getting employment, moving out of the house, personal development, retirement and so on? Another mixed need function of the family is the maintenance and management of the family. Who looks after the money? How are decisions and rules made in the family, and ultimately by whom? What are the family standards of behavior and how are they maintained?

The other family functions considered under the roles dimension of the MMFF include an exploration of the particular families' uniquely established role functions. This includes, both adaptive and maladaptive functions. Also considered are role allocation and role accountability. Allocation refers to how the responsibilities of the family are assigned and the appropriateness of to whom. Accountability refers to the measures taken to monitor and ensure the responsibilities are being fulfilled.

Epstein et. al. (1982) state that roles are most effectively fulfilled when the necessary functions are clearly and appropriately allocated to family members and there there is an

accountability present which encourages the members to effectively carry out their responsibilities. They state that that the role functioning of a family can be evaluated by considering:

"1). Are all the necessary functions being fulfilled?

"2). Has the family reached a working consensus regarding the allocation of roles? If consensus has not been reached, it is possible that one or more role functions will be poorly fulfilled.

"3). Is the allocation of family members to roles appropriate? A family can err by expecting someone to fulfill a function which he is not capable of carrying out, or by overloading a particular individual with too many functions.

"4). Has there been an appropriate allocation of authority (power) to go along with the allocation of a particular function? For example, a family cannot ask an older child to baby-sit and then not provide him/her with the power to maintain reasonable control.

"5). Is there a procedure within the family for making sure that the jobs are carried out?

"6). Is there cooperation and collaboration within the family in the accomplishment of role functions?

"7). Is there sufficient flexibility within the system to permit reallocation of roles when and as needed?"*

Affective responsiveness refers to the families capacity to respond to issues and each other with a full and appropriate range of emotions (Epstein & Bishop, 1981). Emotions are categorized into two groups: Welfare and Emergency. Examples of welfare emotions are happiness, compassion, caring, joy and love. Emergency emotions are anger, fear, depression, sadness, and disappointment as examples. Does the full range of emotions get expressed in the family, and when expressed are they congruent with what has happened? Does the family seem to express only a limited range of feelings (welfare or emergency), or

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* Epstein and Bishop (1981). pg. 462-463.

does the family respond with the emotion that is appropriate? When the members do respond, is the intensity of response appropriate, too high, or too low?

Epstein et. al. (1982) state that the most effective pattern of functioning for family is when the full range of emotions are expressed in quantity and quality, appropriate with the nature of the stimulus. The least effective functioning occurs when the family has a limited repertoire of expressed emotions and/or the degree of expression is not consistent with the stimulus.

Affective involvement is defined by Epstein and Bishop (1981) as the quality and extent to which the family members display an interest in the other family members. They describe six styles of possible affective involvement within a family. These are:

1). Absence of involvement: The family members relate much as "lodgers", with no interest or connection other than the instrumental functions they may share.

2). Involvement devoid of feelings: The investment in others is limited to intellectual involvement. Otherwise there may be no emotional involvement between except at select or demanded times.

3). Narcissistic involvement: The involvement is limited to serving the family member's own needs without an interest in the other members' needs.

4). Empathic involvement: A genuine emotional interest of a family member in the other family members activities and feelings.

5). Over-involvement: An overinvestment of interest in the the other family members which may be intrusive, troublesome and disturbing.

6). Symbiotic involvement: A situation when the involvement may be so strong that the individual family member's boundaries may be difficult to discriminate from the others.

Epstein et. al. (1982) state that empathic involvement is the most functional style of affective involvement. The styles on either extreme, absence of involvement and symbiotic involvement, are the least effective.

The last dimension considered in an MMFF assessment is **Behavior control.** Behavior control is defined as the style of rules a family uses for handling behavior (Epstein & Bishop, 1981). There are three identified areas where behavior controlling rules are often applied. *Physically dangerous situations* such as where children may have to be cautioned or restrained for their own or others' safety. *Situations involving the meeting and expression of psycho-biological needs* such as sleep, hunger, eliminating, aggression and sex. Also, *situations involving interpersonal socializing behavior* with in family members and out of family members.

There are four identified styles of behavior control.

1). Rigid behavior control allows little if any flexibility for altering rules and standards regardless of the nature of the situation.

2). Flexible behavior control allows the family standards and rules to adapt according to the needs of present circumstances.

3). Laissez-faire behavior control exists in families where there are no established rules and there is a wide range of allowed behavior.

4). Chaotic behavior control occurs when the rules and/or style of behavior control is inconsistent. This may create extreme confusion and family dysfunction.

Epstein et. al. (1982) view a flexible pattern as the the most effective style of behavior control. Rigid, laissez-faire and chaotic are described as becoming progressively dysfunctional patterns of behavior control. A healthy functioning family is one where there is a clear understanding of the rules for behavior which are appropriate and consistent, and demonstrate the flexibility to adapt to changing situations. An unhealthy functioning family may demonstrate unclear and/or inappropriate standards. They may have either extreemly rigid rules, or no rules at all.

This completes the family functioning dimensions of the MMFF. Epstein and Bishop (1981) state that as a part of a complete MMFF assessment *additional investigations* into the family's life. This includes an exploration into the social, educational, and vocational environment the family is a part of, and lives in. It is also useful to gather a developmental, medical, and psycho-social background of the family and it's members. It may be determined during the assessment that additional medical or psychiatric assessment and care are warranted.

During the assessment, when it is determined that enough information has been gathered on the presenting problem, other problems in the family may be explored. This may be done simply by asking what other problems or difficulties the family is faced with (Epstein and Bishop, 1981). As with the presenting problem, the other problems are given full and appropriate exploration. As the problems are explored, the therapist conducting the assessment is provided further opportunity to test his or her hypothesis on the family's functioning abilities. This is done by assessing the various MMFF dimensions in the context of the other issues. This will enable existing patterns of functioning to be made clear and provide increased data to support the final assessment.

When the assessment has been completed the next steps include *Problem description* and *Problem clarification*. Epstein and Bishop (1981) include this as the final steps of the assessment. Roy (1986b), who has applied the use and research of MMFF and PCSF therapy to chronic pain, combines these two steps with the Contracting stage.

Roy (1986b) states that the task following an assessment is to identify the problem issues and create a list of problems which all the parties agree upon. This is where the macro stage of **Contracting** begins. With problem description, each of the present parties has an

opportunity to express what they feel are the important problems. The therapist also adds their perceptions of the problems.

When the problems have been listed the next step is to clarify the problems. This implies obtaining a workable agreement from the family on what important problems are facing the family. Epstein and Bishop (1981) describe possible difficulties at this step. They include disagreements between family members and disagreements between a family member and the therapist on the clarification and agreement of the families' problems. If a disagreement between family members occurs Epstein and Bishop suggest that the therapist may attempt to negotiate a resolution between the individuals. If this is ineffective and the issue is not an integral one, a temporary arrangement may be negotiated by which the two members may "agree to disagree." The issue may be returned to later in therapy.

The same approach may be used in a disagreement between the therapist and a family member. A negotiation may be attempted. If this fails to reach agreement they may then "agree to disagree" for the time being, and return to the issue later in therapy. Epstein and Bishop point out that if the disagreement is over a problem which is central to the families functioning it may be important for a resolution to occur before therapy proceeds. If agreement does not come, an outside consultation with another therapist may be offered. If this does not yield a satisfactory result the family may be told that the identified issue is seen as being central to the family's problems and that continued therapy with out due attention to this problem would be ineffective at best. If the disagreement continues therapy may be discontinued. Epstein and Bishop (1981) point out that this event rarely happens and most disagreements either are resolved or disappear during the course of therapy.

Following a workable agreement on the problem list Epstein and Bishop (1981) state that the family should be oriented to their present options (ie. do nothing; solve problems on their own; go elsewhere for treatment; continue on for treatment). The therapist may outline

how they may assist the family in what ever option they choose. Having chosen treatment Epstein and Bishop state the next steps are negotiating expectations and goals and signing a contract. On each problem the family is directed to negotiate an agreement of what they would accept as a successful goal. For example, if a problem is a family member not getting up in time every morning and being late for work, a reasonable expectation or goal would be that the person be up and at work on time. The role of the therapist would be to help the family members express their goals clearly in terms that can be measured behaviorally. The therapist is also available to rework unrealistic expectations into operationalized goals.

Following an agreement on the expectations and goals for the problems Epstein and Bishop suggest a formal treatment contract be signed by the family members and the therapist. This contract would outline the problems, family expectations and goals. Also included are the therapist's treatment expectations which may include: all family will attend sessions as requested; the family will call in advance if they are unable to come; and the family will work hard (Epstein & Bishop, 1981). Generally the therapist and family may contract to meet for three to six sessions staggered by a number of weeks each.

The next macro stage, **Treatment**, may begin with a brief orientation followed by priorizing the problems to work on, setting tasks, and evaluating the tasks (Epstein & Bishop, 1981; Epstein et. al., 1982). Roy (1986b) includes the task setting as a part of the contracting stage but the order of steps is largely unchanged so the difference is only semantic. The orientation might simply include a statement that since an agreement has been met between the family and therapist to collectively work on the issues, they proceed. With the families authorization to proceed, the next step may be to priorize the problems in the order the family wishes to work on them. The therapist may assist the family members to negotiate the order of problems to work on and generally intervene only if the priorized order is counter-productive to effective treatment (Epstein & Bishop, 1981).

When the problems have been priorized the next step of treatment is to develop and assign tasks which will assist the family in moving towards and reaching their stated expectations and goals. The tasks are set by having the family members negotiate amongst themselves. As Epstein and Bishop (1981) state, the tasks should outline each family member's responsibilities. It may occur that a family will be unable to think of an appropriate task. If this happens the therapist may offer a suggested task for the family's consideration. Epstein and Bishop (1981) outline some principles to follow when task setting.

"1). The task should have maximum potential for success."

"2). The task should be reasonable with regard to age, sex and socio-cultural variables."

"3). Tasks should be oriented primarily toward increasing positive behaviors rather than decreasing negative ones. Families often ask someone to stop a behavior rather than asking him/her to do something. We prefer to request positive actions."

"4). A task should be behavioral and concrete enough so that it can be clearly understood and easily evaluated."

"5). A task should be meaningful and important to everyone involved."

"6). Family members should feel that they can accomplish the task and they should individually commit themselves to carry out their part."

"7) Emotionally oriented tasks should emphasize positive, not negative, feelings. Fighting, arguing and open display of hostility should be discouraged."

"8). Tasks should fit reasonably into the family's schedule and activities."

"9). Overloading should be avoided. A maximum of two tasks per session is usually reasonable."

"10). Assignments to family members should be balanced so that the major responsibility for completing a task does not reside with just one or two members."

"11). Vindictiveness and digging up the past should be avoided, with the focus placed on constructive dealings with current situations." •

• Epstein and Bishop (1981). pg. 471-472.

The process of treatment includes the session to session monitoring, evaluation, and resetting of tasks. Epstein and Bishop (1981) state that a family member should be assigned to report back on the task accomplishment during treatment sessions. As the family's goals are satisfactorily reached, new tasks are negotiated for the next problem on the list. If treatment goes smoothly, task setting and evaluation continues for each of the problems. There may new priorities negotiated and possibly recontracting may occur as the family changes in treatment. As a part of the task evaluation it may be determined that the existing task can be improved upon. The task may be renegotiated or a simpler task may be created.

Epstein and Bishop (1981) point out that if a family does not show improvement on task achievement after three sessions it is important for the therapist to address this issue to the family. The family may be asked if they are still committed to working with the therapist on the identified problems. If not, treatment may be terminated and the family directed elsewhere if appropriate. If the family states it is still committed to treatment a consultation with another therapist may be offered to get the treatment on track. If the family refuses this suggestion or does not demonstrate later commitment and improvement, treatment is terminated.

Upon meeting of all the family's treatment expectations and goals, **Closure** is the final macro stage. Epstein and Bishop (1981) identify four steps of closure: orientation; treatment summary; long-term goals; optional follow-up. The orientation would consist of indicating to the family that the goals have been met and it is time to end treatment. The therapist may then ask the family members to summarize treatment and discuss what they have learned. As the family discusses the summary, the therapist may verify or add to the family's perceptions of treatment. The family is also asked to discuss and determine some long-term goals. What specific or general goals do they have for the family? The family is

asked to discuss their current problem solving abilities: how they know when a problem arises and what will they do. Which issues do they anticipate may cause problems? The family is given encouragement on their skills to solve problems but are provided clarification that they may return for assistance if necessary.

Though an option, a follow-up session may be set for a future time to monitor the family's new functioning ability. The follow up session would be set far enough in the future so that the family could have a sufficient opportunity to problem solve with new issues.

Conclusion

Problem Centered Systems Family Therapy and it's assessment tool, the McMaster Model of Family Functioning represents a method for understanding and treating chronic pain within the family. Roy (1985) qualifies that very little direct application and research of this approach to chronic pain has been performed to date. Flor, Turk and Rudy (1987) comment that at present, there is simply an absence of research which supports the superiority or efficacy of this approach over any of the others discussed. This indicates the need for methodologically sound, controlled research to be performed.

However, the current evidence, as outlined in this report, indicates there is an immediate need therapeutically to address the often negative relationship between chronic pain and the family. Though methodologically incomplete, the research literature is suggestive of the the family's role in perpetuating chronic pain and possibly generating the incidence of chronic pain. The negative effect of chronic pain on the health of the spouse and children appears to have validity. Chronic pain may also severely incapacitate a family's ability to function effectively.

There are advantages to utilizing PCSFT for this end. PCSFT was developed in a medical setting for the purposes of expanding treatment to the family, thereby providing a more complete perspective and service. PCSFT is based on the systems view of the family as is Structural and Strategic family therapy. This provides an advantage over the behavioral approach which was helpful in addressing the behavior aspects of the family, but was not equipped to account for the inter-relational aspects of the family and it's possible effect on pain. The PCSFT not only has the strength of a behavioral approach, but also the added understanding of an interactional approach which it shares with the structural and strategic schools (Roy, 1985).

As was discussed in the introduction, the PCSFT has grown out of a desire for a model of assessment and treatment based on research observations. The research, which led up to the development of the MMFF, provides a considerable amount of strength to the PCSFT. Research does not exist to this extent in support of the other treatments' perspectives. This reduces the air of speculation surrounding the model of understanding on which the PCSFT is built. Rather than being solely based on theory and perhaps weak research, the PCSFT has a sound foundation in controlled research.

The steps and dimensions of PCSFT have been operationalized. This has a number of advantages. Unlike the other modes of family therapy, there is a specific sequence of steps to follow. Along with the theory, there is an actual structure to treatment. Following the model, a therapist is always cognizant of where they are in the process of assessment and treatment. This provides increased clarity and ease of assessment and treatment. It also adds a uniformity which may be shared amongst practitioners or researchers for a more standardized treatment.

The MMFF also provides operationalized indices for evaluation. The various dimensions of the MMFF have been drawn from research. They can be used as a valid measure of

changes in a families' functioning. This aids a therapist to determine the effectiveness of treatment. If treatment has been effective there will be a reliable shift in the dimensions towards optimum functioning. The other treatments discussed do not have such a built in tool. This decreases the standardization of their assessment and increases the role for subjective impression.

Another advantage of PCSFT is that it has been used to a greater degree with chronic pain than the other interactionally based treatments discussed. This does not suggest that PCSFT is more efficacious than the Strategic, Structural or Cognitive therapy perspectives with chronic pain situations. This has simply not been tested. What is suggested is that at the current time, PCSFT has had more clinical application to chronic pain situations than the other treatments.

For the reasons and rationale developed and discussed, the PCSFT was chosen as the mode of family treatment for use with families in this practicum.

The Practicum Experience

Introduction

The section will introduce, describe, and analyze the practicum experience which commenced in October, 1988 and concluded in April, 1989. The practicum involved the use of Problem Centered Systems Family Therapy (PCSFT) with two couples and one family. The commonalty was that each family or couple had a family member suffering from a chronic pain ailment. The practicum also included the use of hypnosis as an adjunct treatment for six individuals who suffered from a chronic pain ailment.

This portion of the report will begin by outlining the overall structure of the practicum. This will include a discussion of the practicum's intended Purpose, Setting, Client Recruitment, and method of Case Evaluation. Following this, as there was a dual focus to the practicum, the family therapy and hypnosis sections of the actual practicum experience will be presented and explored separately.

Each of the family therapy and hypnosis sections will begin with a discussion of the utilized techniques and goals for treatment. Each of the involved cases will be presented and discussed separately. The case presentations will include the client or family description, the client's perspective of the problem, the therapist's diagnostic impressions, the therapeutic plan and recommendations, discussion of treatment, treatment out comes, and evaluation measures. Following the case presentations of each section, there will be a discussion during which the important treatment themes and elements will be addressed.

The practicum report shall end with a conclusion in which the relevant issues, future recommendations and personal learning and skill development will be discussed.

Purpose

The purpose of this practicum was to develop my understanding and utility of Problem Centered Systems Family Therapy (PCSFT) and hypnosis as treatment tools to mediate the experience of chronic pain with individuals, couples and families. Along with direct skills acquisition, the use of a single case design analysis was utilized to provide an indication of the interventions' effectiveness in moderating the experience of chronic pain. Of course, this is by no means intended to replace the use of controlled, methodologically sound research, but it is hoped that it may shed some suggestive light on the efficacy.

A question to be explored during this practicum would be, do the treatments of PCSFT and hypnosis have utility in moderating the effects and experience of chronic pain? For both, PCSFT and hypnosis, moderating may be understood as the ability of the treatment to enable the individual, couple or family to more effectively cope and function in consideration of the pain (Elton et. al., 1980; Roy, 1985). This does not exclude, yet certainly does not preclude the primary intention of treatment being the removal of pain. As Roy (1985) pointed out, the complete removal of chronic pain, though ideal, is a highly unrealistic treatment goal considering the present lack of success of all treatment modalities with this endeavor. A more realistic goal is to empower the clients' to realize and utilize the latent strengths and abilities they possess for the purpose of effective coping.

Practicum Setting

The primary settings of the practicum took place at a number of sites. These included the St. Boniface Hospital Pain Clinic and the Psychological Services Center located on the University of Manitoba Fort Garry campus. The St. Boniface Hospital Pain Clinic is a small treatment clinic which provides medical and psychological assessment and care for

outpatient chronic pain patients. A number of the clients involved in this practicum were referred through the clinic. Very little of the actual practicum took place at the clinic. Due to difficulties in obtaining space to conduct sessions at the hospital, a number of clients were seen at Prof. Roy's office on the University of Manitoba campus.

A large part of the practicum occurred at the Psychological Services Center. The Psychological Services Center (PSC) is an academically based clinical instruction and research facility. The facility is directed by clinical Psychology and Social Work faculty on campus. Graduate Psychology and undergraduate and graduate Social Work students are provided supervised clinical training as a part of their field and practicum experiences. A wide spectrum of psychological therapeutic services are provided. This includes individual, couple, family and group based therapies and interventions. The PSC provides excellent recording facilities and training resources for the students to access. Most of the clients involved in the practicum were seen at the PSC.

Client Recruitment

The clients, couples and family were selected according to the criteria that a chronic pain ailment be identified. The range of chronic pain ailments included: Migraine Headache (3); Lower back Pain (1); Temporo-Mandibular Joint Pain (1); Juvenile Rheumatoid Arthritis (1); and Irritable Bowel Syndrome (1).

The referrals came from a number of sources. These included the St. Boniface Hospital Pain Clinic, Psychological Services Center, Student Counselling Services, and physicians. No advertising was necessary as there was an abundance of individuals interested in receiving hypnosis for chronic pain. Couples and families were not so readily available.

One of the couples was directly referred, while one couple and a family grew out of involvement with a client in individual treatment.

Evaluation Measures

A number of standardized measures were utilized during the practicum to provide an indication of clinical change in the client. The measures were utilized as a support to clinical observations and judgement.

The clients' involved in the individual treatment utilizing hypnosis had three measures administered to them prior to treatment beginning and once again upon completion of therapeutic involvement. These measures included the **Visual Analogue Scale of Pain** (VAS), **Beck Depression Inventory** BDI), and the **Health Locus of Control Scale** (HLC).

With the couples and family involved, some measures were completed prior to, and following treatment. The identified pain sufferer completed the **Visual Analogue Scale of Pain** (VAS), **Beck Depression Inventory** (BDI), and the **Family Assessment Measure Brief Scale** (FAM Brief). The other family members completed the Family Assessment Measure Brief Scale (FAM Brief).

The **Visual Analogue Scale of Pain** (VAS) is a self-anchored subjective measure of pain. It's design and application reflect the belief that pain is a personal experience which can only be known on the subjective level (Scott & Huskisson, 1976). The VAS used in the practicum was a straight line with increment points from 0 (no pain) to ten (worst pain ever). The VAS is simply administered by asking the client to circle the number which best

describes their overall sensation of pain most of the time. The advantages of the VAS are that it is easy and fast to administer. There is little orientation needed. The VAS provides a reliable measurement of the client's subjective perception of pain (Scott & Huskisson, 1976).

The **Beck Depression Inventory** (BDI) is a commonly used standardized scale designed to measure a client's severity of depression (Corcoran & Fischer,1987; Beck, 1967). The BDI has twenty-one separate items which measure the cognitive, affective, behavioral, interpersonal and somatic symptoms of depression. Each item has a range of possible answers; each answer with a different score and indication of a certain level of depression. For each of the items the client is asked to circle the response which most accurately describes their response to the item. The BDI is scored by adding up the values of the responses. The range of possible scores are from 0 to 63. The higher the score, the more severe the depression. There are norms for clinical and nonclinical populations. There are also clinical cutting scores which indicate the different depths of depression. The cutting scores are described as follows:

0-4 no depression

4-13 mild depression

13-20 moderate depression

21-63 severe depression

(Steer et al., 1986).

The BDI has been tested for and reports very satisfactory reliability and internal consistency. The test-retest reliability of BDI has been found to be .48 for psychiatric populations and .74 for normal populations over a period of three weeks and three months respectively. This indicates the BDI's stability. However it has also been found to be sensitive to clinical change (Corcoran & Fischer, 1987; Steer et al., 1986). The BDI

significantly correlates with other measures of depression giving it sound concurrent validity.

The **Health Locus of Control Scale** (HLC) is designed to measure the degree to which people perceive their health being within their own control, or being outside of their control (Wallston et al., 1976). Designed as a specialized form of Rotter's Internal-External Locus of Control Scale, the HLC indicates the subject's Internal or External locus of control tendencies on their personal health.

The HLC is an eleven item Likert-type format scale. The subjects are asked to respond on a scale of one (strongly disagree) to six (strongly agree) in response to a series of statements they are asked to consider. Five of the statements are scored in the Internal direction while six are scored in the External direction. The scores of the Internal statements are reverse scored and added to the scores of the External scores to obtain an overall HLC score. The possible range is from eleven to sixty-six. The higher the score, the greater the externality of the subject's HLC; in other words, the greater their sense that their health status is beyond their control. The lower the score, the greater the subject's internal sense of being in control over their health.

The HLC has demonstrated a high degree of internal consistency at .72 between items (Wallston et al., 1976). It also has a high test-retest reliability of .71 over an eight week interval. The HLC also demonstrates concurrent validity by a .33 correlation with Rotter's Internal-External Scale. However the authors point out that the low correlation between the HLC and Rotter's scale also exhibits discriminant validity as it does not measure exactly the same construct (Wallston et al., 1976).

There is much to be understood on the interpretation of the HLC. The rationale in developing the HLC was to have a tool by which health behavior might be predicted (Wallston et al., 1976). It was hypothesized that people who were Internal would exhibit

more health behavior than those who were External. Wallston et al. have published normative data on the HLC. The data indicates that there is a difference between the scores of an identified clinical population and nonclinical population. The clinical population had a higher mean score (40.05) indicating a higher level of externality. Three other nonclinical comparison groups had a mean score which was almost exactly at the halfway mark of the possible range (Wallston et al., 1976). Though the exact nature of the relationship is not completely understood, nonclinical populations are associated with median to low range scores, while clinical populations are associated with more externally related scores.

The HLC will be utilized in this practicum as an indicator of possible improved health functioning. High extreme scores will be perceived as being less associated with health than low to middle scores (around 33). The middle scores will be considered optimum. This may be supported by the research of Crisson and Keefe (1988) in which it was found chronic pain patients whom had internalized locus of control were more likely to exhibit functional coping behavior. The opposite was true of patients who had an external locus of control. They exhibited a decreased ability to cope and reported higher levels of anxiety, depression and overall psychological distress.

The Family Assessment Measure Brief Scale (FAM Brief) is a short fourteen item questionnaire derived from the Family Assessment Measure-III (FAM-III) as described by Skinner et al. (1983). The FAM-III is a fifty item questionnaire which asks information on seven key concepts of family functioning. They are Task Accomplishment, Role Performance, Communication, Affective Expression, Affective Involvement, Control, Values and Norms (Skinner et al., 1983). Norms and clinical cut off points are provided. The introductory article notes that the FAM-III demonstrated a satisfactory degree of

reliability and inter-item correlation. Validity tests were being developed with the intention of determining the FAM-III's *construct, concurrent, predictive* and *clinical* validity.

The FAM-Brief scale was developed by selecting two items for each of the seven concepts. The FAM-Brief correlates very highly with the FAM-III though at present time there is very little research information on it's reliability and validity. However, it is an often used measure of family functioning. The FAM-Brief does not provide a dimension assessment as does the FAM-III. The FAM-Brief provides an over-all score of family functioning which may be compared to provided clinical and nonclinical norms. It may also be used to compare pre and post values as an indication of change in functioning.

The FAM-Brief takes very little time to explain and administer. Each involved family member fills out their own questionnaire and are asked to circle their response to fourteen statements. The possible responses to each item are on a four point Likert-type format with 1 (strongly disagree), 2 (disagree), 3 (agree), and 4 (strongly agree). The over all score is obtained by reverse scoring certain items and adding up the circled values.

The report shall now turn to separate discussions of the Hypnosis and Family therapy sections. The Hypnosis section will be presented first. It was felt that this may aid in the flow of the presentation as a number of clients were initially seen individually and later became involved in family treatment. Therefore, the description of the family treatment cases may build upon the presentations of the hypnotic interventions.

Hypnosis as an Adjunct Treatment With Chronic Pain Sufferers

Introduction

This section of the report will describe and discuss the treatment of individuals who were referred to me at the Psychological Services Center to receive hypnosis training to mediate the effects of chronic pain on their lives. This will include a discussion of the interventions and goals, presentation of the individual cases, and a discussion of the outcomes, important treatment themes and elements.

Hypnosis as Treatment

The best way I can think of describing hypnosis' relation to treatment and therapy is that hypnosis in it's self does not constitute therapy but rather therapy may occur under hypnosis (Crasilneck & Hall, 1975). In other words, hypnosis may be a helpful tool in the overall context of treatment for the client, but it certainly is not a solitary end in it's self. All of the major authors reviewed indicated that hypnosis has much therapeutic utility to contribute to treatment. However, it was also recognized that hypnosis must be kept in the perspective of overall treatment. Just as with a more conventional treatment, substantial care and foresight is required to develop a therapeutic relationship with the client (Crasilneck & Hall, 1975; Udolf, 1987). The therapist must be prepared and equipped to work with the client on the presenting psycho-social issues which they bring with them to treatment and impact upon their lives.

Initially most, if not all, of the referred clients entered treatment with the expressed sole desire of utilizing the magic of hypnosis to alleviate their pain. During the course of assessment and treatment a number of points became very clear. Hypnosis is not the simple

panacea for all the client's problems and the issue of chronic pain could not be fully considered and treated in isolation from the client's life and problems. It became very evident, with all the clients seen, that there were other psycho-social problems and issues that either occurred as a result of the pain or made a significant impact on the client's life and pain. It was most natural that as a part of treatment these issues be explored and attended to. This implied giving the client the full opportunity to air various issues and their associated emotional content. Where possible, behavioral tasks were negotiated as a means to help foster the client's desired change regarding the issues.

Hypnosis was a significant component of treatment. However, it was used with discretion and with an awareness of the overall treatment goal which was to enable the client to function and live life to the best of their potential. In this respect it is most accurate to describe hypnosis as a technique which was used with other therapeutic techniques to meet this goal.

The Process of Hypnosis

Conceptually, I perceived the process of hypnosis being comprised of four parts: **Screening; Rapport Building; Induction; and Suggestion Provision** (Crasilneck & Hall, 1975; Margolis, 1985).

After the client was referred to me at the Psychological Services Center an Intake interview was scheduled. Dr. Thomas, who provided my case supervision for the hypnosis portion of the practicum, joined the first few intakes. At the intake a comprehensive understanding of the client's presenting problem (chronic pain) was gathered. This included information on the history, onset and development of the pain. What their perceptions of the pain were; what they had been told about their pain from the medical establishment and others; what

had been done and what was being done now. Information was also gathered on how the clients' felt their pain effected their lives and what elements in their life may effect their pain. A medical history and list of prescribed drugs being taken were obtained. Other issues in the client's life, related to or unrelated to the pain were also explored when appropriate.

The intake also served as a **Screening** vehicle to determine the clients' appropriateness for hypnosis. The general criteria, as outlined in the earlier section on Indications and Contra-indications for hypnosis were followed. The screenings did not eliminate anyone from treatment, however it was used to safeguard that excessively depressed, psychotic, border-line psychotic, or poor judgement clients were not included as they are generally contraindicated for hypnotic treatment (Baker, 1987; Crasilneck & Hall, 1975; Frankel, 1987; Fromm et al., 1981; Udolf, 1987).

Following a successful screening **Rapport** was developed. This was the first stage in moving towards treatment. The purpose of this was to begin to build a therapeutic relationship with the client, find out what they know and do not know about hypnosis, answer any questions and where appropriate allay any misconceptions and fears about hypnosis. Often asked questions included:

- What is hypnosis?
- Will I be able to be hypnotized?
- What will it feel like?
- Will I be under your power?
- Will I do things that will either scare or embarrass me?
- Is hypnosis risky or dangerous?

To these questions I would often answer that hypnosis may be defined as a state where peoples' perceptions may be a little different than what they normally experience. Most people can be hypnotized, some more than others. The range of the experience is also very individual. Some may wonder if they were ever hypnotized, while others may experience a profoundly distinctive awareness complete with notable perception distortions. Often people describe hypnosis as feeling like they are very relaxed or on the verge of sleep. Some report tingly, warm or pleasantly cool sensations. What one experiences is ones own.

People are often concerned about giving their self-control over to the hypnotist and feeling very vulnerable to being told to perform behaviors they normally would not do and would be embarrassed about. This concern largely comes from our perception of the stage hypnotist who, through a process of elimination, selects members of the audience who are highly hypnotizable and/or enjoy performing. The chances are no one involved is doing anything they do not want to do. This is true of hypnosis; a client will not do anything they do not want to do, unless they want to do it. There is no presumption; they are in control. Besides that is not the intention at all with the therapeutic use of hypnosis. The purpose is not to remove the client's control, but rather to empower them with control. The use of hypnosis in this context is as a therapeutic tool, not an entertainment device. Used to this end, hypnosis is very safe and largely risk free.

When the client and I felt comfortable to move on, the client was told that an **Induction** could now be performed. The purpose of the induction is to hypnotize the client and prepare them for the suggestions they will receive while hypnotized. Through out the practicum I used an induction that was drawn from some other commonly used inductions. It utilized a combination of Braidian, Progressive Relaxation and Imagery techniques. It

proved to be a very effective induction, though a long one. On average the induction took fifteen to twenty minutes, which is quite long. However, the advantages were that it appeared to hypnotize clients to a uniformly substantively deep level, and, as a result of the suggestion of self-hypnosis, it had to be performed only once.

The Induction was as follows:

" Now, what I would like you to do as we begin ... is to begin to relax. Make yourself as comfortable as possible. If you are wearing glasses, contact lenses, or jewelry I would recommend that you remove them ... that's good. You may feel more comfortable by loosening any tight clothing and removing your shoes if you wish. You may sit comfortably with your hands, palm down on your thigh ... that's good. Allow your self to relax ... feel yourself sink into the couch. As you begin to relax I'd also like you to be aware of your breathing (in coordination with the client's breathing) *... in ... and ... out ... in ... and ...out. that's it. Very good. As you are aware of your breathing ... in ... and ... out,... I want you to concentrate on this object that I'll place here* (any simple object will do; I often used one of my wife's earrings). *Focus very carefully on this object ... notice it's shape ... it's color ... it's contours ... it's boundaries ... it's center ... that's very good ... very good. Now, I would like you to continue concentrating on the object ... and as you continue concentrating on the object I would like you to be aware of your relaxed ... slow ... breathing ... in ... and ... out ... in ... and ...out. Very good. Now as you breath, I want you to imagine that you are breathing in and out a special gas that will make you feel relaxed and sleepy. As you breath in and out you will begin to feel more relaxed ... more sleepy ... more relaxed ... more sleepy. What I will do is count down from 10 to 1. As I count down you will feel more and more relaxed ... more and more sleepy. Very soon your eyes will feel so heavy ... very heavy ... that you will not be able to resist closing them. And as you feel more and more relaxed ... more and more sleepy ... and you close your eyes ... you will become very hypnotized.* (At a pace slightly slower than the client's breathing) *<u>Ten</u> ... eyes, heavier ... and heavier ... <u>Nine</u> ... heavier ... heavier ... <u>Eight</u> ... more relaxed ... sleepy ... heavy ... <u>Seven</u> ... your eyes are closing ... more and more heavy ... <u>Six</u> ... deeper ... heavier ... sleepy ... hypnotized* (most clients had their eyes closed by this point) *... <u>Five</u> ... relaxed ... hypnotized ... <u>Four</u> ... deeper ... and deeper ... <u>Three</u> ... feeling very relaxed ... sleepy ... hypnotized ... <u>Two</u> ... deeper ... deeper ... hypnotized ... <u>One</u> ... very hypnotized ... very hypnotized ... very good* (if the client has not closed their eyes by the time one is reach the process of counting down may be repeated

as if it was a part of the plan, or the client may be asked to slowly close their eyes and deepen the hypnosis). *Very good ... very relaxed ... and hypnotized. Now, as you closed your eyes, you will have been aware of a particular sensation around your eyes. This was the feeling of profoundly deep relaxation. It may have been a warm flowing feeling ... or a cool comfortable feeling. I want you to be aware of that feeling, what ever it was. Now I would like you to imagine this feeling of relaxation is spreading from your eyes to the other parts of your body ... back across your temples to the back of your head ... to your crown ... forehead ... cheeks ... jaw ... chin ... down to your neck ... shoulders ... flowing down to your arms ... forearms ... wrists ... hands ... fingers ... down from your shoulders to your upper back ... across your rib cage to your chest ... abdomen ... lower back ... hips ... thighs, top and bottom ... knees ... calves and shins ... ankles ... feet ... toes. Very ... good. Now as you are feeling very relaxed ... completely relaxed ... I am going to count down once again from 10 to 1. As I approach one you will become even more hypnotized. Ten ... deeper and deeper ... Nine ... more and more hypnotized ... Eight ... so relaxed and hypnotized ... Seven ... deeper ... deeper ... Six ..... Five ... deeper and deeper ... Four ..... Three ..... Two ..... One ... very deeply hypnotized. Very good, that's it. Now, as you are very hypnotized I would like you to imagine the object I had you concentrate on as we began. What I would like you to do is imagine the object as if it was in front of it right now and you were looking at it. As you imagine it notice it's shape ... it's color ... it's contours ... it's boundaries ... it's center ... that's good ... very good. When you have a clear image of the object I would like you to let me know by simply lifting your your right pointing finger ... that's it ... very good. Allow the image to go away and just be aware of what a pleasant and relaxing experience hypnosis is ... that's it. Now I would like you to imagine something very enjoyable and very pleasant. I would like you imagine a very special place where you feel completely relaxed ... completely at ease ... happy ... and content ... and healthy. This place may be a park ... beach ... cottage ... where ever. Its a special place where you felt just right and away from all worries. Imagine this place ... what would it feel like if you were there right now? ... Imagine what you might see ... touch ... hear ... smell ... possibly taste ... create as full an image as you can ... experience the feelings of comfort, safety and relaxation. When you are fully in your special place, I would like to know. When you are*

there simply lift your right pointing finger again ... that's it ... very good. Now take a few moments to enjoy your special place (a minute or so). *Ok, I'd like you to leave your special place. That's it ... continue to feel very hypnotized ... very hypnotized. Now, anytime you wish to be hypnotized and access your special place, all you have to do is on your own, count down from 10 to 1. This will bring you to the very hypnotized state you are in now. As all along, you will have complete control. You may do this on your own to practice hypnosis. You will find that the more often you practice, the stronger and more effective the hypnosis will become. When you are complete, and it is time to return to your normal waking state, you will do as we will now, count up from 1 to 10. As we reach five your eyes will open, yet you will still be hypnotized. When ten is reached you will be completely awake. In fact you will feel refreshed, rested and enthusiastic for the rest of the day.* (At a pace slightly faster than the client's breathing) *Ten ... waking up ... Nine ... more and more awake ... Eight ... Seven ... Six ... eyes beginning to open ... Five ... eyes open ... more awake ... Four ... Three ... Two ... One, Any sleepiness or grogginess will soon be gone and you will be left feeling completely awake and refreshed!* "

This would complete the initial induction. This induction was usually carried out during the first treatment session. It served several purposes: it provided the client with an introduction to hypnosis; suggestions of the special place and self-hypnosis which the client could practice with on their own; a therapeutic springboard on which new treatment suggestions could be built.

After the initial induction the client's were asked about their experiences. As to be expected there was a range of reported experiences, but all indicated sensations of deep relaxation and, to different degree's, altered perceptions . The individual responses will be considered more in depth during the case presentations.

Though the initial induction was quite long, it was not repeated after the first treatment session. In future sessions, when new suggestions were added, the induction simply consisted of having the client count themselves down to self-hypnosis.

Suggestion Provision implies the process of adding specific suggestions designed to move the client towards their stated treatment goals. However, the process begins before the induction. The specific suggestions were negotiated between the client and myself. This had the dual purpose of enabling important feedback from the client to be utilized in developing the most appropriate suggestions, and reinforcing the sense of control and empowerment of the client. This is an important aspect of treatment as it is necessary to counter the feelings of lack of control and hopelessness which are often associated with chronic pain (Pilowsky, 1969; Pilowsky et al., 1977; Pilowsky & Spense, 1980; Pilowsky & Bassett, 1982).

The emphasis of the suggestions was on enhanced coping behavior and feelings rather than the gross removal of pain symptoms. As may be recalled from an earlier section, a number of authors commented on the need to respect the unconscious functional meaning the pain may have (Crasilneck & Hall, 1975; Meldman, 1960). This was taken very much to heart during the development of the treatment suggestions. Elton et al. (1980), Spiegel (1967) and Udolf (1987) support the notion that suggestions be used, not to simply remove symptoms, but rather to replace symptoms or dysfunctional behaviors with more functional and adaptive ones while building on and supporting the client's strengths.
Generally, the suggestions utilized were of the nature that the pain sensation would be altered, attention would be redirected away from the pain to a healthier focus, or improved coping behavior and perceptions be reinforced. The specific suggestions used will be described in the case presentations.

Hypnosis: Case Presentations

Case #1

Name: J.M.

Referred By: J.M. was referred through the St. Boniface Pain Clinic where J.M. has been an outpatient for quite sometime.

Period Seen: J.M. was seen for intake at the Psychological Services Center on November 3, 1988. There were three subsequent treatment sessions (Nov.10, Nov. 17, Dec. 5; all of 1988). Treatment was terminated January 13, 1989 after J.M. missed two scheduled treatment sessions.

Description of Client: J.M. was a forty year old man who experienced disabling migraine/tension headaches. As a result of the headaches he had been unemployed for the previous three years. He was divorced and currently living in a blended common-law arrangement. His eldest son was living with J.M., his common-law wife and her two children. J.M. also had two other children from his first marriage which dissolved in 1985. J.M. expressed that there were also difficulties present in his current relationship and family. J.M. had not completed high school and had been previously employed as a auto-mechanic, carpenter and insurance salesman. The jobs were often obstructed by his headaches and accompanying depression and anxiety. J.M. had also acknowledged an addiction to pain killing drugs which he used to alleviate pain and elevate his mood. There were many health care professionals involved with J.M. and his family. He was involved with the St. Boniface Hospital Pain Clinic. He was also seeing a psychiatrist for his depression. J.M. was receiving individual and family therapy through Family Services of Winnipeg Ltd. J.M. and his common-law wife were also involved with an ongoing

Personal Growth and Human Relations Workshop. J.M. received Methadone (1.5 ml. 3 times a day) for pain, Parnate (10 mg. 2-3 times a day) for depression, and Tylenol #1 (4 tablets 4 times a day) for pain.

Situation As Seen By Client: J.M. said that he experienced migraine headaches from the age of 16. He said that they first occurred after a friend, while playing, gave J.M. a "karate chop" to the back of his neck. J.M. was knocked out and shortly afterwards began to experience the headaches. Since that time, and progressively in the last few years, J.M. had experienced increased difficulties in functioning. He attributed this to the headaches, anxiety and depression he experienced and his addictive dependence on pain killing drugs. J.M. was for the most part quite insightful about his condition. He recognized that he was stuck in a perpetual cycle of drugs, pain, depression and anxiety. He stated that this inhibited his ability to function with ongoing responsibilities and problems. Likewise, his mounting problems created anxiety and depression which lead to pain and drug abuse. He expressed that he hoped the use of hypnosis might help relieve pain and replace his excessive need for drugs.

Diagnostic Impressions: J.M. was faced with a multitude of interloping problems ranging from Macro level financial, employment and health care problems, through family level interpersonal and role confusion conflicts to personal level coping difficulties. J.M. complained of chronic headache pain initially, but later confided that the headaches were not as much a problem as was the depression, anxiety and drug abuse. He said the drugs largely fulfilled the role of alleviating depression and excessive worry. J.M. had many concerns and issues about his ability to work and provide. He also expressed that the depression seemed to set in during the collapse of his first marriage. He said his wife had

been emotionally punishing to him; something he also related to his own mother in his family of origin. J.M. said that he frequently felt overwhelmed and helpless to solve his problems.

J.M. could very easily get into a cycle of non-activity which fostered his feelings of inability to cope, failure and worry. These feelings made it difficult for J.M. to be active with work or anything and with time became a self-reinforcing cycle. J.M. commented that he escaped from this trap through a number of means. One was to force himself to do something active and the other was to take drugs. More often he had been utilizing the later solution. The pain behavior seemed to reinforce this pattern as it prompted increased drug intake, inactivity and the accompanying feelings of anxiety and depression.

Treatment Plan/Recommendations: It was very apparent that a solitary focus on the presenting issue of pain would be futile and possibly counterproductive. Upon discussion with Dr. Thomas, it was agreed that hypnosis may have a role to play as a tool to encourage relaxation, clear thinking, feelings of control, and an elevated mood as a replacement for drugs. J.M. was also involved with a number of other health professionals for his series of other problems. While attempting to not replicate or counteract treatment elsewhere, behavioral changes to J.M.'s lifestyle could be developed as a part of treatment that would reinforce a more positive sense of himself and his abilities to cope and function.

Treatment: J.M. was involved in three treatment sessions. Much of the time was spent discussing J.M.'s history, family and personal issues. J.M. was a very verbal client who at times found it difficult to focus on one issue. He had a propensity to dominate conversations. On the one hand he was quite engaged in treatment, yet on the other, it was

sometimes difficult to keep him on one topic. J.M. appeared to want to use his treatment with me as an opportunity to talk about his many, confusing, and interrelated problems. After the first session, J.M. was given an audio-tape on which there was an introductory hypnotic induction. J.M. had expressed that he had been hypnotized before but he had not found it very effective. He said he was unsure of hypnosis and did not want to feel any sense of lessened control. I explained the nature of hypnosis to him and that he would be in control. I gave him the tape as a "safe" introduction to hypnosis. During the following session J.M. was given a live induction with general suggestions of relaxation, control and well-being. He was also given the suggestion of a "special place" where he was relaxed, healthy and content. J.M. was a moderate hypnotic subject who reported that the hypnosis had been very effective in relaxing him. We also discussed the role of drugs in his life and alternatives. We set some minor behavioral tasks which J.M. could begin to break the cycle of his depressive lifestyle. This included some very moderate exercise and activity.

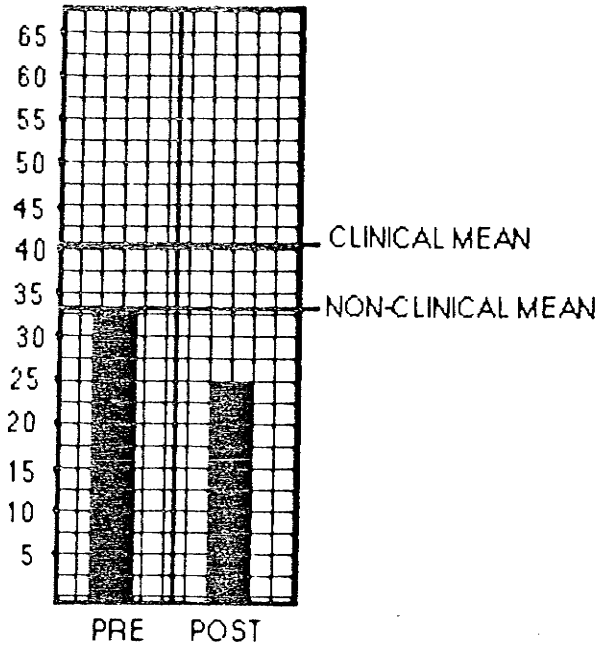
J.M. began to miss scheduled appointments after the second session. We rescheduled a number of times and did meet once more before we agreed to mutually terminate treatment. J.M. had started a part-time job and was finding it very busy. He also said that he was already involved in so many other treatments that he was becoming confused. J.M. also expressed that his depression was quite disabling at times and prevented him from completing what he wanted to do. I informed his ongoing counsellor at Family Services of our treatment termination and my concern regarding J.M.'s depression. This counsellor was seeing J.M. regarding this and other issues on a regular basis.

Outcome: J.M. was a very troubled individual who, for a number of reasons, did not complete treatment. This included an already full-time load of treatments being received, and a deepening depression. J.M.'s severe depression level on the BDI increased following

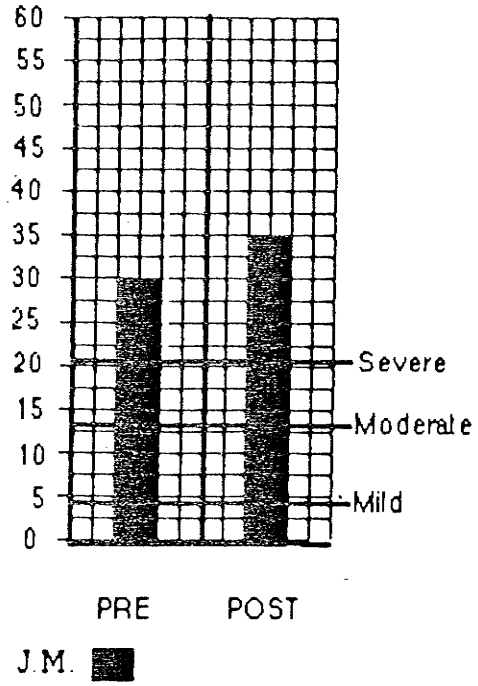
treatment (BDI: Pre-30; Post-35). His Health Locus of Control became more internal following treatment (HLC: Pre-33; Post-25) which may be interpreted as a positive indication of treatment. Consistent with his verbal reports, J.M. appeared to experience a drop in pain (VAS: Pre-8; Post-5). Prior to termination J.M. stated that he felt the real problem centered on his depression and drug abuse. At this point he did not feel able to pursue treatment at the PSC. On a positive end note, a further conversation with J.M. indicated that he was working part-time and taking an adult education program to upgrade his high school education which he had not yet completed.

Measures:

Health Locus Of Control

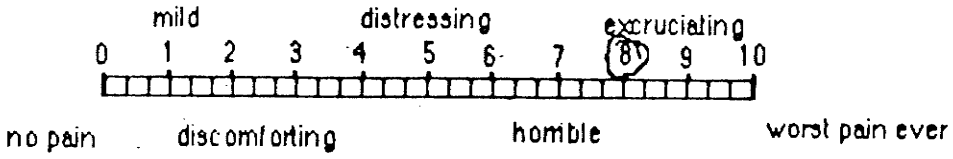


Beck Depression Inventory



Visual Analogue Of Pain

PRE



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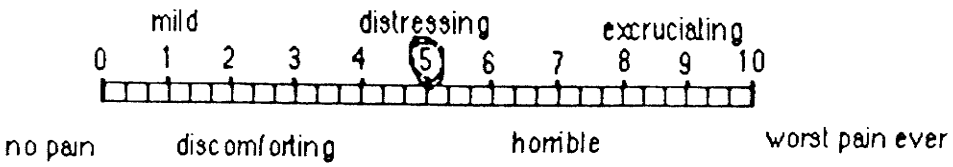


Case #2

Name: S.C

Referred By: S.C. approached the P.S.C. upon the counsel of her friend who was a student involved with research at the P.S.C. and had heard hypnotic interventions were being offered for chronic pain sufferers.

Period Seen: S.C. was seen for intake on November 10, 1988. She was seen for only one treatment session on November 17, 1988. She was terminated after she missed a number of following appointments.

Description of Client: S.C. was an attractive 29 year old woman who had experienced periodically debilitating Irritable Bowel Syndrome (IBS) for the last 10 years. She had received a number of operations for her IBS with no desirable outcome. She was possibly going to have a significant portion of her intestine removed. S.C. was prescribed Sulfasalzine (500 mg six times a day) to help relieve her intestinal distress. She was trained as an x-ray technician but has been released from a number of jobs of late as a result of the IBS. She also experienced an unfortunate skiing accident in 1986 in which she broke her neck. She has recovered quite remarkably, but has been left with some numbing in her back as a result of nerve damage. She was working part-time as an x-ray technician but was having extreme difficulty fulfilling the physical demands of the job. She was considering being retrained for new employment. As a result of her accident, and especially the IBS, S.C. was experiencing a great deal of difficulty effectively coping with employment and social situations. She has lost a number of jobs and friends as a result of her health. It was not uncommon that she would miss a considerable amount of work due

to her IBS which made her vulnerable to job loss. She also commented that she had lost many friends because her IBS would severely interfere with her ability to freely socialize and travel. As a result she was a lonely, insecure woman who was lacking self-confidence in work and relationships and was very self-absorbed in her illness which completely dictated her life.

Situation As Seen By Client: S.C. stated that all the disruption in her life was the result of IBS. She reported that she came from an average family where there was no problems to speak of. She said her problems began approximately 10 years ago when she entered an x-ray technician course at Red River C.C. It was at that time that she first experienced the IBS. She described the period as exceedingly traumatic and claimed that she had very little recollection of the period. She admitted that it was a very stressful time but does not attribute stress as a cause. S.C. was adamant that the cause of her IBS is completely physical, though she did acknowledge that it definitely was exacerbated by stress. She was interested in receiving hypnosis in the desperate hope that it may help relieve her pain and bowel dysfunction so that she might lead a normal life.

Diagnostic Impressions: S.C. was very staunch in her belief that the IBS was completely biological in genesis. She expressed that a number of past employers and friends had suggested that it was all in her head. She interpreted that as meaning she was "crazy." I suspect this is why she so robustly rejected the possible impact of her mental/emotional state having an effect on the IBS. However, the IBS had appeared to take on a life of it's own effecting S.C. in all areas of her life. Her employability had been effected, as had her self concept and interpersonal relationships. S.C. had serious doubts about her abilities to perform employment tasks, cultivate and foster friendly and intimate relationships, and

trust her personal strengths. She had experienced a significant amount of failure and rejection as an result of the IBS. A number of jobs had been lost because of excessive sick time off. She also said that she had lost some friends because they didn't understand her illness and had little patience for last minute cancellations or plan alterations. Though not in specifics, she also related that a number of significant relationships with men had ended as a result of the disrupting IBS. When she was sick, she was completely bed-ridden and unable to participate in the relationship. She said at first they were understanding but this only lasted for a short time. They left her after a period of time.

Her personal experiences with employment, friends and significant male relationships had wielded a powerful impact on S.C. irrespective of the IBS. As she put it, "theres only so much rejection a person can take!" S.C. was stuck in a very guarded position of being afraid to extend herself in employment and personal situations. As a result of her past rejection she felt very hurt and angry. She said expressed anger at being unfairly judged as crazy or lying about her condition. She felt it was safer to do nothing and avoid the inevitable humiliation. This was especially true of S.C. and her lack of personal relationships which has left her very lonely and socially uninvolved. She did say that she has a couple of close understanding friends but they were not enough. As she put it, "I want to have a normal life which includes secure employment, friends and a family."

Treatment Plan/Recommendations: The treatment plan proposed would include hypnosis and a further exploration of S.C.'s psycho-social and relationship issues. The hypnosis may have had utility as a tool to prompt relaxation, increase S.C.'s sense of somatic self-control, build feelings of self-worth and reinforce healthy behavior activity.

S.C.'s psycho-social and relationship issues could have been be further explored, partly for the value of the process in it's self, but also that healthy behaviors could be negotiated and gradually implemented.

Treatment: S.C. attended only one treatment session during which much of the in depth information on her employment and relationship issues were discussed. She spoke quite freely about her IBS and personal issues and how they impacted each other. However, she was not keen to have such an involvement as a part of her treatment. She stated that she puts a lot of energy into maintaining a positive approach to life and did not want to dwell on her problems. Unfortunately, as she explained, this meant ignoring her relationship and social problems. As she put it, "I need all of my energy to focus on myself; to keep my spirits up, and stay healthy. I want to leave the past behind me and move towards the future." I pointed out that these issues were still effecting her today. Despite my gentle suggestions and prodding she refused to pursue the issues. I decided to go along with her wishes and maybe return to it at a later time.

S.C. expressed that at this time she was interested in hypnosis for pain relief and increased body-control. S.C. was given a live hypnotic induction with suggestions of relaxation and a "special place" where she might feel completely healthy, comfortable and safe. She appeared to be an average hypnotic subject as she reported that the experience had been very relaxing. I explained that in future sessions we might explore more specific suggestions for her IBS.

Unfortunately, this was S.C.'s only treatment session. She missed following scheduled appointments saying that they unexpectedly conflicted with her part-time work schedules. I speculate that S.C. either did not find the hypnosis effective or she did not want to be

involved in treatment which she perceived may involve the exploration of her personal life. She was terminated shortly after.

Outcome: It is difficult to discuss S.C.'s outcome as she did not complete treatment. Also, S.C. did not fill out either of the pre or post measures. However, at the time of termination she was still in need of therapeutic treatment to address her IBS and associated personal issues.

Case #3

Name: A.M.

Referred By: A.M. was referred by her physician.

Period Seen: A.M. was first seen at intake on October 20, 1988. A.M. participated for four treatment sessions (Oct. 26, Nov. 2, Nov. 9, Nov. 23; all of 1988). Treatment was terminated on November 23,1988.

Description of Client: A.M. was 23 year old student in her fourth year of an honors course at the University of Manitoba campus. A.M.'s pain complaint was periodic migraine headaches. She recognized that she often experienced severe headaches following a very stressful period when she was working against deadlines. A.M. was a very active person. She was involved in student politics, edited a college newspaper, worked part-time for a monthly magazine, and was taking four university courses. She presented as a very dynamic and motivated person who truly enjoyed all the activities she was involved in. She was prescribed Anaprox (250 ml. twice a day), Percocet and Ergamar (when ever she had a headache). She came from a professional family and did not report any disturbance. She described her family as being very supportive and understanding , yet also very busy with all the family members involved in consuming projects.

Situation As Seen By Client: A.M. initially did not express a developed understanding of the cause of her migraine headaches. She said that she had experienced the headaches intermittently since she was in her early teens. She was not aware of a precipitating event which set the headaches off. She said that both her parents have had disabling migraines

and her father on occasion still had them. A.M. said she was aware that her migraines could be triggered by certain foods (chocolate, cheese, alcohol) but said she suspected the headaches were caused by largely genetic factors. She expressed that did not want to become reliant on drugs for controlling her pain and she wished to learn hypnosis as an alternative.

Diagnostic Impressions: Through out the course of involvement a growing theme was the relationship of A.M.'s headaches to stress. Through discussion of her cycle of migraines a pattern became very clear. A.M.'s headaches almost always followed an intensely stressful time during which she would become overwhelmed with article deadlines, school assignments and editorial responsibilities. As she put it, "*I enjoy everything I do, and I just don't know when to say no to it.*" A.M. acknowledged a number of important clues to her headaches. She liked to keep very busy with what she enjoyed and would rarely, if ever, turn down requests for her to do work. She recognized there were frequent times when she would take on a terrific load of work and responsibilities which would create a great deal of stress for her. She said that when she was up against deadlines she would push herself even harder so that she would complete the tasks. She recognized that she was most often unaware of the stress and it's effects on her until after she finished all the work and was left with a headache. A.M. Did not have any ongoing stress reduction or coping techniques except sleeping. She did swim, but this generally went to the wayside when she was busy. She said that she never relaxed except when she was forced to by a headache. It was almost as if her headaches functioned as a fuse. When there was too much stress, and her tolerance level surpassed for too long a period, a headache would appear which would force her to relax.

Treatment Plan/Recommendations: It became very clear to me that a central issue of A.M. was her relationship with stress. She was use to, and partly thrived on being very busy with what she enjoyed. However, there was a very fine line between this and disabling, headache producing stress levels. A.M. stated that she wished to learn hypnosis to relax and bypass some of the pain. I agreed with her that hypnosis may be a helpful tool to help her relax, but this would in all likelihood be an incomplete solution to the problem. I expressed that her extremely busy lifestyle was conducive to bringing on headaches. I suggested a more complete treatment must include an opportunity to learn and recognize healthy stress limits, more free relaxation time, and regular exercise. A.M. was very accepting of this though she admitted she was not use to relaxing.

Treatment: A.M. proved to be a motivated client of average hypnotic ability. During the course of treatment she was provided with three hypnotic suggestions which she could utilize on her own. The first suggestion was that of a Special Place which she could access when she practiced the self-hypnosis. The special place is an imagined location, real or created, which the subject associates with relaxation, comfort, health and safety. A.M. chose a park she frequented in the past. This suggestion was designed as a relaxation tool which A.M. was encouraged to practice every day for a minimum of 5 to 20 minutes. The second suggestion was directly designed to alter the somatic experience of a migraine headache. This suggestion consisted of hand-warming and head-cooling which encourages the peripheral blood flow and a lessening of vascular tension in the brain. A.M. was asked to imagine warming her hands over an open camp fire while concurrently experiencing a comfortably cool breeze blowing on her forehead. A.M. was asked to use this suggestion when she either felt headache prone or a headache coming on.

Treatment also consisted of discussing what level of work commitments she was willing to carry while considering a healthy balance which included regular exercise and relaxation. A.M. decided she was going to set limits on the reporting work she did for the local magazine as this was often sprung on her with out warning and could produce a lot of stress. Even though it was a half-time position, she often put in close to a full weeks hours on it. We discussed how A.M. might be aware of stress build up. She said that she was largely aware of stress through physical tension in her body, but she often did not give herself a chance to recognize it. A third suggestion was given to A.M. under hypnosis. During her daily practicing of self-hypnosis for relaxation and headache control, she could also utilize her body awareness like a stress thermometer. She learn what it feels like to be relaxed, and what it feels like to be tense. This was called a "body check." The intention was that A.M. could first learn the procedure while hypnotized and transfer this ability to her everyday waking state. A number of times a day, or at key times, she could give herself a quick body check to help determine her stress level.

Outcome: A.M. presented as an overall well functioning individual. Though she did suffer from an ongoing pain ailment, it was not disrupting her life to the degree that her present functioning was seriously hampered. She acknowledge that her headaches on occassion prevented her from partaking in what she wanted to do, but never in what she needed to do. In this respect treatment may have provided the function of preventing the condition from increasing in severity.

A.M. reported a decreased frequency of headaches. By her self-reports she indicated the occurrence of no headaches from the period of beginning the hypnosis. Her overall pain rating dropped following treatment (VAS: Pre-2>3; Post-1). Though due to the initially low score, it is difficult to attribute significance to the change. A.M. said that she practiced the

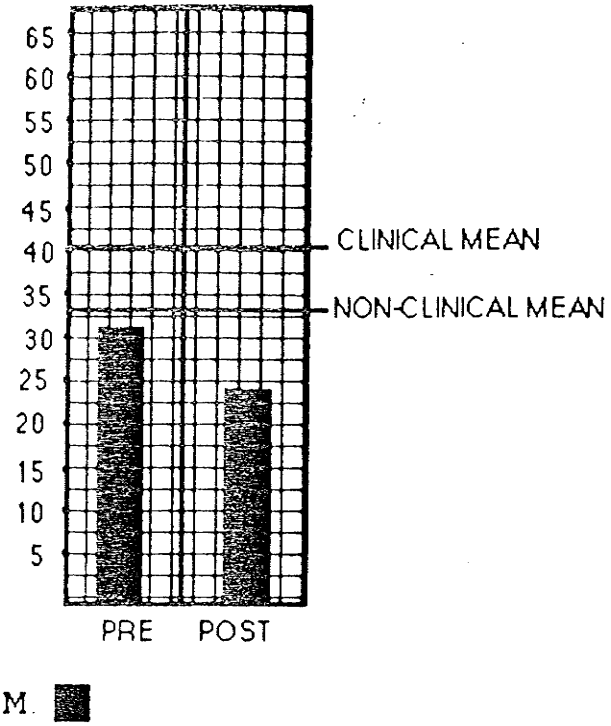
self-hypnosis everyday and found it to be a successful stress release on it's own. She felt that her use of the suggestions had been very effective in their own right. However, A.M. also followed through with making behavior changes. She made a concerted effort to exercise at least three times a week and take time to just sit around and relax. She has maintained a high level of activity, but in a seemingly manageable balance. A by-chance meeting with A.M. on the campus revealed that since we terminated treatment she had successfully entered college politics. Instead of taking it on as an additional responsibility, as she did in the past, she gave up the time consuming position with the magazine.

A.M. was a person very receptive to the notion of hypnosis and making adjustments to her life-style. It was apparent to me that both the hypnosis and lifestyle changes combined to prove an effective stress release. A.M. considered her overall lifestyle and whether it promoted health or not. Her scores on the Health Locus of Control scale (HLC: Pre-31; Post-24) indicate that A.M. had a strong sense of being in control of her health. Her internal locus actually became stronger following treatment as indicated by the decreased score. This may have been the result of the success she experienced with treatment. A.M.'s score on the BDI dropped after treatment. However, her scores were well below the clinical level of depression.(BDI: Pre-13; Post-7) which suggests the depression was essentially a non-issue.

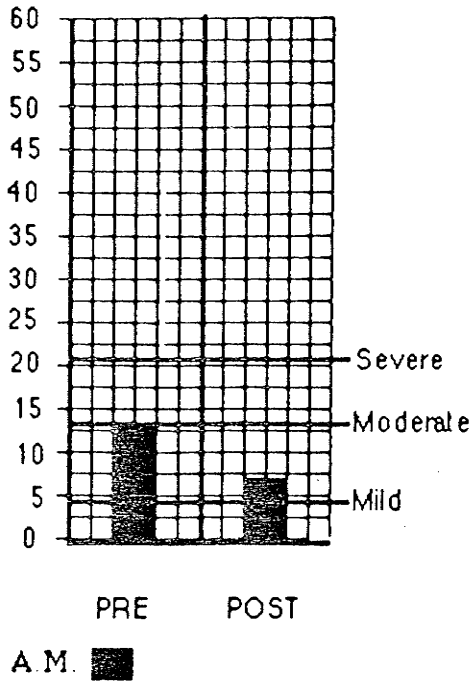
The measures used indicated general movement in the desired direction. The non-clinical levels supported my impression of A.M as a high functioning individual who entered treatment as means to learn a stress management technique and "fine-tune" her-self.

Measures:

Health Locus Of Control

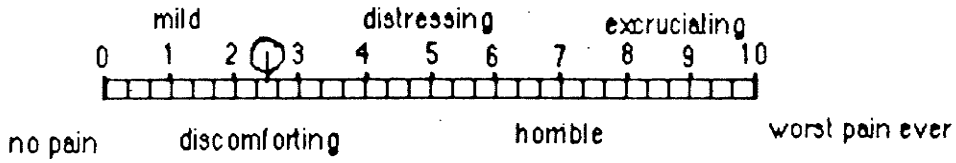


Beck Depression Inventory



Visual Analogue Of Pain

PRE



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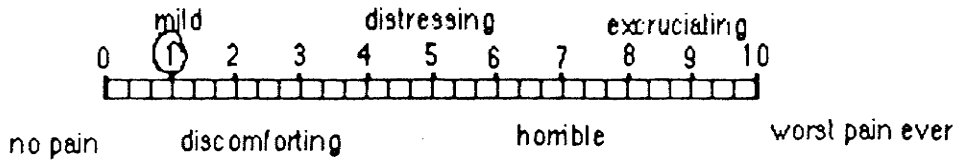


Case #4

Name: C.B.

Referred By: C.B. was referred to the PSC from a counsellor at University of Manitoba Counselling Services.

Period Seen: C.B. was seen for an intake interview on February 9, 1989. She was seen for six subsequent treatment sessions (Feb.17, Mar. 2, Mar. 13, Mar. 20, Mar. 30, April 13; all of 1989). She was terminated on April 13, 1989.

Description of Client: C.B. was a 25 year old, recently married woman who was experiencing pain and partial disability as a result of Juvenile Rheumatoid Arthritis (JRA). She often experienced extreme swelling and pain in her ankles, knees, elbows and wrists and required a cane to help her walk. The JRA first affected her in 1985 after an accident in which she fell and badly damaged her knee. Due to extensive drug allergies C.B. had a very limited range of medication options to control her symptoms and pain. She had been prescribed a multitude of drugs to reduce inflammation and curb the pain but experienced a great deal of undesirable side effects. She had been taking prescribed Cortizone Steroids for inflammation up until September, 1988. C.B. said she stopped due to the side effects of depression and excessive weight gain. She was a very overweight woman. C.B. saw a psychologist in September for her depression but found it to be too expensive and afterwards began to see a counsellor for free counselling at the University of Manitoba Counselling Services. C.B. was taking no medication at the time of our involvement. She was a student in her first year of university planning to a professional faculty. C.B. was a very positive and expressive person who was conscious of wanting to live life as fully as possible irrespective of the JRA.

Situation As Seen By Client: C.B. presented herself as a person who was very interested in doing many activities and pursuing numerous ambitions. Aside from her art she was also a performing singer. Her primary complaint was that the JRA was preventing her from physically doing all that she wanted. She described her JRA as being primarily physiological and genetic in nature and cause. She said that one of her siblings (she came from a family of five children) also had rheumatoid arthritis. C.B. was also aware that just as her JRI pain and symptoms could affect her mood, the opposite was also true. It was for that reason that she attempted to be as mentally and physically active as she could reasonably be, and also keep a positive attitude. However, she was becoming increasingly aware of limitations to her abilities and endurance for following her interests. She had a very pleasant, happy disposition. However, C.B. said that she often felt unhappy because of her pain and these feelings were hidden behind a mask of happiness. She said that there were few people she felt she was able to talk to about her feelings, and it was a new experience for her to share her feelings as she had been taught in her family to keep her chin up and always look on the bright side of life. She wanted to change this and share more of what she experienced with others, in particular her husband.

C.B. said that she also wanted to loose a substantial amount of weight that she had gained since she had got married during the summer of 1988. She wanted to do this so that she would feel more healthy and have less pressure on her joints. Extra weight on her joints exacerbated the JRA pain and swelling. C.B. said that she also wanted to look more attractive to her husband. She described their relationship as being very positive and mutually supportive. Though she said she felt her husband loved her just the way she was, she wanted to loose weight as she was much lighter when they married.

C.B. was interested in hypnosis as a tool for her to control her JRA pain and swelling so that she might be able to function more fully.

Diagnostic Impressions: I largely concurred with C.B.'s view of her situation. Despite her JRA C.B. impressed me with her candid self-discussion and healthy attitude. She desired to live as best she could within her limits. She was beginning to come to terms with her limits (which were mainly physical) through counselling at the University of Manitoba Counselling Services. A number of important issues arose. C.B. did not feel that she was being honest with people about the extent of her pain. As she put it, she always felt she had to wear a "Bozo the clown happy face." She had numerous good friends but maintaining a happy and positive facade got in the way of honesty and intimacy. She often felt this way about her relationship with her husband. Also, C.B.'s weight was a problem for her self-concept. She spoke very openly of her strengths and self-value yet said she wished to be lighter so that she would feel more physically attractive to her husband.

C.B. expressed that she did not have any tools for relieving stress and pain. She had a very low threshold for stress before it would raise pain levels. She also was unable to take most pain killing and anti-inflammatory drugs due to her allergies. Her main means of coping was to make sure she got adequate rest, keep appropriately active and remain positive.

Treatment Plan/Recommendations: Through our initial discussions it appeared as though hypnosis may be useful as a tool for C.B. to practice relaxation and direct pain modification. I also felt it may have been helpful for providing motivation and support for C.B. to exercise and loose weight. Along with this, I felt it important that C.B. begin an exercise program. Treatment originally began as such, but after the suicide of one of

C.B.'s friends, changed direction. We then began to explore various issues that were triggered by the death of her friend.

Treatment: After the intake, C.B.'s therapeutic involvement began with two sessions of hypnosis. The first session was a live induction. During the first attempt at induction C.B. began to giggle and said that my suggestions of her feeling "sleepy" reminded her of old style hypnotists and sounded "corny." I changed the choice of words to reflect feelings of increasing relaxation. Once again she began to giggle and came out of induction. This time we discussed what was happening. She admitted that she was a little uncertain of being hypnotized as she was afraid of losing control and under my control. I explained to C.B. that she was in complete control during hypnosis and that she could not be coerced into doing something she did not want to do. Her ability to pull her self out of the induction process twice was evidence of that. After this C.B. proved to be an excellent hypnotic subject. In the first treatment session she was given general suggestions of relaxation and a Special Place (she used her bedroom) where she felt completely at ease, content and at peace from all problems. She was also given the suggestion of self-hypnosis so that she could use and practice the suggestions on her own.

In the second session C.B. self-hypnotized herself and was given a further pain specific suggestion. C.B. had previously identified that when she was experiencing JRA swelling and pain she achieved relief by immersing her self in warm water. This second suggestion was that of C.B. imagining herself floating on her back in warm bouyant water. She was asked to imagine her- self becoming one with the water so that she could not tell the separation between the two. Then she was asked to imagine small warm golden ripples moving through the water and herself. She was told to imagine that these ripples would flush out any discomfort she may be feeling and replace it with healing warmth, relaxation

and comfort. She was told that upon completing the hypnosis she would feel alert, relaxed, and enthused about the rest of her day. She was also told she would feel motivated to do some moderate exercise.

C.B., unlike many of the other subjects, was able to describe and explain her experiences while hypnotized. At first this surprised me, but then I later attributed it to her being an artist and often working tangibly with imagined material. She reported that she found the experiences to be profoundly effective in creating relaxation, pain relief and elevating her mood.

The following sessions focussed on issues arising out of the death of a friend whom had committed suicide the weekend before. She had not had an opportunity to express her feelings of grief and felt very alone with her feelings. She shared her feelings of futility, sadness and anger about her friend's death and the impact that had on her. She explained that she was taught to not express negative emotions such as sadness as it was perceived as personal weakness. This was true in the situation of her friend's death as it was in many other aspects of her life. Her friend's death had a profound impact on her. She said that it forced her to evaluate her own life. She said that she became very aware of her mortality especially because of her JRA and it's effect on her. She said that she wanted to lead a more emotional rich life which at times was limited by her feelings that she had to always appear happy and together. She admitted that in general she was usually happy and positive, but sometimes she was in pain as a result of the JRA and felt discouraged. She wished she could be up front and share this with people as this would foster increased intimacy.

This was discussed over a number of sessions. She was encouraged to share these issues and feelings with her husband. She described her husband as a very emotionally sensitive man. As they were newly married she said she was not fully use to such intimacy but was

anxious to try. In the final session she explained that talking with her husband about her feelings actually seemed to bring them closer together and create more intimacy. She said that in their relationship she had always been accepting of her husband's feelings but had remained tentative with her own. She was appreciative of being able to share her hurts and pain along with made her feel good. It was agreed that there was no further need to continue with treatment.

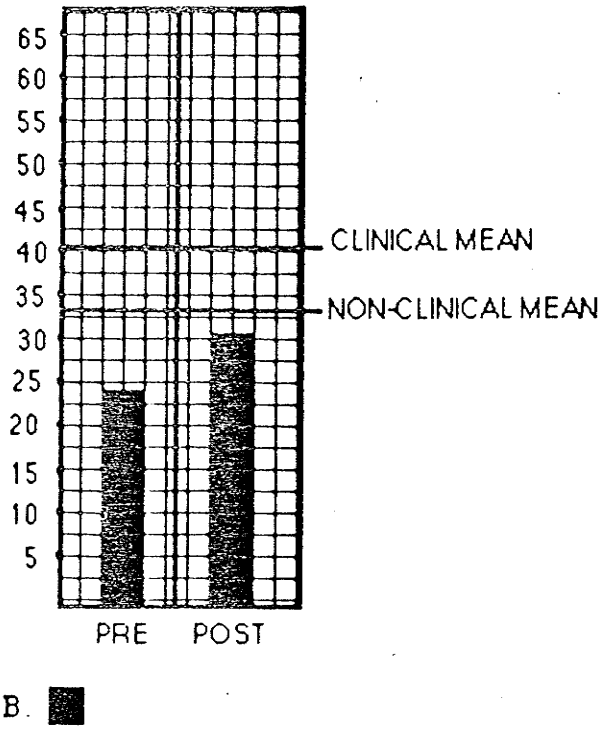
Outcome: C.B. had a generally positive outcome. Though she initially came to treatment for pain control, only a small portion of overall involvement centered on pain. Most of the treatment focussed on other issues which were collateral to the pain or arose during the course of treatment..A considerable amount of the clinical work dealt with C.B.'s sense of self-concept, self-worth and acceptance of JRA. My clinical impressions suggest that C.B. made substantial inroads on these issues. At the completion of treatment she spoke in accepting terms of her disease and limits of ability to control the JRA process and associated pain. She was also implimenting specific behavior strategies as a means to maximize her health and influence over pain. She planned to continue leading as rich a life as possible and not become a prisoner to the pain. C.B.'s HLC scores supported my impression of her as having a strong sense that she was responsible for her health (HLC: Pre 24; Post 31). C.B. stated that there were limits to her control over her health. However, she expressed the strong desire to exercise the control which she did possess.

C.B. indicated that at the beginning of treatment she was feeling somewhat depressed. Her Pre-treatment BDI score was 16 which was approaching, though below the clinical level of 21. Her post-treatment score was 6. It is possible that this change in BDI values may reflect an elevation in mood following treatment. This does mirror my clinical impressions but it must be stated in speculation as the BDI values were below the clinical level.

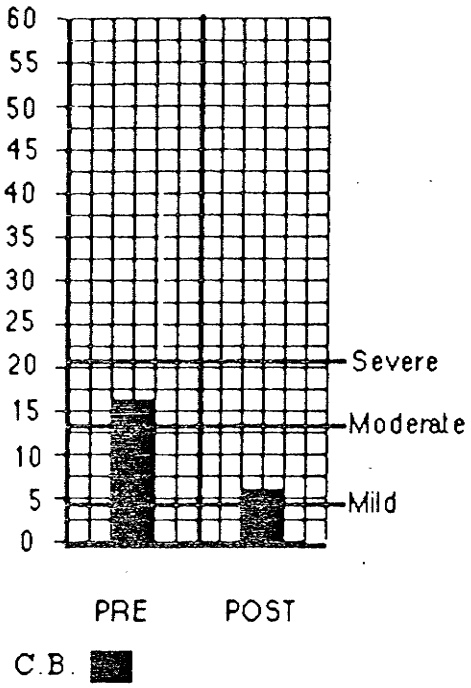
Though C.B. indicated that the hypnosis was very effective for controlling pain, her reported pain on the Visual Analogue Scale (6) remained unchanged after treatment . This is important information as it suggests to me that the success of treatment did not lie in reducing pain. Rather, it lay in the other issues dealt with which included C.B.'s response to her painful condition.What I found significant was that she expressed and demonstrated an improved functioning in response to the pain. C.B. consciously maintained activity as a way to take her mind off the pain. She also seemed much more emotionally animated than previous; she reported an increased intimate sharing with her husband; and she had begun to loose weight and was going to join an aerobic aqua-cise class. These were all positive indications that she received value from treatment.

Measures:

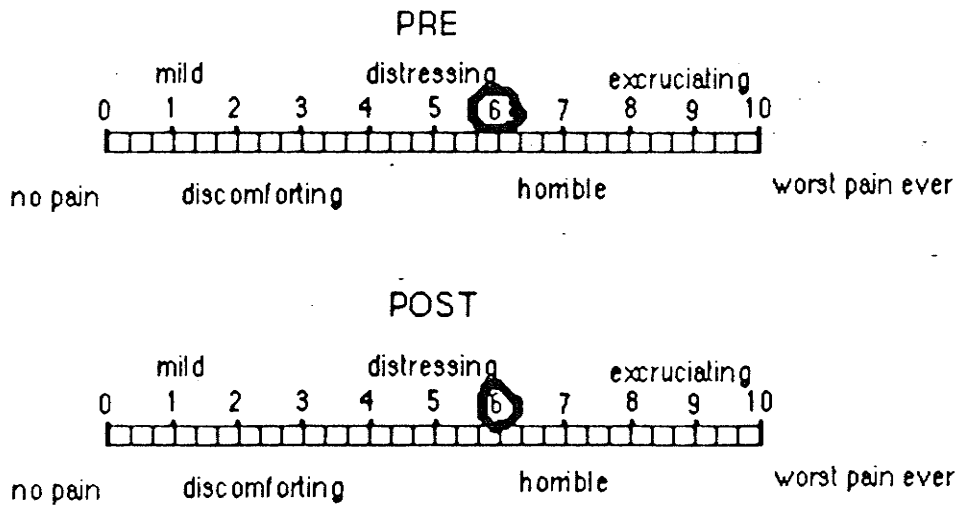
Health Locus Of Control



Beck Depression Inventory



Visual Analogue Of Pain



Case #5

Name: C.R.

Referred By: C.R. was a self referral to the P.S.C.

Period Seen: C.R. was first seen for an intake assessment on November 9, 1988. He was seen for 7 subsequent individual treatment sessions (Nov. 15, Nov. 22, Nov. 28, Dec. 6, and Dec. 13, all of 1988; and Jan. 10, Jan. 17 of 1989). Following C.R.'s individual treatment sessions he and his wife were seen in couples treatment. The couple's portion of the overall treatment will be presented in the next section.

Description of Client: C.R. was a 30 year old man employed as a support staff person. He had many interests which included science fiction and Manitoba history. He had recently got married (his second) to a woman (her first) who also worked on campus. C.R. had a 10 year old daughter from his first marriage. He had previously received individual counselling from P.S.C. in 1985 regarding his first marriage which was breaking up at that time. C.R.'s presenting problem was that he experienced Temporo-Mandibular Joint (TMJ) pain and he wished to try hypnosis as a tool to control the pain. He was also experiencing a dental phobia which he wanted to desensitize through hypnosis.

Situation as Seen By Client: C.R. said that he was unsure of the TMJ and dental phobia's origin though he did relate past traumas he associates with his mouth. He related that when he was five he tripped and broke his teeth on an iron gate. He found the experience very frightening and painful. He thought that the hyper-sensitivity may have also been associated with the death of his mother. Both C.R. and his mother were in an automobile

accident when he was twelve in which his mother was killed. He said his teeth were badly damaged and required emergency dental work. C.R. said that he has always been afraid of the dentist because of the associations with fear and pain. C.R. said that the TMJ began shortly after his first marriage broke up in 1986. He said that he would frequently experience anxiety attacks which triggered jaw pain. Often the anxiety was related to ongoing conflicts he was having with his ex-wife over visitation rights with his daughter. C.R. described that the anxiety attacks began to take on a life of their own and occurring with no connection to anything in specific. C.R. said that the frequency of the anxiety attacks had decreased but he was still very aware of tension in his life and it's impact on his pain. He said that he did not have any method of relieving tension and he hoped to utilize hypnosis for this end. C.R. also wanted to received hypnotic desensitization for his dental phobia. He had been avoiding making his semi-annual dental check up and wanted to do so.

Diagnostic Impressions: My impressions were that C.R. did not have any effective ways of coping with stress. Outside of work he was quite sedentary and did not involve himself in physical activity. C.R. related that the tension and pain often occurred in relation to conflicts he was having with his ex-wife over visitation rights with his daughter. His ex-wife had complete custody of his daughter and used that as leverage to antagonize him. C.R. found it very frustrrating, but also felt he had to walk on egg shells in order to see his daughter. C.R. also said that he experienced times of conflict with his present wife. There was tension between the two of them when C.R.'s daughter spent the weekend with them. His new wife and daughter were having difficulty adjusting to each other. He sometimes felt very frustrated that his wife and daughter did not get along better. It became apparent to me that there were often occasions when C.B.'s emotional responsiveness was restricted, especially in the communication of anger. He acknowledged that he was most likely to

experience TMJ and anxiety over the family conflict. I became aware of the value of including C.R.'s wife in treatment.

Treatment Plan/Recommendations: The proposed treatment plan would include counselling regarding the issues which created anxiety for C.D. This included past and present issues with his ex-wife, especially in relation to his daughter and ongoing issues with his new wife. This counselling included opportunity for C.R. to express himself but also consider behavioral strategies for improved coping and functioning. Hypnosis had a role to play as a tool for general relaxation and as a specific intervention for the TMJ and dental phobia. Quite early in treatment I saw the value of including C.R.'s wife in treatment at some point.

Treatment: Initially C.R. presented as an average hypnotic subject, but overtime and with practice, he began to display the ability of deep hypnosis. He was provided with the suggestions of a Special Place (he used his bathtub) where he felt safe, relaxed and completely in control. He was also given specific suggestions intended for his use with TMJ. The specific suggestions were those of transforming feelings of tension to relaxation. Part of the suggestion was that C.R. would use his body awareness as a sort of barometer to help determine his tension level so that he could recognize it and do something about it before it is difficult to manage. Following this C.R. received hypnotic desensitization for his dental phobia. This technique consisted of having C.R. priorize various images he associated with going to the dentist in order of stress producing intensity (I.E. Making the phone call to make the appointment, driving to the appointment, waiting in the dentist's office, etc.). Gradually moving through the various image associations, C.R. replaced the sense of anxiety and fear with the feelings of relaxation and control he experienced in his special place. It took a number of sessions to complete the process. About half of each

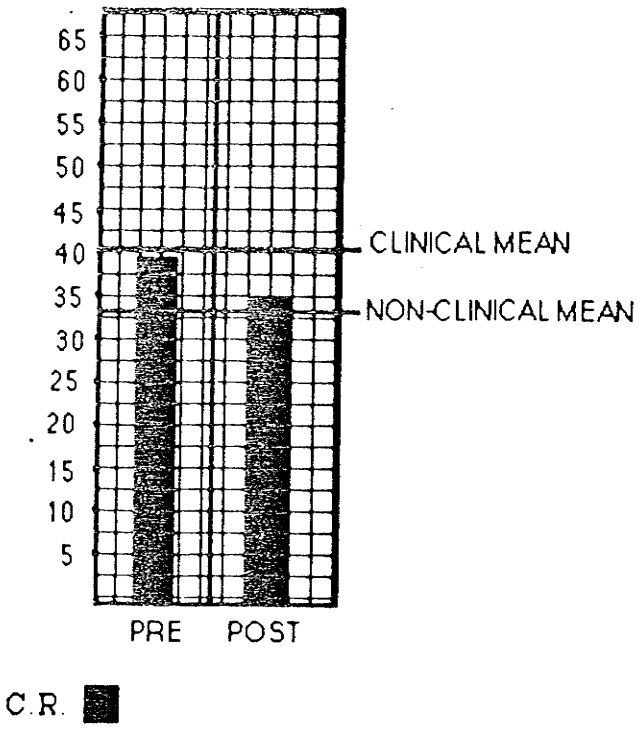
session utilized hypnosis while the other half focussed on various personal issues of C.R. On the last individual session, C.R. was asked to bring his wife along to discuss their common concerns.

Outcome: C.R. reported a generally positive outcome. He said that since learning the hypnotic techniques he was experiencing a significant decrease in the frequency of TMJ and intensity of pain. This may be reflected in the reduced VAS scores (Pre-3; Post-1) though the actual value reduction was marginal and possibly insignificant. C.R. said that the desensitization for his dental phobia was effective in increasing his comfort with the various stressful images he associated with the trip to the dentist's. However, a follow up discussion revealed that he had not yet made an appointment to see the dentist as he had hoped. He said he was going to get around to it. C.R. said the hypnosis was also effective in reducing the effects of stress on him. He was feeling more in control of his anxiety and pain. This may be reflected in the direction C.R.'s HLC score moved (Pre-39; Post-35) though it remained above the non-clinical mean.This suggests that C.R.maintained an External locus of control. He felt his health was outside of his control.

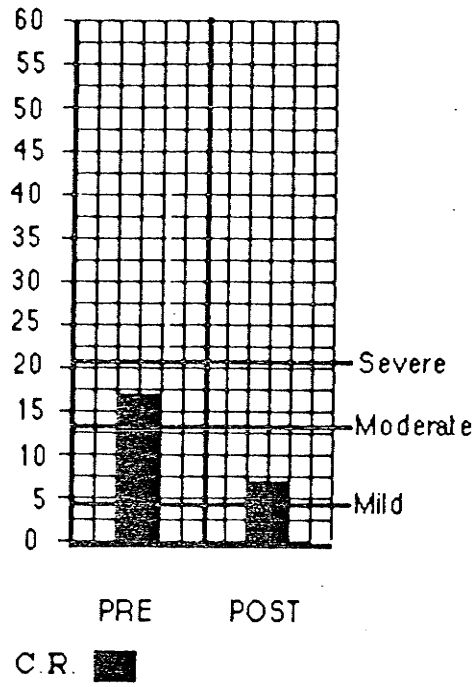
C.R.'s BDI scores (Pre-17; Post-7) suggest that a depression approaching the clinical level was diminished following treatment. C.R. had since started physical workouts co-jointly with his wife for enjoyment and stress release. He said that it helped him reduce the frustration he often experienced in his relations with his ex-wife. He said that he had come to accept the conflict between himself and his ex-wife and did his best to cope with it on his own. The final outcome of C.R.'s treatment was the agreement to invite his current wife to join in further treatment. She readily agreed.

Measures:

Health Locus Of Control

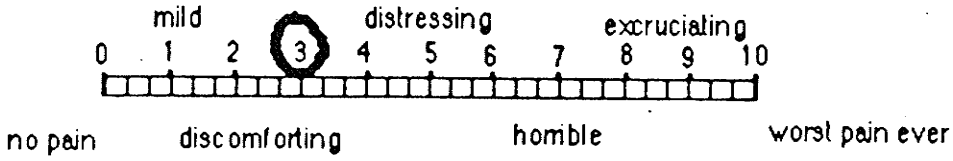


Beck Depression Inventory

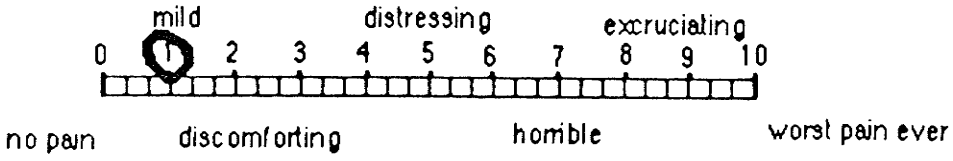


Visual Analogue Of Pain

PRE



POST



Case #6

Name: R.B.

Referred By: R.B. was referred by the St. Boniface Hospital Pain Clinic.

Period Seen: R.B. was first seen for an intake/assessment interview on October 13, 1988. He was seen individually for 13 treatment sessions (Oct. 19, Nov. 2, Nov. 9, Nov. 18, Nov. 22, Nov. 30, Dec. 7, Dec. 14, all of 1988; and Jan. 4, Jan. 10, Jan. 25, Feb. 1, Feb. 8, of 1989. His family joined treatment for 5 following sessions. The family involvement will be discussed in the following section under the B. Family.

Description of Client: R.B. was a 21 year old man who stated that he had suffered from migraine/cluster headaches from the time he was 5 years old. He was currently on Disability Insurance as a result of the extreme intensity and frequency of his headaches. He had been away from work and on disability for over one and a half years (since Sept. 1987). He had previously been employed as an assistant manager of a restaurant. He was living at home and reporting intense conflicts with other family members. He was currently an outpatient with the St. Boniface Hospital Pain Clinic and a neurologist regarding his headaches. He was prescribed Anaprox (275 mg. twice a day) and Inderal (80 mg. twice a day) for pain control. He also received Amitriptyline (25 mg.) for pain. R.B. frequently took non-prescription Tylenol on a daily basis as an added pain killer. R.B. reported that he experienced a headache everyday, often as soon as he woke up. On numerous occasions R.B. had his family and friends bring him to the hospital for an injection of Demerol (125 mg.) when the headaches were severe. The problem of drug dependence was imminent and

may have been reflected by the increasing frequency of R.B.'s trips to the hospital for demerol injections.

Situation As Seen By Client: Although R.B. related at length the many highly stressful situations he had experienced, he categorically denied their having any appreciable effect on him. He could remember always having headaches. In particular, he remembered a serious string of headaches which followed a neck injury at age 11. He said that as a result he missed a substantial portion of school in the two following years. R.B. said his most recent bout of headaches occurred after he attempted suicide when he and a girlfriend broke up in September, 1987. He spent 20 days in the psychiatric unit at the Victoria Hospital. Immediately after this, his car was stolen, found, returned and then blown up by someone. He believes he knows who did the act (his ex-girlfriend's ex-boyfriend). He said he began to experience severe intractable headaches from that period onward which have prevented him from working. R.B. stated that he felt the headaches were 100% neurological in origin and would not give any credence or consideration that stress may have been playing a role to any degree. R.B. stated that he has accepted that his headaches are completely beyond his control and he does not see the value in worrying or letting problems get to him. R.B. said he was skeptical, but he was interested in trying hypnosis to lessen the effects of his headaches.

Diagnostic Impressions: While there may be a neurological basis to the headaches, I was struck by the preponderance of stressors in R.B.'s life and his flat out denial of their impact. R.B. would freely discuss the issues but would not acknowledge any effect they had on him. By R.B.'s description, his life was virtually stress free. He stated that even his severe headaches did not get him down. He certainly presented himself as being very jovial

and generally carefree. However, his stresses were significant by my estimation. He described a past relationship with a young woman whom, by his description, he loved. R.B. gave her his credit card for her use when she went on a trip to Banff. As it turned out, she brought another man along with her, charged up $2000.00 worth of charges and refused to see him anymore. Interestingly R.B. admitted that he felt "burned" by this woman, but he "still carried a torch for her." He said that he was only interested in this woman, no other.

R.B. also described an highly tense and dysfunctional home life. He lived with his parents and sister. R.B. said he did not get along with any of his family members and wished to move out. He described great marital problems between his parents who separated when he was 14, yet continued to live in the same house, the father downstairs and the rest of the family upstairs. R.B. explained that he negotiated between his parents so that they would remain in the same house for financial reasons. His mother still cooked, cleaned, and took care of his father despite constant fighting and arguments about money and personal issues. R.B. described his mother as an over-involved meddler who was always after him to do things. She was partially disabled with arthritis. R.B. admitted that he did nothing to contribute to the house (clean, pay room and board, etc.) as he either had a headache or was angry at his mother. R.B.'s father had recently been diagnosed as having a degenerative neurological disease which was rendering him more and more dependent upon his tenuous family. R.B. described his father as a previously emotionally and physically abusive man. R.B. was very angry at his father and could not feel compelled to help do to the past abuse. R.B. said he did not get along with his sister either whom he felt got away with her share of the household responsibilities because she worked. She was the only family member who currently worked. This created extreme financial pressures for the family.

R.B. claimed that none of the pressures effected him in anyway other than he wished he did not have headaches so he could work and move out. He did not acknowledge the effects of the stresses but experienced daily debilitating headaches. My impression was that they were intimately connected. R.B. appeared to have completely cut off his awareness of stress and it's effect on him.

Treatment Plan/Recommendations: The treatment plan included the use of hypnosis to provide the suggestion of a stress barometer so that R.B. could learn to monitor his stress, a general relaxation suggestion, and a suggestion specifically directed at modifying the sensation and effects of the headache. The plan included continued discussion and counselling on his family and other issues as they effected him. This was with the desire to have R.B. express his perceptions and feelings on these issues and possibly raise his awareness of their effects on him. An additional plan was to discuss possible behavior alterations that may contribute to enhanced functioning.

Treatment: R.B. was initially provided with a audio-taped general hypnosis induction. R.B. stated that he was wary of giving control over to someone else in hypnosis. It was explained to him that he would not loose control, but rather would gain self-control through hypnosis. He was given the tape to listen to every day for the following week as a safe introduction to hypnosis. Following this R.B. proved to be an above average hypnotic subject. He demonstrated some phenomenon associated with deep hypnosis such as amnesia. Over a number of sessions he was given a live induction and the suggestions of self-hypnosis (so he could practice on his own), a Special Place (for general deep

relaxation) and hand warming and free flowing blood through the head (to alter the somatic effects of the headache).

A considerable amount of time was spent discussing R.B.'s personal and family issues. As we spoke more about his various issues I became more convinced of their profound effect on him, despite his ongoing denial of such. This was especially true of the possible effects his chaotic family life was having on him. R.B. readily acknowledged that there were problems in his family and that he might be interested in having his family members join us to explore the problems. He also described that this might be an opportunity for somethings to finally come out in the wash, largely in his favour. This was seen by me as the logical direction to go in treatment. Arrangements were made for R.B.'s family to join us in treatment.

Outcome: R.B. appeared to be a good hypnotic subject and claimed that he found the hypnosis to be profoundly relaxing. The suggestions intended to alter the somatic symptoms of migraine had a marginal reported effect. R.B.'s Vas score dropped from the Pre-score of (6) to the Post-score of (4) indicating an overall drop in pain. However, by his own report, the frequency of severe headaches that required demerol injections markedly increased. The frequency of these injections increased from 6 in October, 1988 to 12 in December,1988. R.B. stated that he religiously used the self-hypnosis to put him to sleep at night and relax when tensions were very high at home.

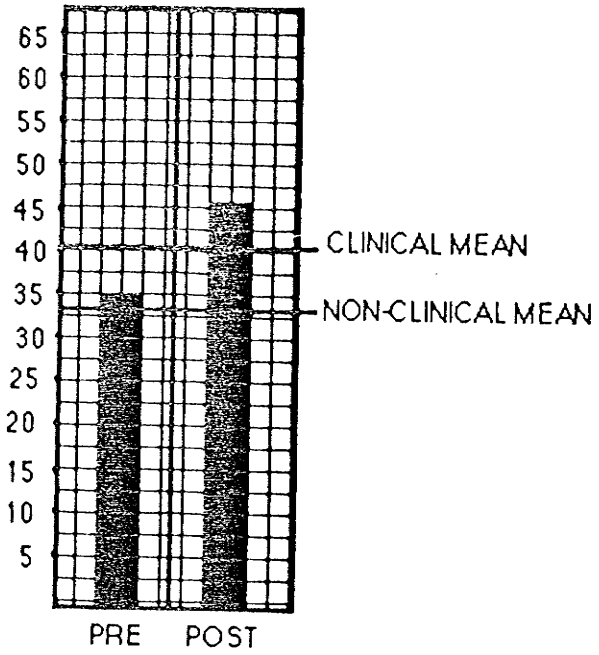
Through out his involvement, R.B. was adamant that his headaches were beyond his control. This may be reflected in his clinically high Health Locus of Control scores (Pre-35; Post-46) which was significantly higher than the median of 33. His increased post-score coincides with his reported increase of severe headaches and need of demerol injections. This may have also been related to his failure to reduce his pain and his growing awareness

of the family problems outside his control. The pre and post scores of the Beck Depression Inventory indicate that R.B. may have been experiencing a depression (Pre-16; Post-17) approaching the clinical level.

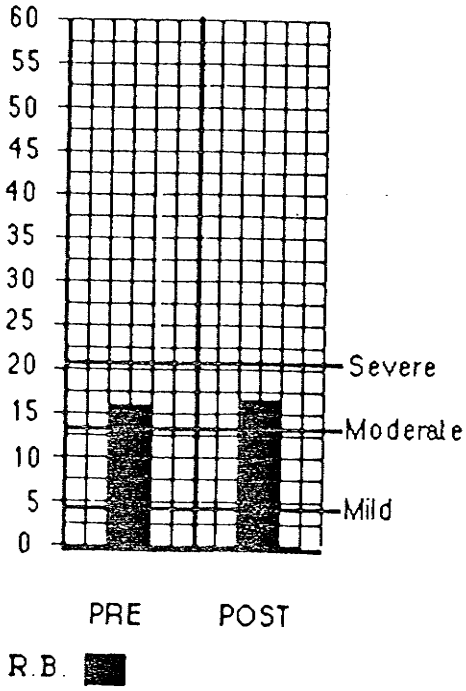
Near the end of R.B.'s individual treatment he began to acknowledge the effect of his family's tensions on him. He often blamed his family for the lack of success he was experiencing in treatment. For this reason, I asked R.B. to invite his family to join us and discuss some of the problems they share. This will be discussed in the next section under the heading of the B. family.

Measures:

Health Locus Of Control

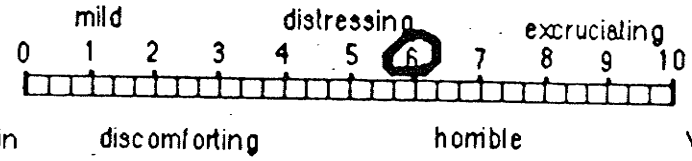


Beck Depression Inventory

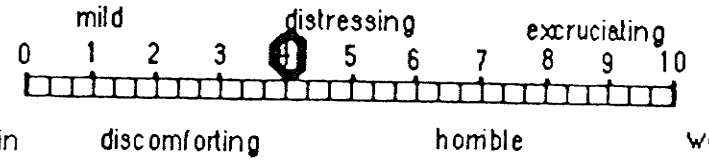


Visual Analogue Of Pain

PRE



POST



Discussion

Three of the total six individual cases involved in this practicum indicated improved functioning, and decreased intensity and frequency of pain symptoms. This total number also includes the two individuals who dropped out prior to the completion of treatment. The determinants of improved functioning, as indicated in the case descriptions, included the three measures used, the clients' self reports and my own observations.

Hypnosis appeared to provide a viable treatment tool for working with this population. It was effective in reducing the individual's stress through increasing relaxation. It also displayed utility in modifying the experience of pain by either directing attention away from the pain (such as with the use of the Special Place), and altering the sensation or replacing the pain with a more functional experience (Somatic suggestions, Body Awareness Checking and Mood Alteration).

Hypnosis played an important role in the overall treatment. However, in consideration of the overall context of treatment it is inaccurate to attribute sole credit to hypnosis as the catalyst of change and improved functioning. Treatment also included counselling for personal issues, and the development and implimentation of behavioral strategies.

The clients who responded successfully to treatment were not only open to the possibilities of hypnosis, but were also prepared to explore the wide range of personal issues which impacted on their lives. This included their perceptions, beliefs and feelings related to the issues. As I worked more with the clients I became increasingly aware of my reluctance to solely focus on the use of hypnosis with pain and to exclude an exploration of the client's other outstanding personal issues. I felt that this approach would simply not be complete treatment and may miss important issues and content which impacted on the client's life and pain. In many respects I attempted to direct the treatment away from the sole focus on pain

to the larger life picture of which pain was apart. This included outstanding issues, relationships with significant others, and lifestyle. Approximately two-thirds to three-quarters of the clinical involvement time was spent on the later with hypnosis taking on a supporting role. This is a good way to describe hypnosis' place in treatment.

Used alone, hypnosis may prove effective with the alteration of some pain symptoms. However, it has further utility as a tool to initiate and support overt and covert behavioral changes as a part of the overall treatment package. This is where the use of hypnosis may provide an important treatment addition for therapeutic practitioners, including social workers.

In summation, I believe the treatment provided for the clients presenting with chronic pain demonstrated potential utility. I became aware of, just as in all therapeutic contexts, the central need for the universal treatment skills of communication, developing a therapeutic relationship, exploring issues and prompting change. It was from this framework that all happened or did not happen. The hypnotic treatment skills were relatively easy to learn but did require sound judgement and active creativity to fit into this millieu in a way which was appropriate and effective. Appropriate, in that it was related to the treatment focus, and effective in that it helped strengthen the gains of treatment.

The Use of a Family Based Treatment With Chronic Pain

Introduction

This portion of the report will present and discuss the treatment performed with the couples and family involved with the practicum. Each of the couples and family had a family member who was identified as suffering from a chronic pain ailment. Two of the identified chronic pain sufferers had previously been involved in the hypnosis intervention already presented.

This section will discuss the techniques and goals of the intervention. Following this, the actual cases will be presented including a description of the couple or family, the situation as seen by them, assessment, treatment and outcome. The section will end with a discussion of the important themes and elements which arose out of the assessment, treatment and outcome.

The Family Treatment of Chronic Pain

The McMaster Model of Family Functioning (MMFF) assessment and the accompanying Problem Centered Systems Family Therapy (PCSFT) were used together as the mode of understanding and treatment of the couples and family presenting with a member suffering from chronic pain. The MMFF, as was discussed at greater length earlier, consists of illuminating the major family problem issues and assessing the family's functioning abilities on six dimensions: Problem Solving; Communication; Roles; Affective Responsiveness; Affective Involvement; Behavior Control.

After an understanding of the interactional patterns and issues amongst family members are gathered through the assessment, the PCSFT may begin. As discussed earlier, this includes problem priorization, negotiation and assignment of behavioral tasks to address the problems. Treatment consists of an ongoing monitoring of the task accomplishment with possible renegotiation and setting of new tasks. Treatment may be considered complete when either all the identified problems and issues have been satisfactorily addressed through the tasks or the treatment is terminated due to the non-commitment of the family or the inability of the therapist to facilitate change.

Treatment Goals

The treatment goals of the family intervention differed quite significantly from the individually based intervention in that the family intervention placed less of an emphasis on the individual's experience of pain. As Roy (1985) comments, the use of a family based treatment with the intention to reduce the chronic pain patient's level of pain is largely untenable. There is an unsubstantial amount of evidence to support this possibility. However, there is highly suggestive evidence that the family as a whole, and individual family members are affected by the presence of chronic pain in the system. The incidence of personal difficulties and compromised health are often present in the family members of chronic pain patients. Also, certain interactional patterns may evolve in a family lending that family reduced functioning capabilities.

The goal of the family treatment was to explore the issues and functioning capabilities of the family and work to resolve these issues through fostering improved functioning. The key goal is enhanced family functioning. The hypothesis is that if the family's functioning is improved, the family members will be better equipped to solve their shared current and

future problems. This also follows from the research of Westley and Epstein (1970) which suggested that difference between effective and ineffective functioning families was not whether or not the family had problems (all families had problems), but rather how the family dealt with and resolved problems.

My intention was to move away from the presenting problem of pain very soon, and move towards the general framework of family functioning of which other issues, including the chronic pain are a part. This does not imply ignoring the issue of the chronic pain but rather putting it into the overall context of the family issues and functioning. Often a family entering treatment may scapegoat the identified pain patient and his pain as the sole problem. If the pain was removed all the family tensions would be removed. While the removal of pain may certainly be wished for the patient, it is unrealistic considering the relative difficulty in eradicating such pain. Rather, the focus is placed on helping the family consider how they may best work and function together in consideration of the pain and other presenting problems. The presenting problems are addressed in treatment, through discussion and the use of behavioral tasks, however, this is not for the purpose of alleviating the problems as much as providing a vehicle for the family or couple to develop improved functioning.

Though a completely untested hypothesis, it is possible to conceive that reduced family tensions, as a result of improved functioning, may translate into reduced pain in family members suffering from certain ailments (Roy,1985). It would be a definite boon if this were the proven case. At present it is not and thus the focus remains on the benefits of improved family functioning.

This report shall now turn to the case presentations and discussion.

Couples and Family Based Treatment:

Case Presentations

Name: Mr. and Mrs. R.

Referred By: Self. Mr. R. was previously involved with the individual hypnosis treatment (see C.R. case). As the individual treatment concluded, Mr. R. was invited to ask his wife to join treatment. He agreed, as did his wife.

Period Seen: Mr. and Mrs. R. were seen for six sessions (Jan. 25, Feb. 1, Feb. 7, Feb. 22, Mar. 22, Mar. 29; all of 1989).

Description of Couple: Mr. and Mrs. R. were a young couple who had been married for only 10 months. This was Mr. R.'s second marriage, while this was Mrs. R.'s first. They did not have any children from their present marriage, though Mr. R. had a 10 year old daughter from his first marriage. Mr. R. had been involved with the hypnotic treatment for an ongoing problem with Temporo-Mandibular Joint (TMJ) pain and a dental phobia. Interestingly, Mrs. R. explained that she had once been a sufferer of TMJ, but had not experienced it for a number of years since it was surgically corrected. The R.'s presented as a reasonably healthy functioning couple who were deeply committed to each other and the marriage.

Situation as Seen By Couple: The R.s stated that for the large part they felt very positive about each other and their relationship. They stated they felt they did not have any fundamental problems that were threatening their relationship and they saw their involvement with family treatment as an opportunity to "fine-tune" their relationship while addressing some existing problems. They also said that they were willing to consider problems which impacted on Mr. R.'s TMJ. The presenting problem was first identified

while Mr. R. was in individual treatment for his TMJ. He stated that he often experienced more pain during times of increased tension in his home. He stated there were a number of situations which frequently created tension between himself and Mrs. R., but this most often happened when his 10 year old daughter K.R. visited him on weekends. He said that there was frequent friction between Mrs. R. and K.R. as his daughter would create a disturbance when ever she wanted attention or Mr. R. gave Mrs. R. attention. Mr. R. said that Mrs. R. was not trying to get along with K.R. and he wished she would as K.R. was his daughter, albeit from his first marriage, but non-the-less his daughter. Mr. R. said that this problem began after they became married. He said that he experienced anger, sadness and confusion about the situation as he did not know what to do. Mrs. R. stated that she would not "play act" that she liked K.R. as she did not. Mrs. R. said that she found K.R. to be very difficult to like as she was often belligerent. Mrs. R. also said that she felt Mr.R. was pushing K.R. and herself hard for them to be "an instant happy family." They admitted that they felt they were at an impasse on this issue. Mr. R. stated that when there was such tension in their home he was much more likely to experience TMJ.

Assessment:

Both Mr. and Mrs. R. said that on the whole they functioned very well as a couple. They demonstrated some **Problem-Solving** ability with instrumental problems. This was evidenced by their success in solving a problem which had arisen around some unfinished housework. This was a problem they solved on their own just as they had entered treatment. By their description they moved through the first five stages of problem solving (Identification; Communication; Development of alternatives; Decision on one alternative; and Action). They stated that they were at the stage of monitoring their choice to determine

it's effectiveness. Despite their success in addressing this instrumental problem there were other existent problems which had persisted as a result of their inability to solve them.

An example was an issue which revolved around their inability to arrive on time for work or social functions. This issue was identified by Mr. R. He stated that they were often late for work and social engagements because Mrs. R. would either get out of bed late or take a long time to get ready. Essentially an instrumental issue, Mr. R. would become very angry and upset about this as he wished to arrive early or on time for work and social activities. They appeared to get no further than the second stage of problem solving (communication). After some coaxing by Mrs. R. to find out what was bothering Mr. R. (he would express his anger in a masked and often indirect manner), he would say what was bothering him. In this example the problem solving went no further as Mrs. R. did not agree this issue was a problem. She felt Mr. R. was over-reacting to the issue and there was not a real problem.

The R.'s demonstrated considerably more difficulty in solving affective laden issues. This was true of a conflict relating to the difficulties the R.'s were having with K.R. As outlined earlier, the R.'s were unable to agree on a course of action regarding K.R.'s behavior when she was with them for weekend visits. They both had identified the issue and had talked about it, but were unable to agree on an action to solve the problem. This was also the case for another unresolved issue. The R.'s had been unable to decide when they as a couple would like to have children. Along with this they had been unable to agree on how many children to have. Mrs. R. wanted to have one child immediately. Mr. R., on the other hand, wanted to have two or three children a number of years down the line. As with the previous example, both had been able to identify the problem and communicate it to the other, but they had been unable to progress any further. They were unable to negotiate and agree upon a decision.

On many of the issues raised, the R.'s had been unable to progress past the third problem-solving stage. They did seem to be able to identify, communicate, and discuss alternative decisions, but experienced difficulties in choosing one action alternative. At times they demonstrated difficulty getting past the second stage of problem-solving. This was true of emotionally laden issues identified by Mr. R. He would often have difficulty expressing his concerns clearly and directly.

Mr. and Mrs. R. stated that they felt they **Communicated** very effectively. However, with some exploration some difficulties began to emerge. Mrs. R. exhibited clear and direct communication. Mr. R. was generally able to communicate clearly and directly on instrumental issues, but would gravitate to a more masked, yet direct, pattern of communication on affective issues. This was particularly true of issues which were laden with the emergency emotions of anger and sadness. An example would be when the R.'s were deciding what to do on a free afternoon. Mr. R. would generally leave the decision up to Mrs. R. as he didn't want to appear pushy or create a conflict. This would occur even though he would have had something in mind to do. Mrs. R. would then make a decision to go shopping and they both would go off to shop. After this happened a number of times Mr. R. became quite angry as he felt they never did what they wanted. At this time he would express his anger in a masked and indirect manner by slamming car doors and appearing miserable. This might occur for sometime despite Mrs. R.'s attempt to draw out what was bothering Mr. R. After much coaxing Mr. R. would usually express what was bothering him. In session Mr. R. said that he wished Mrs. R. had been more thoughtful of his concerns. Mrs. R. exclaimed that she would be if she knew what they were. She said she couldn't read his mind.

By the R.'s description this occurred quite frequently. Mr. R.'s difficulty in asserting his feelings on instrumental issues could charge them with feelings of hurt and anger. During

the assessment Mr. R. demonstrated difficulty discussing affective issues. This included the issue of Mr. R.'s daughter, and the disagreement on when to have children and how many. On these issues, where there was direct conflict and feelings of anger, frustration and hurt, Mr. R. tended to express himself indirectly through talking at me rather than Mrs. R. He would also express himself through highly intellectualized language free of feelings. The more affective the issue the more he tended to do this.

The R.'s were in the process of solidifying their **Roles**. At the time of treatment the R.'s had been married for only 10 months. They were still designing their mutual roles for the first time. The instrumental role functioning had been allocated between Mr. and Mrs. R. Both Mr. and Mrs. R. were employed. Mrs. R. took care of the finances which was managed from a joint account. She also was responsible for paying the bills. Mr. R. did most of the cooking and they split the remaining housework. The R.'s also indicated that they provided mutual emotional support to each other. They felt they could turn to each other for support when they were bothered by something. This appeared to be true of issues which did not involve conflict between the two of them. When the issue involved a conflict between them there appeared to be a distancing which occurred and a lack of conflict resolution. However, their claim that they demonstrated physical and emotional affection was born out by my observations during the assessment. They stated that they were very happy with the sexual component of their relationship. They both agreed that the frequency and quality of their sexual relations was very satisfactory.

When K.R.visited the nurturance role was being satisfactorily carried out by Mr. R. However, he wished Mrs. R. would take an increased role in the care of K.R. Mrs. R. said that at this present time she was not willing to take on the role of K.R.'s mother as she already had one. Despite this disagreement the nurturance needs of K.R. were being met.

In the function of life skills development, the R.'s appeared to support each other in their respective personal, career and social interests. Mr. R. had varied interests and activities which he pursued apart from Mrs. R. He had written a book and had a keen interest in science fiction. He was involved in formalized activities outside the home. Mrs. R. pursued some different activities with her own friends. Aside from these activities they made a point of spending the weekends and a couple of evenings together. They enjoyed getting together with friends and going to movies.

Mr. and Mrs. R. both indicated that the maintenance and management of their small family was a shared responsibility. Mrs. R. most often made the decisions on the day to day matters of the house. This included the paying of bills. The larger decisions appeared to be shared between Mr. and Mrs. R. Both Mr. and Mrs. R. acknowledged that there were understood rules of conduct between them. This included no violence between them and that they would always attempt to treat the other with respect. Also, as mentioned, they made a deliberate point of spending time alone and socially as a couple.

My assessment of the R.'s was that the roles had largely been allocated. An area of conflict was that Mrs. R. seemed to be the "boss"in the decision making and role accountability. She indicated that she did not like such an exclusive role. This left her feeling like the "heavy" as she was often making decisions alone for the both of them. She wished some of these day to day decisions would be made by Mr. R.

In the dimension of **Affective Responsiveness** both Mr. and Mrs. R. demonstrated an active ability to share welfare feelings of love and tenderness between them. They were quite candid in discussing and telling each other about the positive feelings they had for each other. Likewise Mrs. R. was able to express feelings of anger, confusion and frustration to Mr. R. on various issues. Mr. R. experienced difficulty expressing feelings of anger and disappointment which arose out of conflicts with Mrs. R. He sometimes felt

as if he had not been given an adequate chance to do so as Mrs. R. would overpower him. They both agreed that what would often happen is Mr. R. would hold on to his feelings until it was either coaxed out of him by Mrs. R. or he would express it, often out of context.

Mr. and Mrs. R. demonstrated an Empathic style of **Affective Involvement** between them. They were interested in the activities and feelings of the other for the sake of the other and how it affected their relationship. An example was when Mrs. R. said she wished Mr. R. would be more assertive with her and express what he wanted, not only for his own sake, but also so their relationship would be more up-front and healthy.

Mr. and Mrs. R. appeared to demonstrate different styles of **Behavior Control** in different situations. Between the two of them there was largely flexible behavior control.They said that the important rules in the house are that they treat each other with respect and are not either emotionally or physically abusive with each other. This is true of their meeting and expressing their psycho-biological needs and drives and their interpersonal socializing behavior inside and outside their home. They were in agreement on this and could talk openly about it.

However, Mr. and Mrs. R. seemed to be at odds on the acceptable standards of behavior for K.R. Mr. R. said that he was more tolerant of K.R.'s acting out behavior as he felt she was going through a difficult time with her parents' divorce and Mr. R.'s new marriage. He was willing to allow more latitude with K.R.'s behavior than Mrs. R. Mrs. R. felt that K.R. should not be allowed to get away with the unacceptable behavior regardless of the cause. She expressed that there should be rules which held fast regardless of the situation. An example of this was that K.R. liked to watch t.v. during dinner time and would kick up a fuss if she couldn't. Mr. R. was willing to let her do so even though they had agreed that meals would be eaten at the table. Mrs. R. felt that K.R.'s actions were inappropriate and

should not happen. She would be adamant that K.R. follow the rules and eat at the table. Mr. and Mrs. R. expressed that their problems with K.R.'s behavior only occurred when the three of them were together. My assessment suggests that this may have been largely the result of Mr. and Mrs. R.'s different behavior control style with K.R. Mr. R. had a clearly Laissez-faire style while Mrs. R. was Rigid. This combination of styles would create confusing messages for K.R. The definition of Chaotic behavior control is a situation where styles and rule expectations are inconsistent. This may leave the family members uncertain about what rules stand. I would suggest that the inconsistency of Mr. and Mrs. R.'s behavior control styles could have created either a very confusing environment for Mr. R.'s 9 year old daughter or a considerable amount of room for her to bend the rules and create disruption.

The R.'s presented as a couple with definite strengths as they entered treatment. They were very committed to each other and wished to work on their relationship together. They were prepared to discuss the core issues in their relationship. In some respects the R's difficulties may have been a result of the fact that they were newly married and just setting out in their adjustment of their own mores. However, as a result of limited problem-solving ability, Mr. R.'s lack of clear and direct communication on conflictual affective issues, disagreement on their roles with K.R. and the accepted style of behavior control for K.R., problems did arise. Through the course of assessment four central issues became clear.These issues were:

1). The R.'s difficulty with K.R.'s behavior when she visited.

2). Their difficulty to agree on when to have children and how many.

3). Mr. R.'s difficulty in expressing anger or assert his wants to Mrs. R.

4). The R.'s not being able to arrive at work or social functions on time.

Treatment: The treatment consisted of discussing the various issues mentioned and considering possible actions and strategies as a means to problem solve. The R.'s demonstrated a readiness to communicate and work on their problems. They were also willing to do work on their own outside of the treatment sessions. This was to the degree that after the fifth session they indicated that they felt the presenting problems which brought them to seek treatment had been adequately dealt with. A consultative meeting arranged with Prof. Roy revealed that the problems had been satisfactorily solved by Mr. and Mrs. R.

In relation to the daughter's disruptive behavior during her weekend visits, Mr. and Mrs. R. stated that they agreed to do a lot of one on one activities and supervision of K.R. They recognized the problems occurred when the three of them were together. They agreed that this was not the ideal nor final solution to the problem, but it was what they agreed on for now. It appeared to be working for the time being, but they would evaluate it's success and adapt it down the line if necessary.

With the problem of lateness for work and social events, they negotiated that Mr. R. would tell Mrs. R. in advance of when he wanted to leave. This way she would know when they were leaving and she would have adequate time to prepare herself.

They also discussed the issue of when to have children, and how many. They said that they agreed they would have their first child in the summer of 1990. They had decided they were going to have two children.

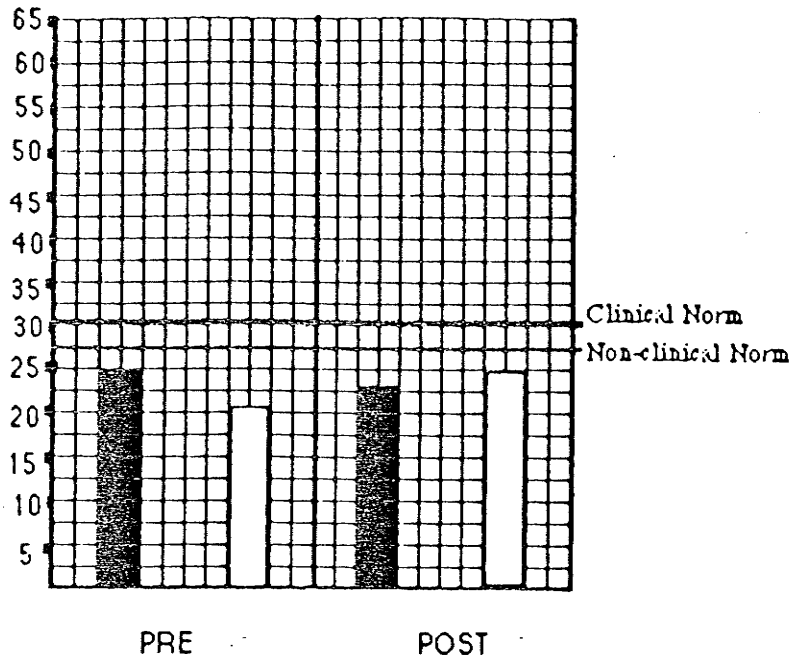
In order to do this negotiating it was necessary that Mr. R. be fully prepared to assert his wishes and feelings. Both Mr. and Mrs. R. indicated that they found the treatment involvement to be very helpful in forcing them to be aware of and evaluate their

communication pattern. This included Mr. R. being more clear in his wants and feelings. It also included Mrs. R. being prepared to allow Mr. R. to have his say.

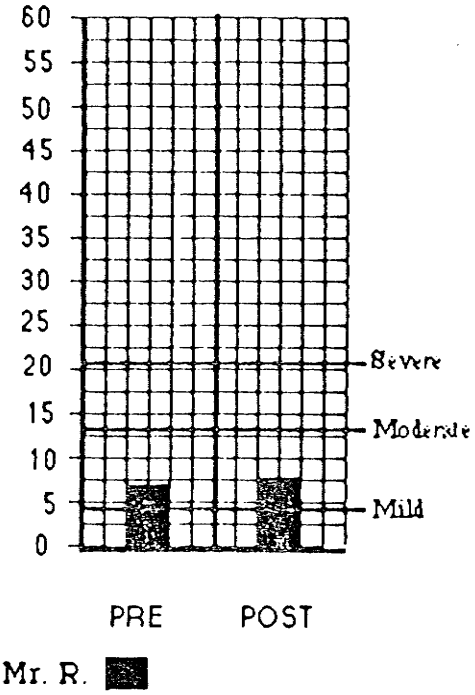
Outcome: The outcome of the R.'s involvement was generally positive. Despite their previous difficulties in solving problems, they demonstrated high initiative and capabilities for working on their problems. My clinical judgement that the R.'s were a non-clinical family was supported by their respective low Pre and Post scores on the FAM Brief scale (Mr. R.: Pre-25, Post-23; Mrs. R.: Pre-21, Post-25). These scores are well below the norms for clinical families and indicate an effectively functioning family. Mr. R.'s self report indicated that his TMJ had all but ceased. His very low pre and post scores on the VAS (Pre: 1; Post: 0-1) again suggest that Mr. R. had a non-clinical level of pain. It would be difficult to attribute this small degree of change to treatment. Mr. R.'s BDI score (Pre-7, Post-8) indicate no change in his non-clinical depression level occurred during treatment. It is interesting that Mr. R.s BDI was markedly reduced from the first score (17) obtained prior to his individual treatment (see C.R. case). To keep in mind, even a score of 17 is below the clinical level.

Measures:

FAM BRIEF SCALE

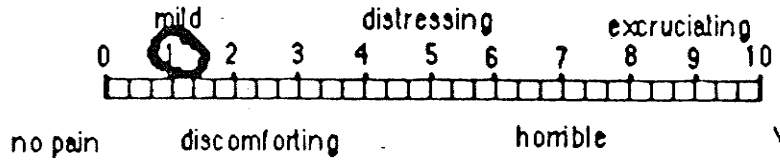


Beck Depression Inventory

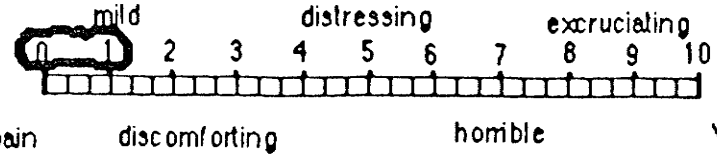


Visual Analogue Of Pain

PRE



POST



Name: The B. Family: Mr. and Mrs. B. and their children, R.B. and S.B.

Referred By: R.B. was seen previously for individual treatment (see Case #6, R.B.). As individual treatment concluded it was recommended that he invite his family to join in treatment to discuss family issues which arose. The family agreed.

Period Seen: The B. family was seen for five sessions (March 1, March 8, March 15, March 22, March 5, all of 1989).

Description of Family: The B. family was a family struggling to maintain it self as an entity. It was faced with extreme financial, medical and intra-familial stresses which were combining to create great difficulties for the B.'s to function effectively. There were two members of the family, Mr. B. and R.B., who were unable to work and function independently. They were very dependent on the remaining family, in particular Mrs. B., for support. Mr. B., approximately 52 years of age, had recently been forced to stop working as a result of a degenerative neurological disease (ALS) which was rendering him disabled and unable to take care of himself. During the first, and only interview he attended, Mr. B. was very unstable both physically and mentally. Perhaps as a result of the ALS he cried a number of times. When he did speak, what he said was unconnected from the conversation.

Mrs. B. was approximately the same age as Mr. B. She had severe arthritis and described herself as "disabled." She expressed that she felt responsible for taking care of everyone and the house, and was subsequently having difficulty coping. She took care of the house and Mr. B. Though they did not live in separate residences they had been separated for about 7 years. Mr. B. lived in the basement of the house while Mrs. B., R.B. and S.B. lived upstairs. Mr. B. still took his meals with the family, had his clothes washed by Mrs.

B. and had his portion of the house cleaned by Mrs. B. As his needs increased so did his demands on the family which created considerable tension in the house.

R.B. was 21 years of age and not working as a result of debilitating migraine headaches. He had been away from his previous job as a assistant manager of a take-out pizza restaurant since October, 1987 (at the time, approximately 18 months previous). R.B. was receiving disability insurance benefits. As a result of his debilitating headaches and considerable personal disappointment R.B. was extremely short and antagonistic towards the other family members.He often was very demanding and was described by the others as "little Hitler". S.B. was 18 years of age. She was the only member of the B. family able to work. She had three separate jobs working in fast food restaurants.

Along with the personal health problems of Mr. B., Mrs. B. and R.B. there was great financial stress as S.B. was the only family member earning money. Rent money was coming in from a second house the B.'s owned. Conflict arose over Mr. B. and R.B. who, despite receiving disability benefits, were not consistently contributing for room and board. Mrs. B. said that she had extreme worries about money. The family members reported that there was often fighting between everyone. With the exception of Mrs. B. and S.B. who generally though not always got along, all the family members were antagonistic and mistrusting of each other. They described themselves as all looking out for themselves, ready to use any advantage to get back at the others.

Situation as Seen By Family: All of the B. family agreed that the main problem lay in the great amount of discord between R.B. and the other family members, in particular Mrs. B. and his sister S.B. The B. family seemed to be largely divided on how they perceived the situation. On the one-side was R.B. who said that all the problems were the fault of the other family.members, in particular his mother, who never gave him any privacy and was

constantly after him to do housework. He said his sister got away with doing nothing because she was employed. R.B. did not think that was fair. The other family members all agreed that R.B. was the cause of the problems in the house. S.B. said that R.B. tried to rule the house like "little Hitler." He never did anything to help around the house and always wanted everything his way. If he did not get what he wanted, he would get back at the other family members somehow. Mrs. B. said that R.B. was very demanding when it came to his migraines; he often had to be taken to the hospital at all hours of the night for demerol shots and demanded absolute silence in the house while he slept into late hours of the morning. She said that R.B. refused to help with the housework or take care of his father.

Mrs. B. felt that all the problems would be gone if R.B.'s headaches were cured. She said then R.B. would not be so difficult to get along with. R.B. also said that he felt the solution was for his headaches to be cured. That way he would get back to work and move out of the house, away from his family. The B. family was very entrenched in blaming the other family members for the problems and stating that the other had to change for the problems to be solved. R.B. stated that the only resolve he saw for the family's problems was for the other members to give him privacy and leave him alone. Mrs. B. felt the solution was R.B. to help more with the house work and his father and also to try and get along better. S.B. felt that R.B. should be kicked out of the house.

Assessment:

The B. family demonstrated a very limited ability to **Problem Solve** on both affective and instrumental issues. Mrs. B. stated that "this family never communicates!" It appeared as though the B. family was unable to identify the problems and move on through the other stages of problem solving. Also, the B. family had difficulty problem solving as they were

unwilling to be flexible on their positions. They expressed an unwillingness to negotiate and compromise. This insured the impossibility of the B.'s deciding on a particular plan of action. This was especially true of Mrs. B. and R.B. Mr. B. was not involved in any of the negotiation to solve problems.

The **Communication** pattern I saw amongst the family members could be best described as masked and direct, sometimes gravitating to masked and indirect. Mr. B. was masked and indirect in his demonstrated communication. This may have been greatly influenced by the ALS which is neurological in origin and can impact the sufferers psychological condition. Aside from his heavily slurred speech the content of what he said was largely incomprehensible and confusing. The other family members admitted that they rarely knew what he was saying or getting at. When he spoke it seemed to confuse matters. S.B. appeared to be the most clear and direct communicator of the family. Both R.B. and Mrs. B. often displayed masked communication. When they talked they were constantly bringing up seeming unrelated issues and examples of the others misdoing. This appeared to constantly confuse matters and raise frustration levels to the point where they were in a heated argument, often without knowing what they were originally discussing. This seriously inhibited the B.'s ability to problem-solve.

The **Roles** of the B. family were in serious turmoil. This was certainly true for both instrumental and affective roles. The instrumental roles were being covered, but only nominally. The only income for the family, other than rent from a second house, was Mr. B.'s and R.B.'s disability benefits and S.B.'s wages. Mrs. B. who managed the finances, said that the financial situation was distressingly tight. She said that she was constantly worried about money. This was compounded by both Mr. B. and R.B.'s apparent resistance to contributing financially. Mr. B. and R.B. said that they felt they should not have to pay anything towards room and board as their portion of rent money which came in from a house they owned was kept by Mrs.B. ($180.00 each per month). R.B. said that he

used the $900.00 he received each month in disability insurance benefits to pay off some large bills he had. Mrs. B. said that she did not not think this was fair but felt powerless to do anything.

Mrs. B. had sole responsibility for carrying out the cooking and cleaning in the house.All that needed to be done was being completed, but Mrs. B. openly stated that she felt overwhelmed with all the work she had to do. She said that she never had a moments rest and wished R.B. in particular would pitch in as he had a lot of free time. R.B. said that he would not help for a number of reasons. He did not want to chance bringing on or exacerbating a headache through physical work. Nor did he want to contribute unless his sister, S.B. contributed a share equal to his. Mrs. B. did not expect this of S.B. as she was fully employed. They had been unable to solve this issue and as a result Mrs. B. carried out all of the household instrumental functions on her own.

Mr. B. was unable to contribute to the upkeep of the house as he himself was becoming increasingly dependent on the support of the family. Conflict also arose over the care of Mr B. Mrs. B. was taking care of Mr. B. who was unable to care for himself and required a considerable amount of assistance with all of his functioning. Mrs. B. expressed that she felt unable to cope with the pressures of having to take care of the house and Mr. B. alone. Mrs. B. wanted help from R.B. and S.B. R.B. and S.B. stated that they were unable to contribute towards the care of Mr. B. Mr. B. had been physically and emotionally abusive towards the entire family in the past. They could not feel compelled to assist him. Apparently Mr. B. used to drink heavily and was disruptive at home. Mrs. B. agreed that this all happened but said, "why can't you just forget about the past and help him?" R.B. said that he felt bad that his father was ill, but he still thought he was a "jerk" and was "pissed off at him". S.B. agreed with R.B. saying that "it just wouldn't feel honest to help him". It would betray their true feelings. As a result Mrs. B. took care of Mr.B. alone.

Mrs. B. was almost exclusively responsible for the nurturance and support of the other family members. This included the care and support for Mr. B. from whom she was separated. There appeared to be no support shared between any of the other family members except for S.B.'s occasional statement of concern for her mother.She would support Mrs. B. exclaiming that she felt Mrs. B. was under a lot of pressure due to the inactivity of R.B.

Mrs. B. indicated that she and Mr. B. had not had a sexually or physically affectionate relationship for many years. They had considered themselves separated for about seven years. He was now more like a border in an extended care facility.

There was little evidence of life skills development being provided by any of the family members for the others. Whatever was provided may have been provided by Mrs. B. There was too much disarray present in the family for such functioning to occur. S.B. appeared to be the highest functioning individual in the family. It is difficult to assess whether this may have occurred due to the support of her family, or in spite of her family.

Mrs. B. attempted to carry out the role of maintaining and managing the family system. As she was doing this on her own, and with no support from the other family members, she found this to be a very onerous and largely unsuccessful endeavor. She attempted to set the rules, discipline, and manage the social, financial and health related functions of the home. Mrs. B. explained that it had always been this way. Even when Mr. B. was healthy. Mr. B. had never been involved in such role activities.

There were a number of problems with the allocation of roles. Mrs. B. was over-burdened with an inordinate balance of the role responsibilities. She said that she did not want it this way, but had no other choice. If she did not do everything, nothing would get done. Mrs. B. attempted to allocate some responsibilities to S.B. and in particular R.B., but this was

never carried out. Mrs. B. was unable to make them accountable for their house responsibilities or rules. She wished they would do as she requested but admitted she felt powerless to insure they follow through. R.B. and S.B. would simply ignore her. This led to there being no effectual rules.

Both Mr. B. and R.B. seemed to demonstrate skewed **Affective Responsiveness** with an over representation of emergency emotions. Mr. B., by reports of the family and my observations, was quite emotionally unexpressive except for periodic outbursts of anger or crying. Mr. B. displayed this during the one session he was present. This may have been the result of the neurological impact of the ALS. R.B. expressed a high level of anger and frustration to the other family members and not much more. Mrs. B. said R.B. could be sweet, but only when he wanted something. Otherwise he was yelling, arguing and complaining. Mrs. B. did express welfare feelings of caring and compassion for the others. She also could express frustration and anxiety but demonstrated difficulty expressing anger. S.B. most often expressed feelings of impatience and anger.

There was an over abundance of anger, spite and other emergency emotions in the B. family. They gave the impression of a family in emotional turmoil. However, there was a number of occasions when the entire family present shared a laugh. This unfortunately did not seem to occur often. There was very little feelings of warmth expressed between family members.

Mr. B. demonstrated what would be best described as uninvolved **Affective Involvement**. He gave no indication of being concerned with or interested in the other family members' feelings or activities. By the description of the other family members, Mr. B. was only involved in the house hold in that he was fed and now taken care of. He contributed only in a sparse financial manner. Outside of what he received from the

household, he appeared to have little involvement. This may have been the result of Mr. B.'s ALS which was progressively rendering him dysfunctional and dependent.

R.B. readily said that the only reason he remained at home was the cheap accommodations. He said given the opportunity of being healthy and able to work he would move without any reservations. This suggests Narcissistic Involvement which may have been a function of his needs due to his headaches. However, R.B. demonstrated highly charged affective involvement with his mother and sister. R.B. and Mrs. B. demonstrated Overinvolvement verging on Symbiotic Involvement. Aside from frequent arguing between the two, Mrs. B. felt responsible to be R.B.'s complete care giver. She felt that in her family she was the only person able to meet the others' many needs. She made a point of checking into all of R.B.'s affairs, financial, health, social and otherwise. R.B. seemed to allow this when it met his needs. To a significant degree, R.B. required this as he was often with headache and unable to attend to his personal needs. None-the-less he was very resentful of his mother's "meddling" and struggled to gain increased freedom from his mother. This created a considerable amount of conflict between R.B. and Mrs. B.

S.B. mirrored R.B.'s statement that Mrs. B. was too overinvolved in their lives. She also complained of Mrs. B.'s meddling into her affairs. S.B. was also overinvolved in Mrs. B.'s life affairs. She was completely involved in Mrs. B.'s issues, often giving her advice and expressing her thoughts and feelings. This was particularly true of issues involving R.B. She explained that she would have kicked R.B. out of the house long ago and she couldn't understand why Mrs. B. had not. Mrs. B. said that she would never kick R.B. out as he needed her.

R.B. and S.B. were overinvolved in a negative manner as they were constantly vigilant of the other's actions with intent to find fault. They were often arguing about their belief that

the other did too little to contribute to the household. This seemed to be the extent of their involvement. However, it was constant and ongoing.

R.B. demonstrated Involvement devoid of feelings verging on Absence of Involvement towards Mr. B. They would occasionally watch t.v. together, but outside of this there was little involvement. R.B. said that he felt unable to have a relationship other than this as he felt a considerable amount of anger towards Mr. B. for past abuse. This created a mutual distancing from each other which allowed only a minimal amount of involvement to exist. This was also true for S.B. and Mr. B. S.B. said that she kept little contact with Mr. B. She said that Mr. B. could still be verbally abusive to her so she simply had as little to do with him as possible.

Despite that Mr. and Mrs. B. had considered themselves separated they still maintained considerable involvement with each other. Mr. B. was completely dependent on Mrs. B. to provide meals and household upkeep for him. Due to his condition he was Narcissistically Involved. Mrs. B., on the other hand, felt compelled to provide for Mr. B. as he was in need. This was regardless of his distancing and occasional abusive outbursts when he would throw food Mrs. B. prepared for him if he didn't like it. "I have to look after him", Mrs. B. exclaimed. I would suggest that this is an example of overinvolvement on Mrs. B.'s part. She would continue to take care of Mr. B. despite their being separated and his occasionally abusive treatment of her.

There were no constant rules in the B. household. The members appeared to act and behave as they wished, without restriction or consequence. Mrs. B. was left solely in charge of **Behavior Control**. R.B. and S.B. agreed that Mrs. B. was constantly making and changing rules often in an unpredictable manner. This occurred so often that there were many rule contradictions and effectively no rules. This was true of the three situations where behavior control is needed: Dangerous situations; Meeting and expressing

Psychobiological needs and drives; Interpersonal socializing behavior inside and outside the family.

Mrs. B. acknowledged that this was the case of the household. With the exception of there being no physical violence, very little of any other rules appeared constant. This was especially true in relation to R.B. He would not follow any rules or requests which Mrs. B. put down. However, she was completely unwilling to consider asking R.B. to leave as the result of all else failing. My impression is that this may have been the result of their symbiotic overinvolvement with each other. Both Mrs. B. and R.B. indicated they were unwilling to change their behaviors. Mrs. B. was unwilling to "get tough" and R.B. was unwilling to compromise. This created an environment very resistant to change. In this sense there was considerable rigidity in this family system.

Interestingly, this created a situation where it was somewhat difficult to determine whether this family systems' behavior control was clearly chaotic or rigid. It was certainly chaotic in that there was no consistency in rules and norms of behavior. People did whatever they wanted. However, this pattern was maintained in a very rigid fashion. Mrs. B. was completely unwilling to alter her approach to behavior control. In my final analysis I am compelled to state that this seemingly chaotic situation was largely being maintained due to the rigidity of the system.

As has been indicated, the B. family exhibited profoundly ineffective family functioning. The portrayal of the family indicated that the patterns of functioning had been long standing prior to the onset of the various illness'. However, it may be safe to extrapolate that the new medical and financial pressures would likely have the effect of exacerbating an already dysfunctional situation.

A number of issues were highlighted during the assessment. These included:

1). Both R.B. and S.B., but especially R.B. felt that Mrs. B. was far too involved in their affairs.

2). Mrs. B. felt that she had to do an unfair amount of work around the house, including the care of Mr. B., without any assistance from S.B. and especially R.B.

3). Mrs. B. felt completely unable to discipline and keep control of the household.

4). Mr. B. and R.B. would not financially contribute their full share of the room and board despite Mrs. B.'s repeated requests.

In addition to this I felt a significant issue was the B.'s unwillingness to compromise and negotiate. It arose that before these issues could be solved Mrs. B. and R.B. would have to be willing to negotiate and compromise on issues. They were unwilling to do so. In turn this compromised the potential for any problem solving in treatment.

Treatment: Once the MMFF assessment was complete, attempts were made to move the family through to the contracting and treatment stages of involvement. This was without the involvement of Mr. B. who withdrew after the first session. The other family members indicated that his ill-health was preventing from continuing on. This may have been true but I also suspect Mr. B. was not comfortable discussing issues of the family. Also, this may have been encouraged by the other family members who felt more free to talk in his absence. They were much more ready to discuss problems in the following sessions. There seemed to be an agreement on the list of problems to be worked on. As already identified in the assessment, they focussed on the lack of agreement and togetherness between family members, in particular R.B. and Mrs. B.; R.B.'s feeling Mrs. B. was over-involved in his

life and did not respect his privacy; Mrs.'s B.'s stated need for help from S.B. and in particular R.B. with the upkeep of the home and care of Mr. B.

At this point of involvement it became very apparent that the key members of the conflicts, Mrs. B. and R.B. were not willing to change and negotiate. They pointed their fingers at each other and said the only way the problems could be solved was if the other one changed. R.B. flatly stated the solution to the problem was that his family must leave him alone, or in other words, they change. Mrs. B. stated that she saw the solution being R.B. coming around and doing as he was asked. Mrs. B. was confronted with allowing the others to walk all over her. She said that she had no choice in the matter. She had no way of making the others accountable to her. As a result of her upbringing, she said that she would never consider threatening to kick R.B. out of the house as a good mother would never do that. Mrs. B. said that she was not willing to change her behavior towards R.B. She admitted that she felt the current situation was anything but satisfactory but she could not see herself changing in anyway. The change had to come from the others. She could only see the situation being rectified by the other s agreeing to do what she asked and wanted.

It was pointed out that unless they were willing to be flexible change could not occur. This was an impasse in treatment which was never overcome. The treatment involvement was terminated.

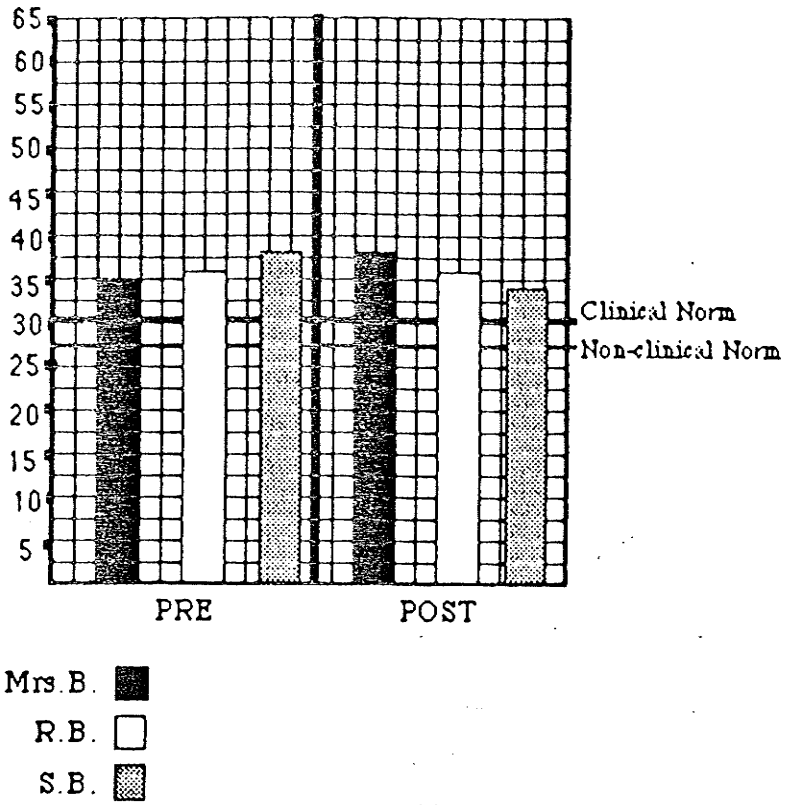
Outcome: As was indicated, the outcome for the B. family was not favorable. A considerable amount of time had been spent sorting out and exploring the key issues the B. family faced. If any positive note occurred, it may have been that the family had an opportunity to clearly identify what the problems were and to hear what each family member's perspective was. Unfortunately, there was little latitude to prompt change.

The FAM Brief scale scores indicated that the B. family was far in excess of the clinical families norm mean of 30.4. The Pre scores (S.B. 38; Mrs. B. 35; R.B. 36) suggest that the three family members who filled out the scale all agreed that their family was experiencing difficulties with functioning. The Post scores (S.B. 34; Mrs. B. 38; R.B. 36) suggest that they perceived their family functioning to have largely remained unchanged. This certainly concurs with my clinical observations.

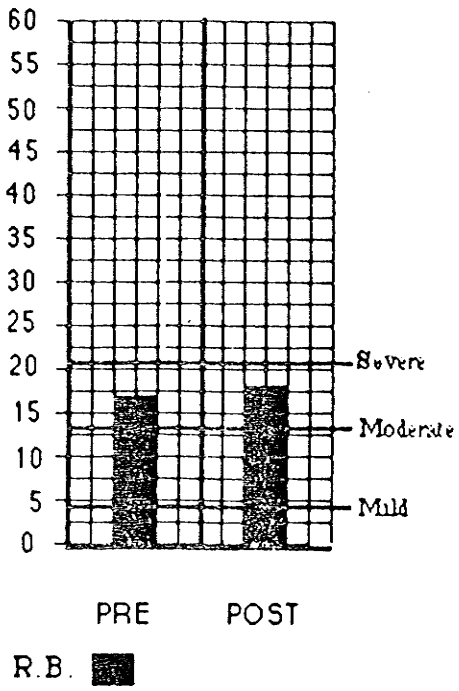
R.B.'s level of reported pain on the VAS remained the same at 4. It may be note worthy that this was still a drop from 6 first reported at the beginning of R.B.'s individual treatment (See R.B. case #6). R.B.'s BDI score increased slightly from 17 (Pre) to 18 (Post). This was also an increase over the first score of 16 recorded prior to R.B.'s individual treatment (See R.B. case #6). May this be indicative of a gradually deepening depression?

Measures:

FAM BRIEF SCALE

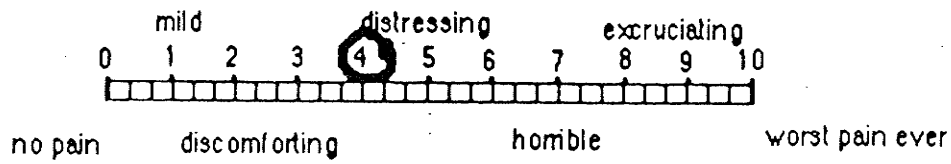


Beck Depression Inventory



Visual Analogue Of Pain

PRE



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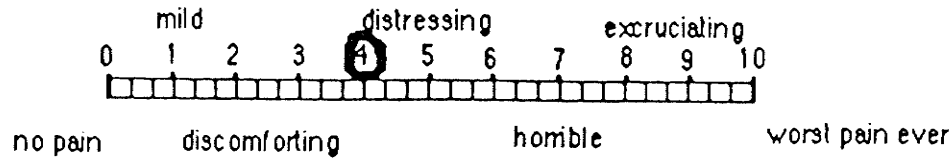


Name: Mr. and Mrs. T.

Referred By: Prof. Roy through the St. Boniface Hospital Pain Clinic.

Period Seen: Mr. and Mrs. T. were seem for a total of six sessions (Oct. 19, Nov. 3, Nov. 9, Nov. 16, Nov. 30, and Dec. 7, all of 1988).

Description of the Couple: Mr. and Mrs. T. had been married for approximately ten years. This was Mr. T.'s second marriage while it was Mrs. T.'s first. They lived in a small country community about thirty minutes from Winnipeg. They had a five year old son. Mrs. T. was employed as a secretary. Mr. T. was currently on Worker's Compensation due to protracted lower back pain. Originally caused by a work related accident, Mr. T. had suffered from the pain for 18 years and had received a number of operations. He had been receiving the compensation benefits since March, 1988. He was previously a heavy equipment operator. As a result of his lower back pain, Mr. T. was unable to work with heavy equipment and was possibly going to be retrained for employment by Workers' Compensation. Mr. T. had a past of prescription and non-prescription drug abuse and alcohol abuse.

Situation as Seen By Couple: The T.'s were first seen in November of 1988. In April of 1988, Mr. T. had his pain killing drug prescription rescinded by his doctors. Mr. T. explained that he was experiencing a considerable amount of pain and turned to using large quantities of alcohol and non-prescription pain killing drugs. In April, Mr. T. while under the influence of alcohol attempted suicide by trying to shoot himself with a gun. He was brought to a provincial Mental Hospital where he stayed for a considerable time. After he

left the hospital, Mr. T. entered a residential drug and alcohol rehabilitation program. He completed the program in late September, 1988. With some reluctance Mrs. T. allowed Mr. T. to return to their home. She said that previously she did not want anything to do with Mr. T. and was contemplating divorce. She expressed that the experience had been horrifying and there was no way she was going to expose herself or her son to it again. Mrs. T. said that she was willing to let Mr. T. return, but only if he never drank alcohol or abused drugs again. She also said that another condition was that they agree to work on improving their relationship and solving some long standing issues between them. This included improving the communication between each other.

Mr. T. agreed with all that Mrs. T. said, however he did not seem to feel that the problems were so deeply rooted. He felt that the past was the past and it was best to just move on to the future. He largely felt all the problems would be gone when he started working, and got back on his feet.

Assessment: The T.'s demonstrated an adequate ability to **Problem-Solve** instrumental issues. This was partly evidenced by the fact that they had been able to construct a house together. However, the day-to-day problem-solving of instrumental problems was often hampered by a lack of communication. By their description, most instrumental problems were attended to, but usually by one of them taking care of the problem without input from the other. Mrs. T. expressed that she wanted there to be more communication on such matters as there was often confusion and a lack of cohesion on action being taken. Mr. T. agreed with this and joked that he had left such problems up to Mrs. T. because she did such a good job.

Mr. and Mrs. T. demonstrated a clear difficulty in solving affective problems. There were a number of long standing issues between Mr. and Mrs. T. that had not been identified and

discussed between the two of them. This was largely because such problems were not shared between the T.'s. At the time of the assessment these problems had not been identified or shared previously.

Mrs. T. generally demonstrated a clear and direct style of **Communication**. This was with both instrumental and affective issues. Without any hesitation she could tell Mr. T. directly what she thought or felt. Mr. T., on the other hand, demonstrated difficulty in communicating clearly and directly. This was especially true of affective issues. He often chose to talk through me, rather than directly to Mrs. T. and had to be constantly directed to do so. When he spoke he often began to speak on unrelated topics which confused the conversation. Mrs. T. indicated that this often happened and she had no idea what he was saying. Mrs. T. said that Mr. T. often did not communicate at all, especially when something was bothering him. Mr. T. did seem more able to communicate directly on instrumental issues though what he said was not always clear.

The T.'s instrumental **Roles** were in the process of change. Mr.T.'s role of co-provider had been altered with his leaving work and going on Workmens' Compensation. He was still contributing financially to the family through his benefits, but in a reduced capacity. The instrumental roles were largely allocated and being adequately carried out. However, as indicated previously, Mrs. T. felt that she carried more than her share of the responsibilities and wanted to change this. Although Mr. T. was doing more housework and cooking since he was home from work, Mrs. T. said she still wanted to have a more equal distribution of responsibilities. Mrs. T. usually took care of the finances, grocery shopping, and made sure that the house was cleaned, laundry washed and meals cooked. On top of it she also carried out the responsibility of bathing and putting their son N.T. to bed.

Both Mr. and Mrs. T. indicated that they shared with the nurturance and support of N.T. They commented that they were physically affectionate with each other but provided little active emotional support for the other. Surprisingly, they both agreed that they had a very satisfying sexual relationship. They stated that the frequency and quality of sexual relations was satisfying to both of them.

In the mixed category of roles the T.'s appeared to satisfactorily carry out the life skills development. Despite some inconsistencies in styles between Mr. and Mrs. T., their son N.T. appeared to receive adequate support to develop physically, emotionally, educationally, and socially. This is drawn from their own descriptions of home activity. Their own vocational, avocational and social development is generally not shared between the two of them. By their description, there was very little that they talked about. Mrs. T. stated that they had talked very little about their personal or family plans. Socially, there had been very little activity within or outside the home. This was admittedly lacking in the family. Mrs. T. expressed that she would like to do more socially, especially with her family of origin. Mr. T. said that he was not ready to do so.

The T.'s appeared to function adequately with the maintenance and management of the family. Decisions which had to be made were generally made. The large decisions were made jointly by Mr. and Mrs. T. An example of this was the decisions made during the building of their house. However, much of the day to day decisions were made by Mrs. T. This was due to the relatively limited involvement by Mr. T. and their lack of communication. This would involve the largely instrumental decisions to be made, such as finances. There were rules set up for the conduct of N.T. around the house and socially outside the home, yet there was inconsistencies in their discipline of N.T. when these rules were broken. Mrs. T. preferred to be firm and direct with N.T. while Mr. T. was more permissive.

In terms of **Affective Responsiveness** Mrs. T. was able to express emergency feelings of anger and sadness as well as welfare feelings of love and concern. Mr. T. could express some of his welfare emotions but had difficulty expressing emergency feelings. On the whole Mr. T. expressed a narrow range of affect. He often appeared to be emotionally withdrawn from issues. This created a situation impossible for an empathetic relationship.

Mrs. T. desired an empathic **Affective Involvement** with Mr. T. as she emphasized that she was interested in a full relationship with Mr T. for his sake and the sake of their relationship. As she put it, "I want to be your friend and share our lives." Mr. T. expressed that he was very interested in Mrs. T. and N.T.'s lives. Mr. T. was close to losing his relationship with Mrs. T. and seemed committed to improving it. Despite his limited range of affective responsiveness and little self-initiated interaction with his wife, he also had an empathic interest in their relationship.

Behavior Control. Mr. and Mrs. T. had firm rules for N.T. in consideration of dangerous situations. An example of this was that he was not supposed to play on the road in front of their house or around dangerous machinery. Also Mrs. T. did not want Mr. T. to operate dangerous farm machinery if he had been taking pain killing drugs. There was a laissez-faire approach to the rules for the meeting and expression of psycho-biological needs. Mrs. T. said she wished there were more firm rules around meal times and bed time for N.T. There were inconsistencies around the accepted conduct of N.T. at these times. There was an agreement that anger was not to be expressed with the use of physical violence in the home.There seemed to be few other firm rules for interpersonal socializing behavior outside of this. Mrs. T. attempted to set up some rules for N.T. and the house, but this was done without consultation with Mr. T. Mr. T., on the other hand, said that he preferred to have no fast rules and address behavior issues when the situations arose. This

combination of Mrs. T.'s attempt to create rules and Mr. T.'s laissez-faire attitude to rules created a lack of consistency which at times may have been confusing.

A number of issues arose out of the assessment which was conducted with the T.'s. A large part of the thrust appeared to come from Mrs. T. She said that she wanted some problems cleared up if they were to remain together. Mr. T. went along with Mrs. T. though initially it may have been intended to placate her. He was on the verge of loosing his place within his home and family.

Mrs. T. expressed that she felt there was a wall between her and Mr. T. She never knew what he was thinking and feeling. As she put it, "The communication isn't there in our relationship!" Mrs T. said she wanted to have a more intimate relationship with Mr. T. This included sharing positive and negative feelings. Mrs. T. said that Mr. T. simply did not communicate about anything that was important and concerned the two of them. She found this very frustrating, angering and sad as she felt many of their instrumental and affective problems could be resolved through talking more. She also added that they never did anything as a couple or family outside of the home maintenance routine.

Mrs. T. stated that she was very afraid of Mr. T. beginning to use alcohol and drugs again. Mr. T. said he was in A.A. now, but could not guarantee he would never drink or use drugs again. This was a very sore issue between the T.s' which could incite much anger for the both of them. Mr. T. resented Mrs. T. keeping check on his A.A. meetings drug intake. Mrs. T. made it very clear that she did not want to take any chances and was prepared to do anything to prevent it.

Another issue was that Mrs. T. felt she had much more than her share of the household responsibilities. She described herself as the "Boss" of the house. She felt she was

completely responsible to either do the housework or allocate it to Mr. T. This included the instrumental care, nurturance and discipline of their 5 year old son N.T. Mrs. T. said she found this exhausting and was not willing to continue. She wanted a clear allocation of shared responsibilities within the house and an agreed upon set of rules for N.T. that they would both ensure were carried out. Mrs. T. said she did not want to feel like the "heavy" with N.T. or Mr. T. anymore. Mr. T. was very prepared to discuss this with Mrs. T. He said that he did not realize Mrs. T. felt this way and he wanted to balance the responsibilities out.

Since the suicide attempt Mr. T. had no contact with Mrs. T.'s parents, who happened to live across the road from them. Mrs. T. said that this was very hard for her as she often felt like the go between her parents and Mr. T. Her parents baby-sit their son during the day so there is generally a lot of contact between the two households. She said that Mr. T. was avoiding her parents because he was embarrassed about the suicide attempt and mental hospital stay. Mr. T. admitted that he felt very uncomfortable about what happened and could not face her parents now. He said that he would like to wait a while before initiating contact with them.

The T.'s presented as a couple attempting to work on some serious issues. In order to solve these issues they would have to alter some of their functioning patterns.

The various issues were discussed and priorized in the order of their importance to the T.'s. The agreed and priorized issues were:

1). Lack of communication on house upkeep rules and N.T.'s rules.

2). Lack of intimacy and communication on affective issues.

3). Mr. and Mrs. T. feeling they did nothing together as a family.

4). Mr. T.'s lack of contact with his in-laws.

Mr. and Mrs. T. agreed that they wished to work on these issues together in treatment.

Treatment: The T.'s were successful in negotiating and solving their instrumental problems, but had difficulty addressing their affective issues. This inevitably led to the termination of treatment. Mr. and Mrs. T. were able to negotiate clear responsibilities for the instrumental roles in their house. Both Mr. and Mrs. were satisfied with the split in responsibilities they negotiated for the cooking, cleaning, laundry, shopping and finances. They also discussed and agreed upon rules for N.T. This included acceptable meal-time conduct, bed-time procedure, wake-up procedure and general behavior. They agreed to share in ensuring the rules were carried out.

In the following weeks they commented on their surprise of how well N.T. seemed to behave now that there were some rules. They also expressed that they felt the instrumental needs of the house were being satisfactorily met. Mr. T. said he was enjoying doing the work as it filled his day and he knew Mrs. T. appreciated it. Mrs. T. said that she really appreciated the division of work as she now had time in the evenings and weekend to relax. They both also remarked that they were proud of having worked together on the solving of the instrumental problems.

Mr. T. in particular said he felt a large part of their problems had been solved. Mr. T. emphasized that they were now communicating much better than before and he felt very good about how things were turning out. Mrs. T. agreed that this was the first time they had really talked about anything which involved them as a couple or family for many years. She said, "*yes we are talking now, but not about important things.*" She was still very frustrated and angered by Mr. T.'s emotional distance from her. She said for instance that

they had never discussed their experience of the suicide attempt by Mr. T. Mr. T. said that he wasn't prepared to talk about it. He said he was seeing a psychologist about the incident and was working out his problems there. Mrs. T. became livid stating that it made her very angry that Mr. T. would discuss his important family issues with a stranger, but not with her. She explained that their relationship was on the line about the issue and she did not want to go on pretending it did not happen. Both Mr. and Mrs. T. expressed a considerable amount of anger at each other on the issue. Mrs. T. expressed what a horrifying experience the suicide attempt was and how angry she felt at Mr. T. Mr. T. retorted by saying he felt completely abandoned by Mrs. T. during his time at the mental hospital and he was not certain he could forgive her.

I suggested that it might be helpful was to set up some ground rules so that they could feel safe in expressing themselves and hearing the other. I was thinking of this largely for Mr. T.'s sake. He became very defensive on this emotionally laden issue and in order for him to feel safe enough to discuss it and other affective issues some rules would be necessary. It would be the framework from which they could learn to solve affective problems effectively .

Unfortunately there was not a further opportunity to negotiate such rules between Mr. and Mrs. T. Shortly after the last session Mr. T. went back to work. He worked the evening shift which prevented them from attending appointments together as Mrs. T. worked the day shift. Subsequent attempts to coordinate a meeting time were found to be impossible. Because of their conflicting schedules they often saw each other only on the weekend. After a number of failed attempts to set an appointment, treatment was terminated. The T.'s were referred to contact Prof. Roy for further treatment when their schedules allowed it.

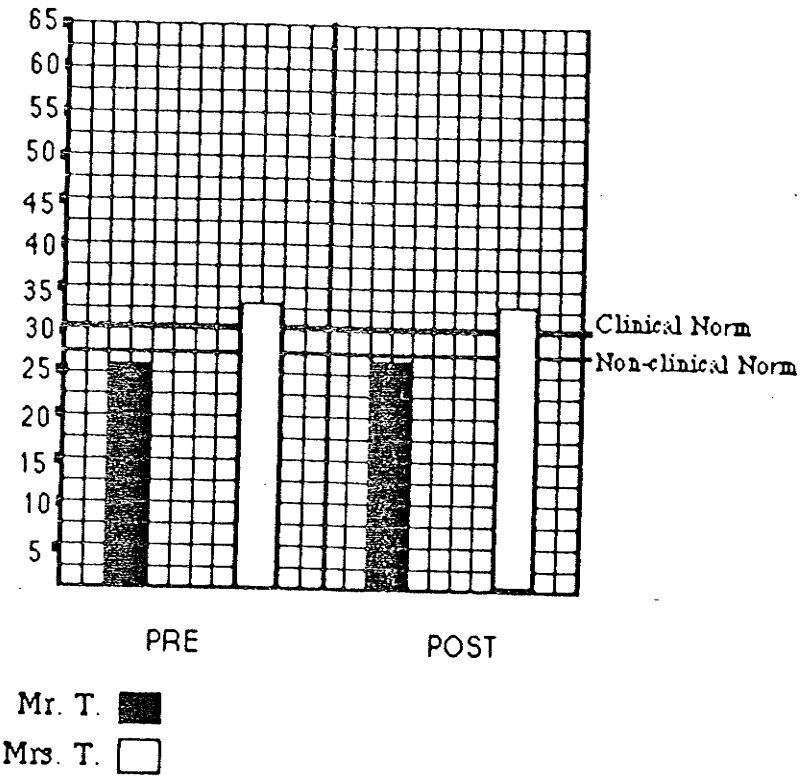
Outcome: In many respects treatment ended prematurely. The T.'s dealt with the instrumental difficulties they had identified, but not the affective issues. While it is true that a conflict of schedules prevented treatment from continuing, I question the ability of Mr. T. to address the affective issues in his relationship with Mrs. T. Mrs. T. was prepared to discuss the affective issues feeling they were key to their troubled relationship. Indeed, she felt she did not want to continue in the relationship with Mr. T. if the problems were not solved. This was very threatening to Mr. T. who suggested that there were no deep affective problems in their relationship. He was prepared to work on instrumental problems but not affective. He emphasized his belief that creating some instrumental rules would solve a lot of the problems they shared. Mrs. T. felt that the problems they shared were much more severe and deeply rooted.

This discrepancy may possibly be seen in their respective FAM Brief scores. Mr. T., who had difficulty acknowledging the affective issues reported a score of 26 prior to treatment. This is below the norm for non-clinical families and may reflect his desire to idealize the family he was close to loosing. Mrs. T.'s Pre score of 33 is above the clinical mean and indicates she perceived substantial problems in their family. Their post treatment scores indicate no significant change (Mr. T.-27, Mrs. T.-33). This concurs with my observation that Mrs. T. acknowledged there were still substantial problems while Mr. T. did not.

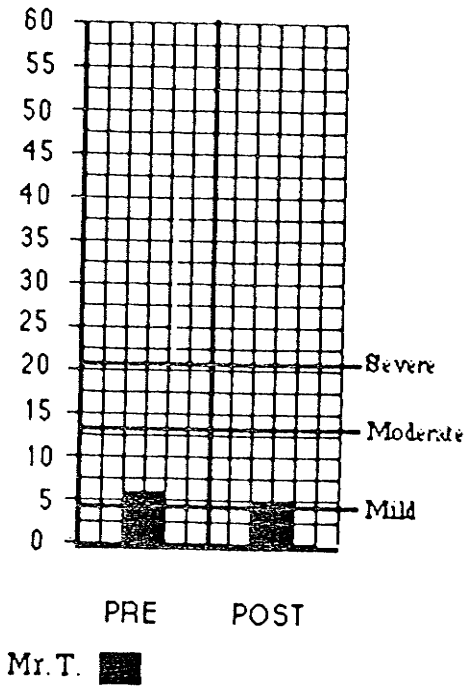
Mr. T.'s report of pain on the VAS increased from 5 to 6 following treatment. It is possible this reflected an increase in tension at home. It also may have reflected that he was back at work driving heavy equipment. This was a situation which originally exacerbated his lower back pain. He was to avoid such work but he had recently started working in an equipment compound moving heavy equipment. Mr.T.'s BDI score decreased from 6 to 5 following treatment. This may indicate a slight decrease in a mild depression.

Measures:

FAM BRIEF SCALE

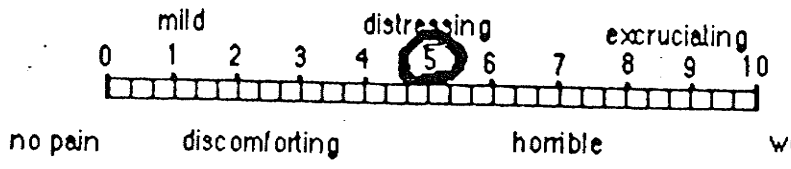


Beck Depression Inventory



Visual Analogue Of Pain

PRE



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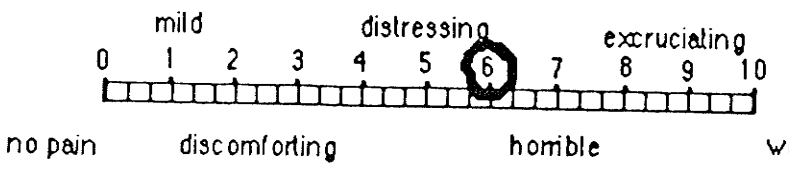

Discussion

Two couples and one family were involved with this portion of the practicum. As indicated in the case presentations, one couple demonstrated marked improvement in family functioning, another couple demonstrated partial improvement in family functioning, while the family did not improve. In consideration of the two couples who demonstrated improved functioning there were a number of commonalties identified which may have lent themselves to greater success.

One observation was that despite their many problems they remained functioning at the instrumental level. The instrumental needs of these families were largely being met and they were able to solve some instrumental problems. On the other hand, the B. family was in a much deeper state of disarray.The instrumental needs of the family were being met, but there was a marked inability to solve the instrumental problems they shared as a family. As Epstein et al. (1982) suggest, families which are able to meet the instrumental needs may function at a higher level than families who are not. Also, these families indicated a preliminary ability to problem solve, at least on the instrumental level, while the B. family did not. This included the willingness and ability to discuss issues and negotiate solutions to the problems.

I believe that this is an important point. As is demonstrated in a comparison of the three cases, change in treatment was possible only if the couple or family system was flexible enough to permit change. If the members are rigidly entrenched in their positions and behavior, and unwilling or unable to change, there will be a poor prognosis for treatment. This was recognized and pointed out with Mrs. B. and R.B. It ultimately led to the termination of treatment.

Another common factor noticed in the two couples was the ability in treatment to move away from the presenting problem of chronic pain and refocus on family functioning issues. The two couples were largely able to do this early in their involvement and move on to more central relationship issues. There seemed to be a willingness to consider the issues in light of, or in spite of the pain. To be accurate, it is important to point out that Mr. and Mrs. R. perceived their entering treatment as an opportunity to explore and work on their problems through marital therapy. While the pain was acknowledged as possibly having an influence on their problems the R.'s and T.'s were able to explore marital and family issues separately from the pain. The B. family made attempts to move away from the pain, but ultimately returned to a point of unwillingness to negotiate. The pain was attributed as the cause of the problems. Both R.B. and Mrs. B. stated that they were unable to change their behaviors. Often after discussing an issue and reaching an impasse they would agree that nothing could change unless the pain was removed. By taking this position the issues of the family were not dealt with and the status quo maintained. Since the pain could not be removed, and their problems were the result of the pain, their problems could not be solved.

Though the individual family scenarios were all quite different I became aware of the multi-dimensional influences between the family and chronic pain. Often it was difficult to see a clear linear relationship between the pain and the family functioning. I began to conceptualize that the etiological relationship between the pain and the family dysfunction appeared to be somewhat irrelevant. This was because at the point of intervention the family's functioning and the individual's chronic pain seemed to share a symbiotic relationship of mutual exacerbation of the other. This provided an impetus for me to redirect the family away from the pain to family functioning issues and work at that juncture to break a self-perpetuating cycle. I also felt that irrespective of the chronic pain,

there were issues present that had to be addressed as they effected the family in its own right.

Did the involvement of the couples and family have an effect on pain levels? Due to the small number cases involved it is impossible to provide an answer. In one case (R. Couple) there was a very nominal reduction in reported pain following treatment. The other two cases reported either an increase or no change in pain. However, I do not rule out the possibility that improved family functioning may be transferred through reduced tension to reduced pain. It must be remembered that this was not the stated intention of treatment. The intended goal of treatment is to recognize family functioning patterns, and where possible, improve upon them. This is done for the purpose of improving the overall functioning of the family for its own sake, and to enable the family to function at an enhanced level in consideration of the pain.

I believe that there were merits to the use of the MMFF with this population. As discussed earlier in this report, there is substantial evidence that the inclusion of chronic pain in a family may change the family's functioning abilities and patterns. The MMFF is a helpful tool to assess where, in the process of family functioning, the chronic pain may be influencing dysfunction. Due to the detailed categories of the MMFF it is useful for determining where problems arise in the family process.

Another merit I recognized was that the various issues a family has are put into a family process perspective. They are not seen as individual aberrations but rather as a symptom of a dysfunctional family process. The issues are dealt with, but in a manner which highlights and allows change to occur on the interactional level. This allows the family to develop insight into why the problem developed and also how to solve it. This is helpful with families who scapegoat individuals and pain as the sole cause of their problems. The

problem is drawn out in the perspective of the various dimensions. This removes much of the mystery about the problem and places the focus on the family rather than the individual.

The dimensions of the MMFF provide indices of healthy and unhealthy functioning. This provides an assessment of the families functioning and an indication of what interactional changes to encourage the family to adopt so that the problems may be solved and healthy ongoing functioning fostered. It is this enhanced process functioning which enable future problems to be solved at an early stage. As Epstein et al. (1982) pointed out, all families have problems. The difference between healthy and unhealthy families is that the healthy families are able to solve their problems while the unhealthy families can not.

The various dimensions of the MMFF provide a very useful analysis of functioning within the family. As I worked with the MMFF I was surprized by how the various dimensions, while separate, often blended into and complemented each other in an understanding of a problem. In particular I found its power in illustrating alliances and divisions within families. This understanding is enriched by assessing the patterns of communication and affective responsiveness between the divided people. In this way the various dimensions combine to give a very useful picture of the family.

I feel that the MMFF is quite complete as an assessment tool. However, as I worked with and thought about the MMFF I began to wonder if a possible deficit was that it did not formally highlight the inclusion of systems outside the family. The model considers the influences within the family, but very little of the influences outside the family. Epstein and Bishop (1973) describe their vision of the family as an open system consisting of smaller systems and relating to larger systems such as work, education, schools, extended family, and health institutions. The MMFF appears to be very focussed on the familial level and I'm not certain that it routinely assesses the influences of the other systems.

I feel there is a research possibility which would amplify the value of the MMFF with chronic patients and their families. Data are available which indicates healthy and clinical norms. I suggest that the understanding of norms for families with health and chronic pain problems would be helpful. The families studied for the existing norms were not identified as having health problems such as chronic pain. It is entirely plausible that the MMFF norms may be different for the families of chronic pain. Different patterns of functioning may be adaptive and necessary in such families. The norm of healthy functioning in families with chronic pain may have to be altered to accommodate the sick individual. Therefore the relative norms of health and unhealth may accordingly be different. This gap is the result of the current lack of empirical research. Research which would explore this question may be very insightful into the understanding of such families.

My personal goals for the practicum included the acquisition of new clinical skills. The skills I used and the issues I faced were new to me. I became aware of how important it is that the clinical executive skills have a working fit with the larger theoretical framework. This practicum provided such an orientation. I believe that as my comfort and working knowledge of the issues and modality of treatment increase, so will the effectiveness of treatment.

Practicum Conclusion

Introduction

This will be the last section of the practicum report. In this remaining short space I shall hope to summarize the important learnings and contributions this practicum has provided. This will include discussions on my learnings obtained in the individual hypnosis portion of the practicum, the learnings from the family treatment portion of the practicum, my personal future learning goals, value of the practicum for the profession of social work, and my personal learnings.

Learnings from Hypnosis Involvement

In addition to the theory, induction and treatment techniques, I believe I received a substantial working knowledge of hypnosis and the fit between it and the overall treatment of chronic pain. Crasilneck and Hall (1975) stated that hypnosis was not treatment in itself, but rather treatment could occur under hypnosis. By this statement they imply that hypnotic techniques may be used to reinforce the gains of ongoing treatment. By this means hypnosis has value. There is nothing therapeutic about the state of hypnosis in itself. I am reminded of Crasilneck and Hall (1960) who demonstrated that the state of hypnosis with no suggestions was undecipherable from a non-hypnotic state. Hypnosis in such conditions is inert or neutral. It is when therapeutic suggestions are provided under hypnosis that it takes on treatment value. These suggestions used were not arbitrary, but rather grew out of ongoing treatment. This puts hypnosis into the perspective of not being the end-all treatment in itself, but rather a complement to overall treatment.

As a adjunct to over all treatment, hypnosis demonstrated efficacy in a number of respects. In a number of the cases, hypnosis was effective as a tool to alter the perception and experience of pain. In this practicum hypnosis was not used simply to remove the experience of pain. The literature reviewed was generally disapproving of such an approach for good reasons. The simple removal of a possible psychosomatic symptom with out accompanying insight could prompt the creation of a more dysfunctional symptom. If the pain is physical in origin it is still important that the client maintain an awareness of it's existance in some form. Complete removal of physical symptom could lead to further injury or unawareness of important information.

When dealing directly with the somatic sensation of pain, hypnosis was used to either alter the sensation by changing it to feelings of warmth, comfort, or tingling, or deflect the client's attention away from the pain by the use of a fantasy. In each case the stimuli was kept, though the perception of it may have been changed.

Hypnosis was also utilized as a tool to reinforce desired overt and covert behaviors of the client. An example of covert behavior reinforced during hypnosis was that of approaching problems with calm rather than becoming extremely anxious. An example of an overt behavior may be reinforcing the activity of moderate exercise everyday. Suggestions were also given with the intention of instilling a positive mood in the client so they might better complete their daily tasks and experience reinforcing satisfaction. These suggestions were directly drawn from the ongoing treatment in which traditional therapeutic techniques were used.

An important aspect of the hypnosis, especially the self-hypnosis, was the sense of self-empowerment for the client. The clients were told directly that any success they experienced was their own, as they were creating the effects of hypnosis in themselves. Three of the clients commented specifically on this point; they felt they were gaining some

control over their pain which used to control them completely. However, an enhanced sense of control was gained through the use of hypnosis and also through behavioral strategies. Knowing there were actions that could be taken to minimize possible or inevitable pain helped give a sense of control back to the client.

As was stated in the previous discussion on the hypnosis cases, I became increasingly aware of my hesitancy to use hypnosis as the sole therapeutic focus. I felt that it was important to explore and treat issues in the client's life experience that were affected by chronic pain. Likewise, I felt it was important to explore and address issues in the client's life that possibly exacerbated the pain directly or indirectly. Also, if I determined that the pain served a functional role in the client's life, I felt inclined to move away from hypnosis and utilize other therapeutic approaches. Orne (1983) suggests that hypnosis is largely ineffective for functional chronic pain. This is for the reason that if the pain is filling an important need or function of the client, they may simply not respond to the suggestions. This may occur within or outside of the client's awareness (Orne, 1983).

I believe it is for these reasons that a complete treatment package necessitates the use of a full-range of therapeutic skills. This includes appropriate medical interventions, supportive counselling skills, behavioral strategies, and as an adjunct treatment, hypnosis.

Considering the efficacy of treatment on a case by case basis, I believe there is merit in the treatment offered. As indicated in the case presentations, three of the four clients who completed treatment demonstrated improved coping and functioning following treatment. This was the primary goal of treatment. This did not always necessarily translate into decreased pain as one of these clients reported that her pain following treatment had not changed. One client who failed to improve at a functional level actually reported a decrease in VAS pain as did one of the two clients who did not complete treatment. Also of note,

these same three clients reported a marginal decrease of depression on the BDI following treatment.

I believe the limitations of treatment are imposed by both the client and therapist. The client's limitations include their conscious and unconscious resistances, their innate hypnotic susceptibility and situational hypnotizability. The therapist's limitations to treatment may include their general therapeutic relationship building skills, clinical skills, knowledge of hypnosis and belief in hypnosis. While I believe that the client may be ultimately responsible for the self-creation of a hypnotized state, the therapist is responsible for creating an environment which will foster this. I also speculate that the beliefs of a therapist may possibly be transferred to the client in a way which may influence treatment positively or negatively.

Learnings From the Family Involvement

Aside from an opportunity to learn the theory and practice of the MMFF and PCSFT, I feel that I was able to learn much more. I was able to recognize the cyclical and, at times, undecipherable relationship between pain and family functioning. This was very much in line with the research and theory on chronic pain and families. In the cases I was involved with, I perceived the impact of long standing pain on the functioning of the family. The increased tension and disruption of the pain frequently impacted the roles, communication patterns, problem-solving, affective involvement, affective responsiveness and behavior control of the family members. This in turn had a profound impact on the family's ability to problem solve.

An often recurring theme was the effect of pain on communication. The well family members often commented that "this family doesn't communicate anymore," or there was "a wall" between them and the pained family member. These family members stated that there was very little shared dialogue on their problems. Either the problem-solving was left

up to one person or it was avoided all together. As was seen in a couple of the cases, there were unclear roles accompanied by a chaotic set of rules. I believe that there is evidence to support the notion that the inclusion of a chronic pain patient in a family will not only have a detrimental effect on the other family members, but will also exert a negative influence on family functioning.

I also was aware of what appeared to be a positive relationship between family dysfunction and exacerbated pain. Increased family tension through increased family discord appeared to possibly translate into increased pain for the patient. However, I found it difficult to differentiate between the influences of the pain on family functioning and family functioning on pain as these dynamics often appeared to be inter-twined in a self-supporting and catalyzed relationship. I often saw both dynamics at work in the family.

It may be the result of this inter-causal relationship between pain and family dysfunction that is a difficult pattern to break. It may be a relationship which is difficult for a family to be able to conceptualize on their own. Also, addressing one of the variables may not be sufficient to upset the pattern. It is for this reason that I support the inclusion of family assessment and treatment along with individual interventions for pain reduction. This includes medical treatment. These approaches together may compliment each other to provide the most complete treatment for the chronic pain patient and his family. I would conceptualize the relationship between these two approaches to be connected, yet have separate goals. The individual intervention may include medical input and treatment along with a treatment program similar to the individual treatment program discussed in this practicum. The goal of the individual focus would be to work on the range of personal issues influencing or influenced by the pain and develop a lifestyle that is conducive to optimum personal functioning and reduced pain. The family treatment would consider the process functioning of which this individual is member.

Regardless of whether the identified pain patient is involved in individual treatment or not, I would perceive the role of family treatment to be that of exploring and improving overall family functioning. This is not just in relation to the chronic pain but also to the other issues the family is faced with. The chronic pain may be explored as an issue which effects the family as a whole, but not as the sole problem. The attempt would be to move away from the primary emphasis on chronic pain to the overall family functioning issues (Roy, 1986b). A stated goal of treatment would be to improve the family's capacity for functioning effectively with the chronic pain, but not that treatment will reduce or remove pain (Roy, 1985). Though there may be a possibility that improved family functioning could reduce some types of pain via reduced tension , this would not be one of the goals due to the lack of empirical evidence to support this notion.

A number of issues arose which I felt were important to discuss in the context of family treatment. I recognize that to be effective as a family therapy practitioner utilizing the MMFF and PCSFT, it is absolutely necessary to have a working knowledge of the theory and practice of the models. This of course goes without saying. I became aware that, as with all therapy, it is necessary to utilize the full range of treatment executive skills which include clarifying and expanding communication, stimulating transactions between family members, labelling and interpreting transactions, and establishing and maintaining a session focus. These are all important for clear, focused effective treatment.

Related to the skill of establishing and maintaining a focus in treatment, I became aware of the need, as therapist, to remain cognizant of the present point in the process of assessment and treatment. This was necessary to create focus and flow. In other words to know where we are, and where we were going. Without this, as occurred on occasion, the focus becomes muddled and there was not a clear sense of direction.

I also became aware of the importance to maintain a separate, objective sense from the couple or family involved. Some may call this preventing oneself from being pulled into the family's "pathology" or style of interacting and functioning. This is absolutely necessary for the therapist to remain effective and provide non-partisan observations, feedback and suggestions. If this does not happen the therapist may begin to collude with the dysfunction of the family without recognizing it.

I believe that it is also important that the therapist feel able to explore where their intuition draws them in the assessment or treatment. These clinical hunches may provide valuable inroads and insights into the intervention process. I also suggest that increased effectiveness with the MMFF and PCSFT will occur when the therapist is able to incorporate with flexibility, other family treatment perspectives of understanding into the model. I believe that this may be done while still maintaining the process and integrity of the intervention. It would not dilute the MMFF and PCSFT, but would rather compliment them.

Personal Future Goals

Substantive though this practicum has been, in many respects I feel I have just received an orientation to the topics of chronic pain, hypnosis and family therapy. Previous to my practicum I had very little exposure to family theory and practice. I believe that I now have the basic theory understanding and experience necessary to learn and function as a beginning family therapist. I realize that it is imperative I continue the learning and practice process in order that I flesh out my abilities as a family practitioner.

I have been trained and supervised under the model of the MMFF and PCSFT. Whereas I feel quite fluent on the theory of the model and have the beginning competence to work

with the model, I believe that I will need to work with a range and variety of families and situations in order for my learnings to continue. This will involve working with numerous families while following the MMFF and PCSFT. I believe it is through this activity that I will continue to meld theory and practice together to create a working knowledge. In other words, I am aware of the need to do more of the same. Ideally this will be supervised. However, I am aware that I may not receive supervision specific to the MMFF and PCSFT. If this is the case, I will have to remain cognizant of the models as I perform the work on my own.

As I increase my working familiarity with the MMFF and PCSFT I will also want to further develop my general executive skills of creating and maintaining a therapeutic focus, clarifying and facilitating communication, encouraging transactions, and identifying and interpreting transactions. These are integral to any successful therapist's repertoire of skills as is the sensitivity and ability to listen effectively and express oneself in an accurate and approachable manner.

To round myself out as a family practitioner, I will wish to expand my awareness of other approaches to theory and treatment of families. I suspect that I will not forsake one approach for the other as I am exposed to new ideas. My hope is that I will use the new knowledge to build onto my existing knowledge, thereby expanding my abilities and flexibility for working with families.

I have received a considerable amount of supervision on the theory and use of hypnosis. I am convinced that hypnosis in collaboration with other therapeutic techniques is a useful treatment tool. I would like to expand my knowledge and application of hypnosis to other situations where it is indicated as an appropriate addition to treatment. This would include

the treatment areas of addictions, phobias, habits, and self-concept and self-esteem building.

Aside from from new applications of hypnosis, I am also interested in expanding my actual skills of hypnosis. The induction I used during the practicum was effective though long and drawn out. I would like to learn a range of inductions which are effective yet also quickly implemented. During this practicum, I utilized a traditional approach to hypnosis in which the induction was used to formalize a trance during which suggestions were implemented. I am also interested in developing my understanding and use of waking trance hypnosis as taught by the followers of Milton Erickson.

I believe that in order to further my education of hypnosis in a credible manner I must seek membership with the over-seeing body for Canada, the Society for Clinical and Experimental Hypnosis (SCEH) Inc. This body insures that those practitioners who are using hypnosis therapeutically have the educational and theoretical foundations to do so competently. The ASCH frequently offers certifying workshops to professional applicants.

As I indicated in my discussion on the learnings from the hypnosis cases, I recognized the important need for competent interview and counselling skills. I wish to further develop these skills along with my communication skills of listening and expression. I believe these are the basic tools of my trade. I also have interest in expanding my knowledge and use of behavioral strategies as a means to reinforce and foster desired outcomes.

Value For the Profession of Social Work

I believe that the learnings provided by this practicum have value for the profession of social work. The family portion of the practicum was applicable to many social workers working within the medical or mental health fields.The profile and awareness of chronic pain is increasing. Chronic pain clinics are growing in number across North America. Often within these clinics there is a family assessment and treatment component as a part of overall treatment. Social workers often are primarily involved with constucting the assessments and providing treatment for these families.

Whether it be in a chronic pain clinic, hospital, Worker's Compensation Board or mental health agency, social workers are being faced with chronic pain sufferers. I believe that it is important to have sensitivity to the issues surrounding chronic pain and the family which will best enable the practitioner to treat the family effectively .

The hypnosis portion of the practicum also has benefits for social work. Hypnosis may be a useful therapeutic tool when it is used with discretion and clinical judgement. The therapist must also be trained and supervised by a competent instructor. I believe that hypnosis may be a powerful adjunct tool for social workers to reinforce treatment goals and desired outcomes. It has been demonstrated as an effective tool to support overt and covert behavior changes in the client and to encourage an increased sense of empowerment and self-control over pain. Baker (1987) points out his belief that hypnosis will be in the forefront of research and treatment involving the influencing relationship between the body and mind. In this added sense, hypnosis has relevancy to the health-care profession of which social work is a part.

The hypnosis has been conducted as a complement to individual treatment. This practicum demonstrated a workable fit between hypnosis and other individual therapeutic treatments.

Social workers may consider hypnosis to support the other treatment modalities being used.

The individual intervention also has a fit with the family treatment focus as previously discussed. Together they may provide a powerful response to what confronts clients and their families. What has been presented in the context of chronic pain, but I feel it may be applied to other health care situations social workers are faced with.

End Note

It is difficult for me to not become expansive and sentimental as I write these few remaining words. A I complete this practicum I also complete the final requirements for my Master's of Social Work degree. I can not help but reflect on the enduring process of this practicum and degree. Certainly these last words signal more than the endorphin rush triggered by the completion of this large, all encompassing task. These words mark the beginning of transition in my family and myself. Now my concerns shall divert from thoughts of university and academic survival to that of career, family and guilt free N.H.L. play-offs' enjoyment.

As I began the development of the practicum proposal, I was very aware of wanting to learn everything I could about all that interested me in a professional sense. This was not an easily achievable endeavor and certainly got in the way of uninterrupted sleep during many a placid night. I began to realize that I was not going to get all that I wanted in one shot, so I had best settle on what I felt was most important for me learn. I did some late-night fretting and decided I wanted to work with both individuals and families in the context of chronic pain. I also decided that as a significant part of the individual treatment I would learn and utilize hypnosis. I decided on the use of the MMFF and PCSFT for the families.

I was anxious to learn hypnotic techniques as was I anxious to learn a specific approach to family therapy. I had not had any exposure to either. In particular, I had little experience working with families in any context and I wanted to gain valuable supervised exposure.

As a result of this design there was a dual focus to the practicum: Family therapy with the spouse or family of the chronic pain patient utilizing the PCSFT model and individual treatment utilizing hypnosis.

I believe that I received some valuable benefits as a result of this practicum arrangement. I was exposed to a wide range of theory, skills and experience for both family treatment and hypnosis. I also worked closely with two skilled supervisors who provided a great deal of knowledge, skill and interest to the practicum.

There was certainly no scarcity of learnings to be absorbed. In fact at times, as a result of the broad base of the practicum, I felt I had spread myself out too thin to do all the necessary work. This was especially true during parts of the practicum write up. I began to wonder if I was doing twice the amount of work and fantasized what it would have been like if I had focussed on only one topic. As I think of this I admit that there would have been an advantage to this. It's possible that I may have been able to focus entirely on one discipline and gain a highly specialized knowledge of it. However, I quickly catch myself thinking otherwise. The truth is, if given a second chance, I probably would have done much the same. I feel I received a broad base of knowledge and experience from which I can now expand. Indeed, as I complete this practicum, I am aware that it is now I will begin to perform the greatest learning.

My pursuit of the M.S.W. degree, and in particular the practicum, enabled me to learn a great deal about literary research, organizing skills and writing. These are highly valuable skills which I will be able to bring with me and utilize where ever I go. In themselves, these skills were a great learning acquisition.

On a personal level I learned a great deal about my tolerance and endurance for many things. Though I often was confronted by self-doubt, uncertainty and exhaustion, I never once entertained the notion of quitting. It truly feels as though much time and activity has passed since I first started the practicum, let alone M.S.W. program. At some point I

resigned myself to the fact that this was a long term project which would require endurance.

During the long course of my practicum and M.S.W. program I often experienced periods of uncertainty related to decisions to make, directions to go, and fates to occur. This seemed to be a resounding theme of my program. During some idle readings I came across an adage which struck me as a truism: "***Before there is light, it is dark.***" I began to recognize that there was a pattern to my process of learning. As I immersed myself into my studies and projects, there were periods of great confusion and self-questioning as I struggled to interpret and address the tasks ahead of me. Sometimes this internal struggle seemed overwhelming. Yet, as I stayed with the problems and struggled to find the solutions that best expressed me, the answer or direction would gradually dawn on me. Interestingly, the answers often presented themselves when I gave up.

This was perhaps the greatest personal lesson I received from the practicum and program; an internal sense that even though the answer or solution to a recalcitrant problem may appear impossible to acquire, with patience it will come. It was as if I had to just accept the difficulty of the struggle and give in. By releasing myself from the struggle, the solution would come to me on it's own accord. I began to realize that in the process of learning there may be a time of darkness and confusion, but if allowed to pass on, will be followed by the light of insight.

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