HYPNOSIS IN THE TREATMENT OF CHRONIC PAIN – AN ECOSYSTEMIC APPROACH

by

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David and Stephen: my centre

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SUMMARY

In this study, the use of hypnosis in the treatment of chronic low back pain is described in terms of Ecosystemic thinking, as opposed to traditional conceptualisations of hypnosis. Six case studies were used. Each is described in detail, as well as the therapeutic rationale behind each case, in order to present the reader with an understanding of the thinking behind using Ecosystemic hypnotherapy.

Key terms:

Pain; Chronic pain; Chronic low back pain; Treatment of chronic pain; Therapeutic rationale; Case studies; Hypnosis; Ecosystemic hypnotherapy; Ecosystemic perspective

CHAPTER 1

INTRODUCTION

1.1 Chronic pain

Pain is easily one of the most common health problems today. According to Bishop (1994), up to 80% of all visits to physicians involve pain-related complaints. Bishop (1994) states that chronic pain can be categorised into three main types, namely chronic periodic pain, chronic intractable benign pain, and chronic progressive pain.

Chronic periodic pain is pain that is acute, but intermittent. For example a person who suffers from migraine headaches may have excruciating headaches that last for hours or days, but then may have several pain-free weeks or months.

Chronic progressive pain is found, for example, in cancer patients. The person experiences continuous pain that becomes worse as the disease progresses.

Chronic intractable benign pain is present most of the time, with varying intensity. One of the most common examples of this category is low back pain. People who suffer from low back pain generally experience their pain continually and find they can do little to reduce it.

The current study focuses on chronic low back pain sufferers. According to Belar and Kibrick (1986), over 18 million Americans suffer from chronic painful

back disorders. They cite National Centre for Health Statistics which estimate that in the United States approximately ten million outpatient visits are made to non-federally employed physicians each year for back pain, almost one million more visits than for upper respiratory infections.

The monetary impact of back pain on society is enormous. Maniadakis and Gray (2000) conducted a study into the socio-economic costs of back pain in the UK. They found that, although back pain may not be a life threatening condition, it constitutes a major public health problem in Western industrialized societies and exhibits epidemic proportions. Back pain is a leading reason for physician visits, hospitalizations and other health and social care service utilization in the UK. Maniadakis and Gray (2000) report that in 1994-1995, 116 million production days were lost due to incapacity to work related to back pain.

Macfarlane, Thomas, Croft, Papageorgiou, Jayson and Silman (1999) state that the cost of back pain in the US is $25 billion in direct medical costs. According to Macfarlane et al. (1999), as much as 80% of the population in the US is affected by low back pain symptoms at some time in their lives. Hutubessy, van Tulder, Vondeling and Bouter (1999) state that in the Netherlands, the direct health care costs of musculoskeletal diseases in 1988 were the fourth highest, accounting for 6.6% of the total health care costs in that year.

No data for the prevalence of chronic pain in South Africa currently exists. Nevertheless, there is little reason to suppose that, in proportional terms, the figures for South Africa are any different from those in any other industrialized nation.

What are the costs for the individual who suffers from low back pain? Banks and Kerns (1996) state that chronic pain is psychologically different from acute or occasionally recurrent pain in meaningful ways. In the first place, chronic pain amounts to quantitatively more aversive stimulation than acute pain and is, therefore, likely to be more stressful psychologically. According to Banks and Kerns (1996, p.103) chronic exposure to pain can "tax cognitive, behavioural and emotional resources in terms of the demands that it makes on the sufferer to conceive of and implement cognitive and behavioural coping strategies, as well as to tolerate the pain emotionally".

Pinsky (in Roy, 1989, p. 3) in describing chronic intractable benign pain lists the following phenomena:

- Mood and affect changes that are in themselves significantly dysphoric
- Drug dependency or abuse, of varying severities with their attendant CNS effects
- Multiple surgeries and pharmacological treatments with their own morbid side effects, separate form the drug dependency issues
- Escalating psychosocial withdrawal with increased loss of gratification from normal social interactions
- Interpersonal conflicts with significant others

- Increasing hopelessness and helplessness as increasing dysphoria is not relieved by mounting numbers of newer or different therapies
- Decrease in feelings of self-esteem, self-worth and self-confidence
- Decreasing ability to take pleasure from the life process, contributing to profound demoralization and, at times, significant anhedonia, if not depression
- Escalating physical incapacities secondary to the complaint of pain because of fear of increasing pain, discomfort, and the fear of causing more bodily harm, based on the belief that their ongoing pain is a signal of increasing bodily damage
- Conflicts with medical care delivery personnel with resulting dissatisfaction and/or hostilities

What impact does chronic pain have on the family? According to Roy (1985a, p.305) "the presence of a chronic pain patient in a family system is highly disruptive." Roy (1986, p.113) states that "a well-functioning family can, in a reasonably short time, become almost totally dysfunctional when one of its members gradually assumes the role of a chronic pain patient."

According to Roy (1989), the research literature on the impact of chronic pain on the family has addressed the following issues:

1. Heightened psychological distress in the spouses of chronic pain sufferers
2. Compromised and less satisfactory sex life
3. Changes in roles resulting in additional responsibilities for other family members, especially the spouse

4. Changes in communication patterns with multiple consequences, such as reinforcement of pain behaviour, the loss of ability to communicate openly and directly, and increased collusion
5. A heightened level of general marital distress

The spouse and the children are likely to feel a great deal of confusion about the true nature of the pain problem. The family may feel the chronic pain sufferer is imagining the pain because, as far as they can ascertain, there is no organic problem. The family is often uncertain as to how to treat the chronic pain sufferer and what to realistically expect from him/her. The chronic pain sufferer's spouse may also feel the loss of a partner with whom he/she can share thoughts and feelings because the person is irritable and/or depressed most of the time.

Chronic pain thus has far reaching implications: economically at a national level, for the individual sufferer and for his/her family. The current study describes the impact of chronic pain on each participant and his/her family system. Although a considerable body of literature exists which does address the effects of chronic pain on the family system, these effects are different or manifest in a different combination for each individual. From an ecosystemic perspective it is vital to examine how chronic pain is embedded in each individual participant's total ecology and to consider the possible meaning of and function served by each participant's pain before embarking on treatment.

1.2 Hypnosis and pain

The application of mesmerism to surgical pain emerged early in the 19th century when effective clinical techniques for pain management had not yet been developed (Chaves & Dworkin, 1997). Mesmer himself began applying his techniques to clinical pain and early reports of the Abbe di Faria (1819) described the application of mesmerism to pain and hinted at its application in surgery (Chaves & Dworkin, 1997).

There is some dispute about when hypnosis was first applied to the relief of surgical pain. An undocumented account of a mastectomy by M.Dubois in 1797 and later reports of surgical procedures by Recamier were followed by the first documented report of a mastectomy by Cloquet in 1829 (Chaves & Dworkin, 1997). Evans (1990) tells us that the Scottish physician, James Esdaile, documented the use of hypnosis in the control of pain. In the late nineteenth century, just prior to the development of chemical anaesthesia, Esdaile used hypnosis widely in India as the only form of anaesthesia for amputations, tumour removals, and other complex surgical procedures. Most of Esdaile's patients survived surgery, which was a rare event in those days because of factors such as haemorrhage, shock and post-surgical infection.

With the advent of chemical anaesthetics, the need for and interest in hypnotic analgesia declined. The newly discovered inhalation anaesthesia was disseminated and won professional acceptance, despite the significant number of fatalities attributed to it. Many authors (Barber, 1977; de Escobar,

1985; Jackson & Middleton, 1978) have, however, pointed out that there are still advantages to hypnotic analgesia and hypnotic anaesthesia. It has none of the side effects or dangers of chemical analgesics and anaesthetics, especially when they are contraindicated due to specific medical or personal conditions. In addition, hypnosis as an adjunct for pain control can significantly reduce the amount of drugs needed (Chaves & Barber, 1976; Harmon, Hynan & Tyre, 1990; Morse, 1977).

The use of hypnotic analgesia has been documented for dental procedures, including routine fillings, root canal treatments, and extractions (Morse, 1977; Morse, Schoor & Cohen, 1984; Toth, 1985). It has also been used for, among other things, the removal of cancerous tumours (Perry & Laurence, 1983), caesarean sections, abdominal explorations, prostrate operations, biopsies (Chaves & Barber, 1976), gastrointestinal endoscopies (Jackson & Middleton, 1978), the surgical correction of ankyloglossia or "tongue tie" (de Escobar, 1985), and for post-operative pain following cancer surgery (Weiss, 1993).

Hypnotic analgesia has been employed to assist in pain management, including the management of chronic head, neck and back pain (Bills, 1993). Holroyd (1996) cites three studies that employed hypnosis, namely Haanen's 1991 study into fibromyalgia; Patterson, Everett, Burns and Marvin's study in 1992 with burn patients; and Syrjala, Cummings and Donaldson's clinical trial in 1992, which used hypnosis for the reduction of pain and nausea in cancer patients receiving bone marrow transplants.

Large (1995) reviews a number of controlled studies using hypnosis for chronic pain conditions. These include Prior's 1990 study of irritable bowel syndrome, Stam's work in 1984 with patients with temporomandibular pain, Olness's study in 1987 with children with classic migraine, and Van Dyck's 1991 study with tension headaches.

The issue most commonly raised in the literature about hypnotic pain control is a search for the mechanism(s) responsible for its functioning. Attempts to deal with this issue fall into several categories, including dissociation theory (Miller & Bowers, 1983), neodissociation theory (Hilgard, 1973), role theory (Hilgard, 1973), psychoanalytic ego theory (Hilgard, 1973), trance logic (Perry & Laurence, 1983), and the mediating effects of various neurochemicals, including norepinephrine and endorphins (Jackson & Middleton, 1978; Kihlstrom, 1985).

Thus far there appears to be a great deal of uncertainty concerning the mechanism at work in hypnotic analgesia, and it appears unlikely that clarity will be reached soon, if at all. The commonality in the traditional approaches to hypnotic analgesia is that they all adhere to a positivist or Newtonian epistemology that emphasises reductionism, linear causality and objectivity of observation (Fourie & Lifschitz, 1989). Within this paradigm, the search for a mechanism appears to be turning into a holy grail.

It may thus be useful to consider the subject of hypnotic analgesia from a completely different paradigm, in order to gain a new perspective on the

subject. Rather than trying to find an explanatory mechanism internal to the hypnotic subject, as has been the case in most of the literature, the explanation will be situated within the ecosystemic paradigm, which emphasises the process between all participants and the way in which the meaning of behaviour is generated in order to influence experiences of reality.

Fourie and Lifschitz (1989) posit the following implications of an ecosystemic conceptualisation of hypnosis and hypnotherapy: hypnosis is a concept, not an entity; hypnotic behaviours are not caused; hypnotic behaviours exist within a domain of consensus; hypnotic induction is a punctuating ritual; hypnotic responsiveness is contextually specified; and hypnotic depth is a culturally shaped subjective experience. From an ecosystemic point of view hypnosis can be defined as a "a concept that describes a situation in which all participants expect the subject to perform behaviours in such a way and of such a nature that they are understood by everybody to be hypnotic" (Fourie, 1988, p.144).

The current study examined the effect that hypnosis, approached from an ecosystemic perspective, can have on the chronic low back pain sufferer and his/her family system. Although some successes have been reported using hypnosis for pain conditions, none of these studies, with the exception of a study by Bassett (1992), have approached the use of hypnosis with chronic pain patients from an ecosystemic perspective. This study proposes that such an approach is vital because the experience of chronic pain is so individual and has to be considered in terms of the context in which it is embedded.

The above-mentioned study conducted by Bassett (1992) with chronic pain patients did employ an ecosystemic approach to hypnosis. For several reasons, however, no definite conclusions could be drawn with regard to the efficacy of hypnosis, approached from an ecosystemic perspective, for such patients. Although Bassett worked with chronic pain patients, no specific category of chronic pain was specified. The researcher also did not stipulate that the participants should already have exhausted the usual medical route and should not be in need of any new medical or surgical intervention. As a result the final participants had widely differing pain complaints and also presented with other medical problems, such as problems with bladder and bowel control, which complicated the treatment of the chronic pain problem. A further problem is that Bassett was left with only two case studies out of the original 14 recruits so that no conclusion could be drawn as to the possible efficacy of this form of treatment.

The current study was not interested in the etiology of pain. As Capra (1983) states, in practice it is frequently impossible to know which sources of pain are physical and which psychological. According to Fourie (1998), approaches that have attempted to find some elusive physiological or psychological disorder, which could be construed as the cause of the pain, have generally failed. The advantage of using an ecosystemic approach is that it does not emphasize the origin of the subject's pain. All the subjects' complaints of pain were, therefore, regarded as legitimate. The main emphasis, from an ecosystemic perspective, lies in creating a context wherein a greater degree

of adaptation to pain may come about, regardless of the presumed underlying pathology.

The success of ecosystemic hypnosis in this study was not decided by its bringing about complete and permanent pain relief for the chronic low back pain sufferer. As Spinhoven and Linssen (1989) state, a more realistic goal when working with low back pain patients is a better adjustment to continuing pain or learning to live with chronic pain, rather than curing pain or pain reduction. Ultimately, the effectiveness and viability of any ecosystemically oriented therapy for the chronic pain syndrome is determined solely in terms of whether or not it has facilitated the development of more functional patterns of interaction and relationships in the participant's ecology.

As stated, the focus of this study was to examine the use of hypnosis from an alternative perspective. However, in order to do this, it is necessary to first gain an understanding of hypnosis from the traditional paradigm. The following chapter will first address hypnosis as viewed from a traditional paradigm, before going on to examine hypnosis as viewed from an ecosystemic perspective.

CHAPTER 2

HYPNOSIS:

THEORETICAL BACKGROUND AND RESEARCH FINDINGS

2.1 Theoretical background

There are several theoretical explanations for hypnosis. These explanations can be divided into two major categories, namely traditional, Newtonian, positivist approaches and the new ecosystemic approach. This chapter will provide a brief outline of these different approaches and look at how each approach views the use of hypnosis for pain management.

2.1.1 Traditional Positivist Approaches

The traditional positivist approaches to be discussed are three broad approaches, the state, non-state, and Ericksonian approaches, under which, according to Fourie (1988), most of the traditional theories can be seen to be subsumed.

State Approaches

According to Barber (1972) and Baker (1990), the traditional state or trance paradigm is based on the following underlying assumptions:

- There exists a state of consciousness fundamentally different from the waking and deep sleep state, which is referred to as hypnosis, trance, or the hypnotic state.

- This "state" is usually induced by specific kinds of procedures called trance inductions, although it may also occur spontaneously. All induction procedures generally follow a similar format.
- A person in a hypnotic state remains so for a period of time, and is brought out of it by a command from the hypnotist.
- In this hypnotic state the subject is responsive to suggestions which he/she otherwise could not respond to, for example age regression, hallucination, amnesia and suggested blindness.
- Different levels of depth of trance exist, ranging from light to somnambulistic.
- The deeper the trance the more vivid and intense the subject's experience of suggested phenomena.

Much of the state theorists' "proof" of an altered state of consciousness rests on self-report and inferred experience.

How do the state approaches view pain management?

According to the state approaches the subject is able, through hypnosis, to reach an altered state of consciousness. It is this altered state that is deemed responsible for the subject's ability to deal with pain.

Prominent within the state approaches is Dissociation theory, which explains the specific mechanism thought to be responsible for the analgesic effect of hypnosis. According to Hilgard (1973), the historical roots of this view were planted in psychoanalytic theory with concepts such as "conscious", "sub-

conscious", "unconscious", "id", "ego", "superego" and "subliminal self', all of which divided the person into bits which were believed to be separate from each other. Dissociation theory posits that once the subject is hypnotized, a barrier is created which separates the cognition that feels pain, from the cognition responsible for communicating this experience.

It is maintained that evidence in support of Dissociation theory can be found in the fact that one may find physiological indications of pain in the subject, even though the subject does not report pain. A study reported by Morse, Schoor and Cohen (1984) evidences that Dissociation theory is accepted wisdom. The authors state that the patient "usually was able to dissociate and take a pleasant mental trip" (p.27).

Perry and Laurence (1983) provide a different view on pain management within the state approaches. According to them, the success of hypnosis is related to the manner in which the hypnotic induction interacts with different degrees of hypnotic susceptibility or "receiver characteristics" (p.367). These characteristics include imagery, absorption and dissociation and may vary in a qualitative (different people have different combinations and permutations of them) or in a quantitative manner (all people have different degrees of the three characteristics). The implication is that hypnosis enables the subject to tap into these characteristics through some kind of altered state. In addition, the mechanics of the altered state of consciousness may be different for each case.

Non-State Approaches

An alternative paradigm, which had its origins in social psychology and behaviourist theories, was devised by the non-state theorists in response to the supposedly "unscientific" methods employed by state theorists. Proponents of the non-state theory limit research to observable behaviour while ignoring more abstract inferences.

Non-state theorists reject the concept of an altered state of consciousness and instead propose "role-taking" as a central concept. Sarbin and Slagle (1972) speak of hypnosis as a special kind of social situation, and Spanos (1991) maintains that hypnosis does not refer to a state or condition of the person, but to role enactment.

Barber (1972) identifies the following basic assumptions of this paradigm:

- There is no fundamental difference in the state of a person who is in trance and one who is not in trance.
- Both the person in trance and the one not in trance have attitudes, motivations and expectations toward the communications or test suggestions they are receiving.
- The person who is responsive to test suggestions has a positive attitude, and the person who is unresponsive has a negative attitude.
- The three factors – attitudes, motivations and expectations – vary on a continuum from negative to positive. These factors converge and interact in complex ways to determine the subject's response.

- Concepts such as "trance", "somnambulism" and "dissociation" are misleading and do not explain the overt and subjective responses.
- Responsiveness to test suggestions is a normal phenomenon that can be conceptualised in terms of social psychology constructs.
- The phenomena associated with test suggestions are within the range of normal human capabilities.

How do the non-state approaches view pain management?

Nicholas Spanos was one of the most important proponents of the non-state approaches to hypnosis. According to his view, hypnosis is nothing more than the use of socially-influenced cognitive skills and abilities. Spanos (1986, p.449) explained hypnotic behaviour as "purposeful, goal-directed action that can be understood in terms of how the subjects interpret their situation and how they attempt to present themselves through their actions. ..."good" hypnotic subjects frequently behave *as if* they have lost control over their behaviour ... because their preconceptions about hypnosis and the persuasive communications they receive in the hypnotic test situation define acting that way as central to the role of being hypnotized."

Most of the work carried out by Spanos and his colleagues involved the manipulation of the research situation or context, as well as experimenter expectation cues, in order to show how hypnotic phenomena vary accordingly. Spanos and Hewitt (1980) showed that they could manipulate whether the "hypnotized" part of a subject felt pain as a result of different hypnotic suggestions. Stam and Spanos (1980) demonstrated that the degree

to which hypnosis is effective in reducing pain is a function of preconceptions regarding the efficacy of hypnotic analgesia as conveyed by the researcher to the subjects.

Spanos and Radtke-Bodorik (1979) compared the cognitive strategies used to control pain both by subjects under hypnosis and those not, and found no differences. They thus concluded that the mechanism responsible for hypnosis is not a mysterious automatic process. Rather, it is something the subject is responsible for initiating and is nothing more than cognitive coping strategies, such as distraction, imagining events inconsistent with the pain, coping verbalizations and relaxation.

Ericksonian Approaches

Milton Erickson himself never formulated the theoretical basis of Ericksonian hypnosis. His many followers have, however, explained his methods and techniques in detail. For example, Haley (1973) takes an interactional view to describe Erickson's method. Bandler and Grinder (1975) use a linguistic approach based on transformational grammar to analyze Erickson's patterns of communication. Rossi (Erickson, Rossi & Rossi, 1976; Erickson & Rossi, 1979), as a Jungian-oriented analyst, uses an intrapsychic perspective to understand Erickson.

According to Fourie (1991b), the following elements are basic to Ericksonian thinking:

- A focus on individual, intrapsychic functioning

A central idea in Ericksonian work is that of a dichotomy between conscious and unconscious functioning (Erickson, Rossi & Rossi, 1976; Gordon, 1985). Havens (1985, p.55) states that Erickson believed that the unconscious was an "... observable, demonstrable, phenomenon ... people actually *have* an unconscious mind ... in the same sense that they have an arm or a leg" (italics in original).

Ericksonians believe that the unconscious is a storehouse of resources and untapped potential (Kirmayer, 1988; Lankton & Lankton, 1983). According to Erickson, Rossi and Rossi (1976, p.18), "It is very important for people to know their unconscious is smarter than they are. There is a greater wealth of stored material in the unconscious."

In general, Ericksonian authors view hypnosis as the means by which dissociation between the conscious and unconscious can be achieved (Erickson & Rossi, 1979; Lankton & Lankton, 1983, 1986) and as a way to activate unconscious processes (Ritterman, 1983). Once the resources located in the unconscious are released into consciousness they can be utilized to solve personal problems.

There is, therefore, in Ericksonian thought a focus on the individual and his/her intrapsychic functioning.

- A focus on lineal cause and effect

The focus in Ericksonian hypnotherapy is on lineal, causal relationships and the hypnotherapist is seen to exert a direct or lineal influence on the subject. The hypnotic induction process is explained in terms of a lineal causal relationship and the emphasis on technique also implies a lineal causal view.

- A focus on objectivity of observation

The Ericksonian approach places the therapist outside the client system. The therapist is seen as being able to objectively decide which technique to use, apply this technique from the outside, and objectively observe the effect.

- A focus on hypnosis as an entity

Most Ericksonian therapists are reductionistic in their view of hypnosis as an entity. Erickson (1985) himself speaks of a state of special awareness and Ritterman's (1983) idea that families hypnotize their members carries the implication that a particular entity, which she calls "trance", is induced. Hypnosis is thus perceived as an entity that exists in its own right. The concept of hypnosis, used to describe certain behaviours, becomes reified, and becomes an explanation for rather than a description of a particular class of behaviours considered to be hypnotic.

How do Ericksonian approaches view pain management?

According to Fourie (1988) an Ericksonian approach explains the basis of hypnosis as the only possible response to the special type of communication

leveled at the subject by the hypnotist. The emphasis in Ericksonian hypnosis is on the perfection of techniques in order to obtain hypnosis. According to Weiss (1993), Erickson described the following eleven basic hypnotic procedures to be employed for pain control:

- Direct hypnotic suggestion for the total abolition of pain
- Permissive indirect hypnotic abolition of pain
- Amnesia
- Hypnotic analgesia
- Hypnotic anaesthesia
- Hypnotic replacement or substitution of sensations
- Hypnotic displacement of pain
- Hypnotic dissociation
- Hypnotic reinterpretation of the pain experience
- Hypnotic time distortion
- Hypnotic suggestions effecting a diminution of pain

Erickson specialized in the use of indirect techniques which, supposedly, by-pass consciousness, going straight to the unconscious – the site of hypnosis. Ericksonian hypnosis also emphasizes the matching of subject variables or characteristics to specific techniques.

Commonalities in the Traditional Approaches

Fourie (1988, p.143) states that the state, non-state, and Ericksonian approaches all share two important elements, namely:

- They focus on the individual and his/her intrapsychic functioning

- They see hypnosis as being brought about or caused by an induction/communication process.

2.1.2 The Ecosystemic Approach

The ecosystemic view of hypnosis is a departure from traditional approaches to hypnosis, which locate hypnosis within the psyche of the subject and largely ignore the context within which hypnosis occurs. Within an ecosystemic framework it is assumed that phenomena cannot be understood in isolation, but only in the context within which they manifest (Lifschitz & Fourie, 1985).

Fourie and Lifschitz (1985, 1988, 1989) and Fourie (1988, 1995) delineate a number of characteristics of ecosystemic hypnosis.

1. Hypnosis is a concept, not an entity

From an ecosystemic perspective, hypnosis is not viewed as an entity with its own reality, but rather as a concept describing the behaviours which occur in a particular context defined as hypnosis (Lifschitz & Fourie, 1985). Hypnosis is thus a concept describing a situation in which certain classes of behaviour are **perceived** as hypnotic or involuntary. Whether a particular class of behaviour is perceived as hypnotic, or not, is determined by the opinions and expectations held by those involved in the situation.

2. Hypnotic behaviours are designated as such by mutual qualification

Hypnotic behaviours are ordinary behaviours that are defined as hypnotic by a process of mutual qualification. This process is based on the definition of the situation as one of hypnosis, and on all the participants' ideas and expectations regarding such a situation (Fourie, 1991a). Any behaviour can be mutually qualified as "hypnotic" provided that it fits with the expectations of the people present. Fourie (1991c) states that the process of mutual qualification depends on the socio-cultural definition of the situation. He states that the lifting of an arm in a classroom is likely to be interpreted and acted upon quite differently from the same behaviour in a situation that is designated as one of hypnosis.

3. The process of mutual qualification is an ongoing one

Fourie (1991a) states that the qualification of the first behaviour as "hypnotic" is an evolutionary step in the developing of an ecology of ideas in the hypnotic system. Subsequent to the initial qualification, the participants see that hypnosis is happening, and may be more likely to view and qualify the behaviours that follow as "hypnotic" as well. As each subsequent behaviour is qualified as "hypnotic", the ecology of ideas strengthens around the view that what is happening is hypnosis. According to Fourie (1991a) all participants thus become increasingly convinced of the "reality" of hypnosis.

4. Hypnotic behaviours are not caused by anything

Ecosystemically seen, the hypnotist does not cause hypnosis. Instead he/she organizes the development of a system in which hypnotic behaviours can occur. This is achieved by means of an induction procedure. According to Fourie (1991a) induction has the following two functions:

- It serves as a vehicle for the process of mutual qualification
- It punctuates the flow of events in such a way as to indicate that behaviours during and subsequent to induction could be seen as and qualified as "hypnotic"

Fourie (1988) states that the induction does not cause the hypnotic behaviour, it merely helps to define the situation as a hypnotic one.

Chaves (1994, p.122) believes the following are essential elements of hypnotic induction procedures:

- to create a series of experiences for the patient that help him/her to define the situation as hypnotic
- to facilitate the focussing of attention and the engagement in goal-directed imaginings
- to enhance the expectation that it will be possible to experience the clinical benefits of participating in the hypnotic procedure

Chaves (1994) states that the induction procedure must have face validity for the patient. In other words, the procedure needs to be seen as credible, within the framework of the patient's expectation regarding hypnosis.

5. All participants in a situation defined as hypnosis have ideas and attributions about hypnosis

Fourie (1991c) states that these ideas and attributions play a role in the process of mutual qualification. He states, for example, that onlookers seldom speak to the subject or to the hypnotist when hypnosis takes place. There seems to be a general idea that only the hypnotist should speak and then usually only to the subject. The very silence of the observers, according to Fourie (1991c), helps to qualify the subject's behaviour as hypnotic as does the fact that onlookers tend to pay attention to the subject, rather than to somebody or something else.

With regard to expectations, Chaves (1994, pp.119-120) states that "virtually all patients can be assumed to have expectations regarding the nature of hypnosis, including impressions about how hypnosis is done, who is responsive to it, what the typical outcomes are, and what dangers are associated with hypnosis." According to Chaves (1994), patients will sometimes have very specific expectations regarding such matters as how they will be hypnotized or how they will achieve clinical gains.

Whereas other approaches to hypnosis hold certain client and family ideas about as incorrect and often advocate the removal of such so-called "misconceptions" prior to hypnosis (e.g. Yapko, 1995), the ecosystemic therapist capitalizes on the expectations, attributions and conceptions the client has regarding hypnosis. For example, if the client expects to lose

consciousness in hypnosis, the ecosystemic hypnotherapist can incorporate this expectation into the therapeutic process.

6. There is no hypnotic susceptibility, only hypnotic responsiveness

When hypnosis is viewed from an ecosystemic perspective the concepts of susceptibility or hypnotizability and depth, as embodied in Newtonian thinking, need to be reconsidered. According to Chaves (1994), traditional approaches to the use of hypnosis for pain management have generally emphasized the need to select as candidates patients who are highly hypnotizable. Traditional hypnotherapy approaches regard hypnotic susceptibility as some sort of innate characteristic. Hawkins (1989) states that many therapists do, however, maintain that under certain conditions all people are able to respond to hypnosis. The Ericksonian school, for instance, maintains that the hypnotizability scales only measure one type of hypnotic response (typically a direct suggestion response) and that, while not everybody will respond to this mode, they may well respond to more indirect hypnotic techniques, such as the use of metaphors and hypnotic reframes. Hypnotic failures, according to this view, are due "more to inflexible or inelegant therapists than to "resistant" clients" (Hawkins, 1989, p.28).

The social context within which susceptibility testing takes place has been consistently ignored. Such testing involves a highly structured setting. Fourie and Lifschitz (1988) state that some subjects "fit" well into a structured testing situation to the extent that they respond readily to the hypnotist's instructions. These are the "highly hypnotizable" subjects referred to in hypnosis literature.

Other subjects do not "fit" as well with the situation and consequently score lower on the scales. Sacerdote (1982, p.373) points out that the standardized hypnotizability scales are not comprehensive enough to tap all types of hypnotic capacity and that it may even be unethical "to deprive even a small minority of the potential help of hypnosis because of the negative impact of low hypnotizability scores." Chaves (1994, p.119) states that "in general, patients who are appropriate for any psychotherapeutic intervention are potential candidates for hypnotic intervention".

The second concept that needs to be revised, from an ecosystemic viewpoint, is that of hypnotic depth. Hypnotic depth is defined by Hilgard (1981, p.25) as "a measure of the inferred hypnotic condition believed to accompany hypnotic behavior on a particular occasion". Hypnotic depth is a hypothetical construct inferred from the actual observed behaviour and should not be construed to be an absolute reality.

Lifschitz and Fourie (1985, p.22) state that "the depth conception does not contribute to a clear understanding of hypnosis". Fourie (1983) proposes that the concept of "depth" be replaced by the "width of the hypnotic relationship". According to him, the width of the hypnotic relationship refers to the range of hypnotic behaviours that are possible within the scope of the hypnotic relationship. The scope of the hypnotic relationship can be widened by means of negotiation between all the parties present.

Ecosystemic hypnotherapy

An ecosystemic understanding of a problem opposes the traditional positivist understanding of a problem as something that resides within the individual and is caused in a linear way. The treatment of problems is not seen as lying in the application of "cures" by an expert to the troubled individual.

Anderson and Goolishian (1988) explain that problems exist only in language. Problems do not exist within a problematic component within a troubled individual. A problem is only a problem to those languaging about it, or those who share a consensual domain about the problem. Even while there is some degree of shared understanding of the problem, each person involved in the consensual domain, including the researcher, will have his or her own linguistic reality of the problem. There may be consensus among some members but rarely, if ever, among all. Thus, there is no single or correct view of the problem, but rather multiple views constructed in language.

If problems are constructed in language, they must be solved through language. However, because systems are self-reorganizing when it comes to change (Boscolo, Cecchin, Hoffman, & Penn, 1987), the therapist cannot predict the outcome of a particular intervention. According to Anderson and Goolishian (1988) the most the therapist can do is enter the consensual domain and perturb it in language until the problem changes and is open to alternative possibilities, or until it is no longer considered to be a problem.

The therapist's task is to interact with the members of the consensual domain and their discrepant ideas so as to create a space for change. The therapist must participate in having a dialogue that stimulates members of the consensual domain to have new conversations with each other rather than continuing to have the same conversation over and over again. The therapist must help clients open themselves to others and accept their point of view as being worthy of consideration. The skill of the therapist lies in maintaining the continuance of the conversation until new meaning evolves.

From this explanation it becomes clear that the ecosystemic approach to hypnosis would not involve applying hypnosis to a passive subject in order to cure a problem. Instead, hypnosis is used as tool to perturb the consensual domain or ideas about the problem. From an ecosystemic perspective it is, therefore, important to discover the ideas in the system about hypnosis. These are then incorporated into the hypnotic experience. It also becomes important to conduct hypnotherapy, if possible, in the presence of all the members of the consensual domain, as opposed to hypnosis merely being conducted with the subject.

Fourie (1991a) believes that the power of hypnotherapy lies in the power that is attributed to it by the therapy system. Hypnosis is employed from an ecosystemic perspective not because it possesses some intrinsic power, but because clients and families *believe* that hypnosis is powerful (Fourie, 1991a). Since the client perceives hypnosis to be a potent technique, it acquires the ability to perturb the client's ideas.

Each subject in the current study not only brings with him/her particular ideas about hypnosis, but also about the problem of chronic pain. The participant's ideas on chronic pain constantly evolve as the subject interacts with others and with his/her environment. Once a client enters hypnotherapy, this system of ideas becomes wider as the therapist's ideas about himself/herself, about the client, about the problem etc. are introduced into the system. The therapist's task will be to express ideas that link with those of the client, and yet simultaneously change the client's ideas in a co-evolutionary way. Fourie (1991c, p.172) states that therapy should "provide to the client(s) a source of ideas which are new to them, but not so different that they cannot understand them".

How would an ecosystemic approach view pain management?

Griffiths, Griffiths and Slovik (1990) believe that chronic pain is often the central theme in an ecology of ideas, or consensual domain, and that intervention should be aimed at the level of ideas and meaning rather than anywhere else. According to them attempts should be made to perturb the ecology of ideas, through conversation, in a direction away from pain.

Fourie (1998) concurs that the focus should no longer be on the use of hypnosis as an analgesic, but rather hypnosis should be utilised to facilitate the co-construction of an ecology of ideas in which pain is not the central theme any more. Fourie (1998) believes that hypnosis should be employed to change the meanings around the pain and not to attack the pain itself and

thereby inadvertently give credence to these meanings. Fourie (1998) states that treatment of the pain alone will be mostly unsuccessful because such treatment, by focusing on the pain, confirms it in its central position.

2.2 Research findings

Besides the study by Basset, cited in the previous chapter, no studies specifically employing ecosystemic hypnosis for chronic low back pain could be found in the literature. Numerous others studies do, however, demonstrate the efficacy of more traditional approaches to hypnosis for pain.

Chaves and Dworkin (1997) state that a 1995 NIH Technology Assessment Conference Statement assessed the efficacy of hypnosis for clinical pain control. It concluded that hypnosis has demonstrated efficacy for relief of cancer pain and apparent usefulness for diverse conditions such as sleep disturbance and the broad category of benign chronic pain, including back pain.

According to Chaves and Dworkin (1997, p.368) "hypnosis seems to have an admirable track record for facilitating symptom removal without yielding subsequent symptom substitution." Chaves and Dworkin (1997) state that there are many accounts of invasive surgical procedures performed with hypnosis as the sole analgesic-anesthetic modality. Just as impressive to Chaves and Dworkin (1997) are the many reports of successful postoperative course following major surgery with hypnosis as the sole anesthetic. They state that according to such anecdotal clinical accounts, minimal

postoperative pain medications seemed to be required, and healing seemed uneventful, if not enhanced. Dworkin himself personally observed the successes of using hypnosis as the sole anesthetic agent.

Bills (1993) reports the successful use of a multi-disciplinary approach, including the use of hypnosis, in the management of a patient who had been suffering chronic head, neck and back pain over a period of four years. The patient had in those four years been seen by a number of different practitioners, in various health-care fields, without a great deal of success. Bills (1993, p.1) states that "hypnosis proved a flexible and useful treatment instrument". He considers hypnosis to have been invaluable in helping the patient learn to relax better and to develop a more positive attitude toward her pain.

A key review article by Holroyd (1996) concluded that recent controlled outcome studies comparing hypnosis to other psychological treatments for chronic pain have shown hypnosis to be equally effective or more effective. She notes that, despite clinical and experimental indications of the usefulness of hypnosis for severe and persistent pain, and the fact that hypnosis is a safe and non-invasive procedure, it is still not widely used. Among the studies cited by Holroyd (1996), three recent ones in particular support the greater effectiveness of hypnosis compared to other behaviour therapies. Firstly, the 1991 study by Haanen and colleagues which used hypnotic suggestions for relaxation, improved sleep, and control of muscle pain with patients suffering from fibromyalgia, a chronic condition with significant muscle pain and sleep

problems. The hypnosis intervention resulted in significantly greater reductions of pain, sleep disturbance, fatigue and feeling sick, compared to relaxation therapy plus massage treatment. Furthermore, 80% of the hypnosis patients reduced their pain medication compared to only 35% of the comparison treatment patients.

Secondly, Patterson, Everett, Burns and Marvin conducted a study in 1992 with burn patients. They used hypnotic suggestions for relaxation, analgesia, amnesia and comfort when touched on the shoulder during debridement, which is normally a very painful procedure. The hypnosis patients reported a significant reduction in self-rated pain, whereas two control groups of patients (pseudohypnosis and no treatment) did not.

Thirdly, Syrjala, Cummings and Donaldson conducted a controlled clinical trial in 1992 to compare hypnosis to cognitive-behavioural training for the reduction of pain and nausea during cancer treatment with 35 cancer patients receiving bone marrow transplants. The cancer patients were randomly assigned to one of four groups: hypnosis, cognitive-behavioural training, therapist contact (attention-placebo control), or treatment as usual (no-treatment control). Patients in the hypnosis group had significantly and consistently less pain from oral inflammation and ulceration due to marrow transplantation than patients in the cognitive-behavioural training and therapist contact groups. They also reported less pain even though they tended to use less opioid medication.

Liossi and Hatira (1999) state that studies related to hypnotic treatment of children who undergo bone marrow aspirations clearly demonstrate significant reduction of pain and anxiety. Liossi and Hatira (1999) state that, compared with various cognitive behavioural interventions, hypnosis is equally effective in reducing self-reported pain in bone marrow aspirations.

Large (1995) provides a review of controlled studies using hypnosis for chronic pain. A study conducted by Melzack and Perry in 1975 compared alpha EEG-feedback with hypnosis, in the form of a modified Hartland ego-strengthening tape. Twenty-four patients with established chronic pain syndrome were randomised to six patients receiving alpha-feedback, six receiving hypnosis, and 12 the combination of both modalities. The combination was the most effective condition in reducing pain, and hypnosis was more powerful than alpha-feedback.

In 1980, Elton and colleagues compared behavioural psychotherapy with pill placebo and hypnosis in 30 patients with chronic pain syndrome. The hypnotic approach was individualised to patient needs. The hypnosis group had the best outcomes.

A study by Whorwell in 1984 compared hypnosis, in the form of general relaxation and ego-strengthening suggestion, with supportive psychotherapy in 30 patients with irritable bowel syndrome. There were reductions in subjective pain experience and abdominal distension with hypnosis, but not with supportive psychotherapy.

Stam in 1984 compared the efficacy of hypnosis against that of relaxation training in 61 patients with temporomandibular pain. Both treatment groups improved compared with controls.

A study conducted by Olness in 1987 found that children with classic migraine had a significant decline in headache frequency after learning self-hypnosis, compared with propranolol or pill placebo. Large (1995) believes this is an important study in that it compares a psychological treatment with an "established" drug treatment in 28 children. Interestingly, the drug turned out to be no better than the placebo.

In 1989, James conducted a multiple baseline study of 5 patients with chronic pain syndrome who were classified as highly hypnotisable. Hypnosis was individualised and each patient developed self-hypnosis exercises. Two achieved long-term resolutions, two at the time of the writing of Large's article continued to use self-hypnosis effectively, and one patient showed no change.

Prior in 1990 found that hypnosis reduced rectal sensitivity among diarrhoea-predominant patients in a group of 15 irritable bowel syndrome sufferers. Large (1995) believes this study is significant in that it described a change in an objective physiological measure as a consequence of hypnosis.

A study conducted by Van Dyck in 1991 randomised 55 patients with tension headache to autogenic training or future oriented hypnotic imagery. The

treatments were equally effective. Finally, Spinhoven in 1992 compared autogenics with self-hypnosis in 56 patients with tension headaches and found that both groups improved.

The overall impression from these studies is that hypnosis is an effective therapy in the management of chronic pain. The possibility that hypnosis, undertaken from an ecosystemic perspective, could be equally or even more effective is however, as yet, unexplored.

This chapter has outlined the various conceptualizations of hypnosis. The following chapter will on go to examine the research design employed in the current study.

CHAPTER 3

RESEARCH DESIGN

3.1 A case study approach

This study made use of the case study approach. Yin (1993, p.31) states that the major rationale for using this method is "when your investigation must cover both a particular phenomenon and the context within which the phenomenon is occurring, either because (a) the context is hypothesized to contain important explanatory variables about the phenomenon or (b) the boundaries between phenomenon and context are not clearly evident". The case study method was, therefore, chosen because the researcher wanted to cover contextual conditions – believing they might be highly pertinent to the phenomenon of study.

Hamel (1993) states that the case study method is also the type of study best suited to understanding the way in which the subject under investigation by the researcher is defined or established through the set of meanings that research participants will assign to their own experiences. The set of meanings that participants assign to their experiences is central to an ecosystemic approach. Spirer (1980) concurs that the direct contact of the case study brings the researcher closer to the "real world" of the participants and is the ideal approach to attempt to understand the situation as the participants understand it.

The current study was an exploratory case study. The study attempted to answer what Yin (1994, p.5) calls "what" questions, namely "What are the effects of chronic pain on the participant and his/her family?" and "What are the effects of ecosystemic hypnosis on chronic pain?" Yin (1994, p.5) believes that "this type of question is a justifiable rationale for conducting an exploratory study, the goal being to develop pertinent hypotheses and propositions for further inquiry."

3.2 The sample

Purposive sampling and convenience selection was used in this study. Participants were recruited through physiotherapists situated on the West Rand and in Johannesburg. These areas were selected on the basis of convenience in terms of the time and expense involved in travelling to and from the different locations of those directly involved in the investigation. It was also believed that the relatively large number of well-established physiotherapy practices would yield an adequate number of participants meeting the criteria for acceptance into the study. A letter outlining the nature of the investigation and requesting the referral of suitable participants (Appendix A) was mailed, or faxed, to each of twelve physiotherapists in private practice. Follow up requests were undertaken telephonically in the two instances where no response was obtained within 30 days of mailing or faxing the original letter. The first batch of letters yielded five of the six participants and the follow up requests yielded the sixth participant.

The following criteria were used when selecting participants:

- the participant must have experienced low back pain for six months or longer
- the participant's back pain must not have responded to traditional and conventional medical treatment, and the participant must not be in need of further new surgical treatment
- the participant's pain must be qualified as interfering significantly with his/her quality of life. (Because the experience of chronic pain is so individual, this criterion was only loosely defined by the researcher and was rated subjectively by each participant.)
- the participant and his/her family must give informed consent after the treatment programme has been fully explained to them

A sample of six chronic low back pain patients was chosen for the current study. The sample consisted of three married male participants and three married female participants. Married participants were used because one of the aims of the study was to describe the impact of chronic low back pain on the family system. Male and female participants were included so that possible sex differences in the subject's, and the family's, experience of chronic low back pain could be noted. For example, Roy (1989) found that, with regard to affective roles, children are more affected by pain problems in their fathers than in their mothers.

Initial contact was made with the prospective participants by telephone. The nature of the investigation was briefly explained and it was verified that the

participant met the research criteria. The participants were informed at this stage that it was not possible to stipulate from the outset how many sessions would be employed and that the researcher could not guarantee that any benefits (in terms of permanent pain relief or otherwise) would be derived from their participation in the study.

A letter of consent was mailed or faxed to each research participant and each was asked to sign the letter prior to the first interview with the author (See Appendix B). The letter briefly outlined the aims of the research project and the nature of the individual's participation. Participants were informed that the researcher was interested in finding out what effect their pain has on their day-to-day functioning, as well as on their relationships. Participants were also informed that hypnosis would be employed as a treatment modality.

Participants were informed during the initial telephone call, and in the letter of consent, that they were free to withdraw from the investigation at any time should they wish to do so. The letter also contained the assurance that all information supplied by the participant would remain confidential and would not be communicated to anyone not directly connected with the study.

3.3 Variables

Pain must be present for six months or longer to for it to be defined as chronic. In this study, chronic low back pain functioned as an independent and dependent variable. The effects of chronic pain (as an independent variable) on the family system (as dependent variable) are described. The effects of the

independent variable hypnosis, as viewed from an ecosystemic perspective, on chronic pain (as dependent variable) are also detailed.

In research conducted from an ecosystemic viewpoint all variables are, as far as possible, accounted for and no variables are considered to be "nuisance" variables. As McCaslin (in Spirer, 1980) states, one of the benefits of naturalistic inquiry (which subsumes the case study approach) is that it allows recognition of the multiplicity of causes that may lead to a certain outcome and recognizes that causes and outcomes can interact in a variety of ways. Naturalistic inquiry is not constrained to examining only those outcomes amenable to quantification and allows the researcher to collect information on outcomes not known to be important or anticipated during the design of the study. Therefore, an attempt is made to account for all variables in the final analysis.

3.4 Measuring Instruments

A. The McMaster Model of Family Functioning

The McMaster Model of Family Functioning (MMFF) was used to assess and describe the consequences of chronic low back pain on various aspects of the functioning of each sufferer's family. Such a description was deemed necessary because, as Barber (1986, p.165) states, "the particular way an individual patient's pain is integrated into his or her life will determine some of the twists and turns that treatment is likely to take."

Although some may consider the MMFF relatively old, it does still have its advantages. According to Epstein et al. (1982, p.139) the usefulness of the MMFF lies in the richness of description that the model provides and the fact that the model was developed through a process of clinical and empirical testing. In developing the MMFF, aspects of family functioning were conceptualized and then tested in clinical work, research and teaching. Problems arising in applying the model became the basis for reformulation. Epstein et al. (1982, p.117) believe that "the result is a pragmatic model containing ideas that have worked" as those ideas not meeting the test in treatment, teaching or research have been discarded or modified.

Roy (1985a, p.303) states that, given the substantial changes that families with a chronic pain patient undergo, "it is quite imperative to assess the family functioning on multiple dimensions." Roy (1985a) believes the dimensions of family functioning described by Epstein and his colleagues serve that purpose well. Using the MMFF for the present study was advantageous in that the MMFF has proved capable of assessing the impact of an event (such as illness in a family member) on the overall functioning of the family.

The MMFF allows the family's structure, organization and transactional patterns to be detailed, and all the problems that currently exist are elucidated. Epstein and Bishop (1981) believe that that the MMFF allows the researcher or therapist to focus on the specific problems of the specific family.

According to Epstein et al. (1982) the concepts contained in the MMFF have evolved from studies of normal as well as clinical populations and, as a result, they define health as well as pathology. Therefore, the MMFF helps the therapist and family members become aware of their strengths and not only their shortcomings.

The MMFF is based on a systems approach. Epstein et al. (1982) state that the crucial assumptions of systems theory that underlie their model are:

- The parts of the family are interrelated.
- One part of the family cannot be understood in isolation from the rest of the system.
- Family functioning cannot be fully understood by simply understanding each of the parts.
- A family's structure and organization are important factors determining the behaviour of family members.
- Transactional patterns of the family system shape the behaviour of family members.

Epstein et al. (1982) state that the MMFF does not cover all aspects of family functioning, but focuses on the dimensions of functioning that are seen as having the most impact on the emotional and physical health problems of family members. The six areas of focus in the MMFF are problem solving, roles, communication, affective responsiveness, affective involvement and behaviour control. According to Epstein and Bishop (1981) the MMFF does not focus on any one of the dimensions as the foundation for conceptualizing

family behaviour. Epstein and Bishop (1981, p.448) believe that many dimensions need to be assessed for a fuller understanding of "such a complex entity as the family".

1. Problem Solving

Epstein et al. (1982) define problem solving as the family's ability to resolve problems to a level that maintains effective functioning. Family problems are divided into two types, namely instrumental and affective. Instrumental problems relate to issues that are mechanical in nature, such as the provision of money, food and so on. Affective problems relate to issues of emotion or feeling, such as depression or anger.

Epstein et al. (1982) describe effective problem solving as a sequence of seven steps:

1. Identifying the problem
2. Communication with appropriate people about the problem
3. Developing a set of possible alternative solutions
4. Deciding on one of the alternatives
5. Carrying out the action required by the alternative
6. Monitoring the action
7. Evaluation of success

According to Roy (1989), clinical experience suggests that a family with a chronic pain patient is likely to encounter considerable difficulty in the domain of problem solving, particularly in the affective area. Roy (1989) states that these families are rarely able to go beyond the first stage of the problem

solving process, namely, problem identification. Such families are also likely to blame their problems on pain, rather than on relationship problems. Roy (1989) believes effective problem solving is also affected in varying ways, and to varying degrees, by the degree of investment that patients and family members have in maintaining pain behaviours, the duration of the pain problem, the degree of disability of the pain sufferer, and life-stage issues.

2. Communication

Communication is defined as how information is exchanged within a family and the focus is on verbal exchange. Communication is also divided into instrumental and affective areas. In addition, Epstein and Bishop (1980) identify two other dimensions of communication: clear versus masked and direct versus indirect. The former focuses on the clarity with which the content of the information is exchanged. The latter considers whether the message goes to the person for whom it is intended.

The two above-mentioned dimensions yield four styles of communication: (a) clear and direct (b) clear and indirect (c) masked and direct and (d) masked and indirect. The model postulates that the more masked and indirect the overall family communication pattern is, the more ineffective the family's functioning; the more clear and direct the communication, the greater its effectiveness.

Communication problems are common in a family with a chronic pain sufferer. Roy (1989) states that families who generally engage in clear and direct

communication may find themselves altering that pattern. Spouses may find it difficult to express their feelings when their partner is ill-tempered, distant and unapproachable. Even when communication is direct and clear, especially by the well partner, it may result in reinforcement of pain behaviours.

3. Roles

Epstein and Bishop (1980, p.460) define family roles as "the recurrent patterns of behaviour by which individuals fulfill family functions". The MMFF divides family functions into instrumental and affective areas. Instrumental refers to the provision of resources. The affective area relates to nurturance, support, sexual gratification of marital partners and other affective domains of interpersonal relationships (Roy, 1989).

Chronic illness in one member of the family has profound implications for role functioning for other family members. The occupational roles of back-pain sufferers are often severely compromised. Roy (1989) conducted a study with headache and backache sufferers and found that out of the eight breadwinners in the back pain group, seven were unemployed at the time of the study. Job loss creates financial hardship for the family, and the burden of responsibility to provide financially can fall on the spouse. Job loss also leads to a loss of self-esteem for the individual sufferer. An inability on the part of the chronic pain patient to carry out simple chores can lead to the spouse having to assume additional responsibilities for running the household as well.

Chronic pain often has a negative impact on the performance of tasks associated with nurturance and support. Roy (1989) states that marital partners may have a sense of disengagement from each other and there is often a measurable deterioration in the quality of their sexual relationship. According to Roy (1989), with regard to affective roles, children are more directly affected by pain problems in their fathers than in their mothers. One plausible explanation offered by Roy (1989) is that mothers go to extraordinary lengths to maintain their nurturing and supportive roles in relation to the children.

Roy (1985b) states that because spouses frequently adopt a highly protective attitude they may prevent the patients from fulfilling roles that they conceivably can undertake. On the other hand, according to Roy (1985b), pain may be used to stop performance of those roles and functions that the patient has always found hard or distasteful.

4. Affective responsiveness

Affective responsiveness deals with the actual experience of feelings. In other words, it does not deal with the expression of emotions, but with what one feels. A family should be able to respond to a range of stimuli with the appropriate quality and quantity of feelings.

As an aid to assessment, responses are divided into two classes: welfare feelings and emergency feelings. Welfare feelings are exemplified by positive

emotions such as love, tenderness, happiness and joy; emergency feelings by fear, anger, sadness, depression, and disappointment.

Emotional reactions to illness are many and varied. Roy (1989) states that a common observation is that the spouse of the chronic pain patient, as well as the children, often withholds much of his/her anger and sadness. Roy (1989) finds that comments such as "How can you be angry with somebody who is in pain?" are common.

Roy (1989) believes that chronic pain patients experience a multitude of negative or emergency emotions. Sometimes these emotions are expressed, or, at other times, the only manifestations of such feelings are social withdrawal or even more preoccupation with pain. Roy (1989) states that welfare emotions are neither felt nor expressed and that the prevailing emotional climate within such families is largely determined by emergency emotions.

5. Affective involvement

Affective involvement is concerned with the degree to which family members care for one another, show interest in and value the activities and interests of individual family members. Six types of affective involvement are identified:

1. Lack of involvement
2. Involvement devoid of feeling
3. Narcissistic involvement
4. Empathic involvement

5. Over-involvement
6. Symbiotic involvement

Empathic involvement is viewed as the most effective form of affective involvement. Involvement devoid of feelings, narcissistic, or over-involvement is considered less effective. Lack or involvement or symbiotic involvement is viewed as the least effective.

Roy (1989) states that a rather common pattern between the spouse and the chronic pain sufferer appears to be a mixture of over-involvement and lack of involvement. Patients typically engage in withdrawal from their normal social intercourse and other role-related behaviours, whereas the spouse becomes over-solicitous and anxious to please.

Roy (1984) believes that the affective involvement of the chronic pain sufferer may vary depending on how much pain the person has on a given day.

6. Behaviour control

Epstein and Bishop (1981) define behaviour control as the pattern a family adopts for handling behaviour in three types of situations, namely: (1) physically dangerous situations (2) situations which involve meeting and expressing psychobiological needs or drives and (3) situations involving interpersonal socializing behaviour.

The behaviour of all family members in each type of situation is considered. When assessing the appropriateness of the rules and standards of the family, the age and status of the individuals concerned are taken into account. Families develop their own standards of acceptable behaviour, as well as the degrees of latitude that they will permit in relation to these standards. The nature of these standards and the amount of latitude for acceptable behavior determine the four styles of behavioural control: rigid, flexible, laissez-faire and chaotic.

In situations of rigid behaviour control, family standards are very inflexible and there is little or no room for negotiation and change regarding family rules. Flexible behaviour control entails a flexibility of rules necessitated by specific situations. Laissez-faire behaviour control entails an "anything goes" approach: firm standards do not exist and extreme permissiveness is the rule. In chaotic behaviour control there is no consistent style: rules come and go without obvious reason, and there is much shifting from one kind of behaviour control to another.

Epstein and Bishop (1981) believe that flexible behaviour control is the most effective. They list the remaining styles in decreasing order of effectiveness as rigid, laissez-faire and chaotic.

According to Roy (1984), the presence of a chronically sick person within a family system is likely to result in an alteration of rules and mechanisms of behaviour control. He states that, for less well-functioning families, problems

surrounding the issues of rules are frequently self-evident. Such problems could range from rigid and inflexible rules to a virtual absence of rules. In a study of 20 chronic headache patients and their spouses, conducted by Roy in 1987, he found that 16 of the couples engaged in unhealthy forms of behaviour control. According to him, the rules in these families changed directly as a consequence of significant role alterations. Roy's conclusion was that the presence of a chronically sick person within a family system was more than likely to result in alteration of rules and mechanisms of behaviour control. In a subsequent study in 1987, Roy found that 93% of the back pain and 80% of the head-pain couples engaged in unhealthy behaviour controls, which ranged from rigid to chaotic. Therefore, only seven percent of the back-pain and twenty percent of the headache couples gave evidence of flexible, or healthy, types of behaviour control.

A key question during the assessment is what purpose the pain serves, either for the patient, or for the family. For example, Roy (1986) states that chronic pain in the spouse may relieve the partner of sexual and other marital responsibilities, and the pain may be used to discourage the patient from making demands felt to be unacceptable to the partner. In addition, the healthy spouse may encourage the patient's position of dependency, thus reinforcing the pain behaviour to his or her own end. The perpetuation of chronic pain may also be attributed to personal factors, either as a way of seeking attention, or of avoiding responsibilities, by the chronic pain sufferer. Family members frequently treat this person as an invalid and expect less and

less from him or her. This then decidedly sets the scene for perpetuation of the problem.

Unraveling the meanings of pain that patients and family members attribute to the symptom is also of the utmost importance. Roy (1985b) states that the attribution of meaning to pain by the patient and the spouse is likely to be extremely varied. Rowat and Knafl (1985) conducted a study into the spouse's understanding of his/her mate's pain. Thirty eight percent of the spouses stated that they could not describe their mate's pain and sixty percent of the spouses admitted they found it difficult to understand their mate's pain. Rowat and Knafl (1985, p.262) state that a typical comment was: "I've never heard of people having pain such that there's no apparent cure...people that have pains that can't be explained".

B. The Brief Pain Inventory

The Brief Pain Inventory (BPI; see Appendix C) is a brief and easy to use tool for the assessment of pain in both clinical and research settings. Charles Cleeland, who is currently the director of the Pain Research Group at the M.D. Anderson Cancer Centre, is the original author of the inventory. The BPI is based on the idea that pain consists of two dimensions, namely a sensory and a reactive dimension (Cleeland, 1989). The BPI was, therefore, developed to separately measure both pain severity (the "sensory" dimension) and how pain interferes with the patient's function and quality of life (the "reactive" dimension).

The BPI is a two-page questionnaire and requires approximately five minutes to complete. Comparable information is obtained by self -administration and by interviewer administration (Cleeland, 1995). The inventory asks patients to rate their pain for the last week on zero to ten numerical rating scales presented as a row of equidistant numbers. The use of eleven point rating scales maximizes a trade-off between subject ease of responding and increasing reliability with longer scales (Nunnally, 1978).

With regard to severity of pain, the BPI asks patients to use the zero to ten rating scales to rate the severity of their pain at its (a) "worst", (b) "least", (c) "average" and (d) at the time the rating is made – (e) "now". Each scale for Worst Pain, Least Pain, Pain on the Average, and Pain Right Now is bounded by 0 = no pain and 10 = pain as bad as you can imagine.

Items for the BPI's interference scale were selected so as to tap how pain impairs both level of function (e.g. walking) and social affective well-being (e.g. mood). Using the same type of scales, patients are asked to separately rate how their pain interferes with their Enjoyment of Life, Activity, Walking, Mood, Sleep, Work, and Relations with Others. These scales are bounded by 0 = does not interfere and 10 = interferes completely.

The BPI was first developed in English, but has been validated in several languages and has become established as a standardized instrument for multinational studies (Radbruch, Loick, Kiencke, Lindena, Sabatowski, Grond, Lehmann & Cleeland, 1999). Unfortunately, the BPI has not yet been

translated into any of South Africa's other 10 official languages, although validation studies for an Afrikaans, a Sepedi, a Tswana, a Xhosa and a Zulu version of the inventory will soon be undertaken by the Pain Research Group. The English version of the BPI was, therefore, used for this particular study. Although not all respondents were English first language speakers, the BPI's simple format and its focus on a limited number of relatively universal functions did still justify its use.

Cronbach alpha reliability ranges from .77 to .91 for the BPI. It was anticipated that a number of the participants in the current study would be bilingual. Saxena, Mendoza, Cleeland (1999) conducted a project that developed and validated a Hindi version of the BPI using a sample of bilingual (Hindi and English) patients. This study found alphas of 0.90 for both the interference and severity subscales of the English BPI when used with the bilingual (English/Hindi) group.

Construct validity of the BPI has been confirmed by factor analysis. Factor analysis of the original version of the BPI showed two factors. The pain intensity ratings load high on a common factor (pain severity) while the seven interference items showed high loadings on another factor (interference with function). Validation of the BPI in different languages consistently demonstrates these two common factors (Radbruch et al., 1999). Evidence of construct validity for the BPI was also provided by statistically significant chi-square analyses between patients' pain ratings and opioid and non-opioid medication (Daut, Cleeland & Flanery, 1983).

The BPI has, according to Cleeland and Syrjala (1992), proved useful for pain monitoring and was, therefore, used in the current study to help keep track of treatment progress. The BPI does not need complicated procedures for evaluation (Radbruch et al., 1999). With regard to the pain severity items, for analysis the pain worst item can be chosen as the primary response variable, with the other items serving as a check on variability. In a study by Serlin, Mendoza, Nakamura, Edwards and Cleeland (1995) it was found that pain worst scores of 1-4 correspond to what might be thought of as mild pain, scores of 5-6 as moderate pain (or significant pain) and scores of 7 or greater as severe pain, based on the level of interference with function reported by patients. Alternatively the pain severity items can be combined to give a composite index of pain severity (Wang, Mendoza, Gao & Cleeland, 1996). The current study employed the pain worst item as the primary response variable.

With regard to the seven pain interference items the mean of these scores can be used as a pain interference score, as was done in the present study.

Permission was obtained from Dr Cleeland to use the inventory for the current study. Dr Cleeland also confirmed that the purpose of the study is congruent with the intended use of the BPI.

3.5 Method

All sessions were conducted in the participants' respective homes. The reason for this was to attempt to let the participants feel as at ease as possible, and also to allow the researcher to observe the family in their own environment. Weekly sessions were conducted with participants. It was hoped that this would convey to participants that the researcher viewed their pain problem seriously enough to warrant an intensive approach to treatment.

The first session and part of the second session were used for assessment of the family's functioning, using the McMaster model of family functioning. When seeing the family for the assessment the aim was to have present all the family members living at home. This allowed the researcher to obtain a full range of views. Knowledgeable children were asked to wait in another room, when assessing the parent's sexual relationship.

Whether all family members or any family members were asked to attend subsequent sessions after the initial assessment, was decided on a case-by-case basis.

The second session was also used to assess the participant and, if necessary, his/her family's expectations regarding hypnosis as a form of treatment. The chronic low back pain sufferer also completed the Brief Pain Inventory in the second session.

Hypnosis was employed from the third session on. No fixed number of sessions was set; the number of sessions was decided on a case-by-case basis.

From an ecosystemic perspective, the techniques to be employed depended on each participant's (and family's) expectations and were, therefore, different for every participant. The following ways in which the ecology of ideas could possibly be perturbed were considered in the research design phase: the use of metaphor, reframing, relaxation, externalization, sensory substitution and displacement.

Using metaphor is a creative way of introducing new ideas into a system. In ecosystemic terms, a metaphor is not perceived as having a lineal effect on a client. Instead it is seen as a perturbation of an existing set of ideas.
According to Fourie (1991c) different clients will attribute different meanings to, and respond differently to, the same metaphor, based on their own ideas and on the ecology of ideas existing in the therapeutic system at the time. He states that the more complicated the metaphor, the more there is for them to think about and the wider the range of possible actions for them to take.

Reframing can perturb the way the client system thinks about the problem and help the client understand his/her behavior in a different way. Watzlawick, Weakland and Fisch (1974) define reframing as a change of the client's definition of reality. Watzlawick et al. (1974, p.95) state that to reframe means "to change the conceptual and/or emotional setting or viewpoint in relation to

which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning." According to them a change may take place while the situation itself may remain quite unchanged and, indeed, even unchangeable. They state that what turns out to be changed as a result of reframing is the meaning attributed to the situation, and therefore its consequences, but not its concrete facts.

Watzlawick believes reframing works because once we have perceived the new "reality" we cannot so easily go back to "the trap and anguish of a former view of "reality". Watzlawick (1974, p.103) states, however, that not just any other frame will do, but only one "that is congenial to the person's way of thinking and of categorizing reality". Successful reframing, therefore, needs to take into account the views, expectations, reasons, and premises of those whose problems are to be changed."

Relaxation is not considered, from an ecosystemic perspective, to be a necessary outflow of hypnosis. However, because many clients believe hypnosis to be a powerful relaxation tool, this association can be used therapeutically. Simple relaxation techniques may be defined as "self-hypnosis" techniques. Relaxation techniques are commonly used for chronic pain and, according to Tunks (1982, p.191), can improve the patient's sense of mastery and reduce the sense that stress is overwhelming.

Michael White and David Epston (1990, p.38) state that externalizing is "an approach to therapy that encourages persons to objectify and, at times, to personify the problems they are experiencing as oppressive". The problem is made a separate entity, external to the person or the relationship to which it was originally ascribed. White and Epston (1990, p.38) state "those problems that are considered to be inherent, as well as those relatively fixed qualities that are attributed to persons and relationships, are rendered less fixed and less restricting."

White first used this approach within the context of work with families that presented for therapy with problems identifies in children. White (1990, pp.38-39) believes that externalization, among other things:

- Decreases unproductive conflict between persons, including those disputes over who is responsible for the problem
- Undermines the sense of failure that has developed for many persons in response to the continuing existence of the problem despite their attempts to resolve it
- Paves the way for persons to cooperate with each other, to unite in a struggle against the problem, and to escape its influence in their lives and relationships
- Opens up new possibilities for persons to take action to retrieve their lives and relationships from the problem and its influence
- Frees persons to take a lighter, more effective, and less stressed approach to "deadly serious" problems, and
- Presents options for dialogue, rather than monologue about the problem

Sensory substitution and displacement can also be used to help the patient experience a change in the perception of pain (Barber, 1986). In sensory substitution suggestions can be used to create a reinterpretation of sensations. A sensation of intolerable burning can, for example, be replaced by a sensation of coldness. The substituted sensation need not, according to Barber (1986), be a pleasant one. Barber (1986, p.157) states that such a substitute feeling has several virtues: (a) It allows the patient to know the pain is still there; (b) it is not particularly pleasant, so it is more plausible than, say, a sensation of pleasure; and (c) if one is still feeling uncomfortable – but not in agony – many secondary gains associated with pain can still be obtained without suffering. Barber (1986) believes that suggestions for sensory substitution are most effective if they incorporate the qualities of the patient's personal experience of pain, and suggest a plausible modification of quality.

Displacement of the pain involves moving the pain from one area of the body to another, or sometimes to an area outside of the body (Barber, 1990). The effectiveness of such suggestions, according to Barber (1986), can be increased if the patient is allowed to choose the direction or location of movement. The primary goal is to change the locus of pain experience so that the pain is less disabling or threatening, but, as Barber (1986, p.157) states, an important implication of such modification is that if pain can change in location, then it may also be changeable in other dimensions.

Each participant completed the short form of the Brief Pain Inventory on a weekly basis at the end of each hypnosis session. The decision of the appropriate time to terminate treatment was made on a case-by-case basis.

3.6 Validity

Qualitative research differs fundamentally from conventional quantitative research in its conceptions of knowledge, truth, and objectivity. Quantitative methods insist on unequivocal knowledge based on the assumption that reality can be discovered (Fourie, 1996). To obtain an accurate map of "reality", stringent efforts are made to remove every aspect of subjectivity and researcher bias from the inquiry, since it is believed they will contaminate the data. Moreover, to be able to arrive at an unequivocal outcome reflecting the "truth" the complexities of social relationships and contextual factors must be eliminated or controlled for as far as possible (Fourie, 1996).

In recent times, psychologists have begun to question the applicability of Newtonian research criteria to psychological phenomena. According to Lincoln and Guba (1985, p.114) "it is difficult to imagine a human activity that is context-free". Moon, Dillon and Sprenkle (1990) state that a qualitative research paradigm could be regarded as more suitable for investigating social science phenomena since it relies on the research participants' perspectives to make sense of complex situations and interactions. Since meaning is contextual, not atomistic, qualitative research explores the complex interrelationships amongst events in their meaning creating natural settings (Moon et al., 1990). Qualitative research does not subscribe to the notion of

"objectivity". Instead it is assumed that any social phenomenon can be described "accurately" from many viewpoints and that any point of view can only be partial (Lincoln & Guba, 1985).

The question of legitimacy in positivist research is dealt with in terms of strict criteria of internal and external validity and much attention is paid to scientific methods which guarantee as far as possible the validity of findings (Reason & Rowan, 1981). In qualitative research however, the assumptions of generalizability and absolute knowledge are no longer primary. Because the basic assumptions are different, the issues of validity and legitimization change. Numerous ways of achieving research legitimacy for qualitative research do exist. Those that are relevant to this study will be discussed below.

Moon, Dillon and Sprenkle (1990) state that since the researcher is the primary data collection instrument in most qualitative studies it is important to make the researcher role clear and to make known any researcher biases.
In the current study the researcher is a chronic pain sufferer.

Atkinson and Heath (1987) believe the presentation of findings in quantitative studies is actually limited because the data is presented only after having been organized and categorized. Thus, the reader is given no opportunity to question the researcher's construction and has to concur with the researcher's validity appraisals. The alternative they offer is for the researcher to provide as much true raw data as possible, so that the reader can

determine issues of legitimacy. This study, therefore, needs to provide as much information as possible in the form of rich, detailed descriptions. Each case will be described in full and then a metaperspective will be given which will concentrate on explaining the therapeutic rationale. Lincoln and Guba (1985) state that by presenting a vivid, lifelike description and allowing readers to achieve a personal understanding through their own tacit knowledge, the case study does permit an assessment of transferability.

3.7 Analysis of data

According to Spirer (1980), the analysis of case study data is an ongoing process, which begins as soon as the first piece of datum is collected. This feature of "analyze as you go" distinguishes the case study from other methodologies in which the data collection and data analysis are discrete activities.

Bogdan (1972, p.58) states that "as the researcher is in the field and recording his notes, he then begins focussing on certain recurrent themes, which are revealed in observed behaviour and verbalisation". Certain understandings will begin to develop, inferences will be drawn, new questions will be raised, and themes will develop that will adjust the scope, focus and schedule of the treatment sessions accordingly and determine where the researcher will spend her time.

3.8 Possible problems

A number of possible problems with the present study were identified in the research design stage. Firstly, the possibility that the chronic pain sufferer would be unwilling to see the need for a psychological solution. Roy (1989) states that, for the chronic pain patient, the idea of having a disease is a source of some hope, in that a disease can be cured. According to Roy (1989), reassurance that a disease has not been found – which would normally be a cause for celebration and relief for most people – often becomes a source of great frustration for chronic pain sufferers.

Roy (1989) conducted a study with 32 headache and backache patients, using problem-centered family systems therapy. He states that the backache patients tended to be essentially healthy individuals whose problems commenced with a specific event such as a trauma or accident. According to Roy, the backache sufferers in particular were less inclined to accept that their pain problem could be linked to underlying psychological factors. He believes that by defining these patients' pain problems in psychological terms they may feel their problem is somehow being trivialised and not believed. The therapist, therefore, needs to convey to the patient that they are confronted with serious difficulties in their lives due to the chronic nature of their pain problem, that no one in the family is unaffected by it, and that the goal is to help the family function more effectively.

Problems were also anticipated with getting the whole family to attend the assessment and, if necessary, subsequent sessions. Roy (1989) notes that all 32 patients in his study were asked to bring their spouses to the first meeting. None did. Most stated that it was their pain; they were the patients and did not see the need to involve their partners and other family members. Roy (1989) does state, however, that after the first session patients lost their fear and reluctance to involve their family members.

Problems were specifically anticipated in the current study with relation to getting the spouse of the chronic pain sufferer to attend. Waring (1982) suggests a number of measures to obtain the spouse's co-operation. He tells the spouse that, in his experience, all spouses suffer with the chronic pain of the identified patient and that discussion of the suffering may lead to specific interventions which can improve the patient's clinical condition. Waring (1982) also believes that the initial marital assessment must be a positive experience for both spouses if you realistically expect to have the opportunity to see them both again. He states that the spouse must be able to vent the depression, feelings of helplessness and hopelessness, and anger that are invariably present. He also allows time for the spouse to express his/her feelings, thoughts and expectations about being called in for a joint interview. Waring (1982) finds the spouses' response, far from being a hostile one, is actually one of relief that they have finally been brought into the treatment program.

Problems were also anticipated with regard to the use of hypnotherapy. Evans (1991) states that the typical chronic pain patient will generally have

unsuccessfully attempted several treatment approaches before coming to the hypnotherapist. These will often have included various neurological procedures, manipulative procedures by orthopaedists and chiropractors, and medication. The typical chronic pain patient will simultaneously take many different medications. For many of these patients, the demand, "Hypnotise me and get rid of my pain" is, according to Evans (1991), an invitation to failure. The burden of cure is abrogated to the magic of the technique rather than the patient's taking an active role in his/her treatment.

The following chapter will describe the six case studies in detail, allowing the reader as much contact as possible with what unfolded in each case and allowing the reader to draw distinctions of his or her own. At the end of each case study a metaperspective will be given to allow an understanding of the role of the author as researcher and therapist and an understanding of the process of each case.

CHAPTER 4

REASEARCH RESULTS

This chapter will provide a detailed, narrative description of the six cases undertaken for the study. In this instance, the term "narrative" is taken to mean "communicated meaning" (Fourie, 1995, p.304) and as such, is explicated from a subjective or "participant observer" (Moon et al., 1990, p/360) point of view. The description will be in such a manner as to draw attention to the ecosystemic rationale behind each case. For this purpose, each case will be described in detail and then a metaperspective will be given. While the metaperspectives will concentrate on explaining the therapeutic rationale, the case study descriptions will be detailed enough to give the reader a feel for the characteristics of ecosystemic hypnosis described previously.

In accordance with ethical considerations of confidentiality, the names of the participants have been changed.

4.1 MANDY

Mandy was referred by her physiotherapist, but it was her husband, Dylan, who made contact before the referral could even be followed up. Mandy had been suffering from low back pain for a total of 20 months. She had a lot of referred pain in the left leg and often pain in both legs when sitting and lying.

Mandy had already seen five different neurosurgeons at the time of the referral, none of whom seemed to be able to find a definite cause for her lower back pain. Three weeks earlier, her current neurosurgeon had performed a joint block in an attempt to alleviate her pain. She had been very optimistic because she felt some action was finally being taken. However, the procedure provided no relief and seemed, in fact, only to make her pain worse. Her husband, Dylan, stated in the first telephone call that they both felt as if they had reached the end of the road, with no idea where to go next.

Mandy, Dylan and their two sons (17 and 14 years of age) were present at both the first and second session, which took place on consecutive Saturdays in their home. Mandy and Dylan had been married for 20 years, and were both involved in the field of education. Mandy had been teaching music for most of her life. She stated that she still enjoyed it, because of the one-on-one nature of this type of teaching. Mandy had, however, been off work for two months at the time of the first meeting.

Mandy demonstrated an immediate need to talk about her pain. She explained that she had gone the path of seeking medical help without any discernible benefit. She blamed the doctors for their inability to cure her and felt angry at and abandoned by the medical community. Dylan admitted to sharing these feelings.

Mandy believed that her pain had affected her family. She stated that it felt as if the pain, rather than her family, had become the centre of her life. She

admitted that she had withdrawn from her family to a great extent, because she was so "wrapped up in" her pain. She admitted feeling as though she was "losing" herself, and felt as if her pain determined her whole personality.

Dylan said that his dominant feeling was one of helplessness after seeing so many doctors, with no answers forthcoming. He admitted that he was starting to feel depressed, but felt like he had to stop himself from feeling that way, because Mandy was "so down": "What will happen if I get depressed too?" He admitted to finding it all very stressful. He stated: "Pain is becoming the centre of my life too and I have had enough of it. I don't want to hear about the pain anymore; it 's all we talk about."

Both of Mandy's sons stated that the time she used to spend with them had been affected. They were both active sportsmen, but Mandy no longer went to watch them play sport at school as she did in the past. Her oldest son stated that someone had asked her recently what position he played in the rugby team and he was saddened to realise she didn't know. Both boys admitted that they no longer wanted to talk to her, as "all she talks about is pain". They both complained that she no longer spent the time with them that she used to.

MMFF Assessment

The MMFF was used to determine the level of family functioning in the six areas. The MMFF was started during the first session and completed a week later in the second session.

Roles

Epstein et al (1981, 460) define roles as "the recurrent patterns of behaviour by which individuals fulfil family functions" The necessary family functions can be divided into "instrumental" and "affective" domains. Instrumental roles consist primarily of those functions related to the provision of resources, life skills development, and maintenance and management of the system. The affective roles include nurturance, support and sexual gratification of marital partners.

Instrumental roles

With regard to provision of resources, Mandy's occupational role had been compromised. Mandy's neurosurgeon had not booked her off after the joint block. She found that she couldn't cope at work and got her GP to book her off for six weeks. As a piano teacher she had to sit for extended periods and she physically couldn't manage that. On one occasion, while sitting at the piano, her back went into a very bad spasm. She then started to become anxious before each class, in anticipation of a possible spasm.

Mandy was very afraid of permanent loss of functioning and what it would mean. She feared losing her job, as both of their sons were at private schools and she was worried about not bringing in the money she usually did. Mandy's sense of worth and self-esteem had been affected and she felt she was not pulling her weight and contributing to the family. Dylan agreed that finances were a worry. Dylan stated that he believed Mandy was ready to give

up and that the six weeks she was booked off were the beginning of her never going back to work, rather than time to recover.

Generally, Mandy was afraid of hurting herself and, therefore, engaged in protective behaviour. She limited what she did on a daily basis. She stated that she felt overpowered by the pain and relieved when each day came to an end.

With regard to life-skills development, tasks necessary to help the children complete school had been affected. Mandy no longer made herself available to help the children with homework and no longer took an active interest in their life at school, including going to watch them play sport or discussing their day at school. Dylan had to take responsibility for these tasks.

Affective roles

With regard to affective roles, nurturance and support between the patient and spouse, nurturance and support between the patient and children, and adult sexual gratification had all been affected. Mandy felt her pain had become a barrier between her and the family. She admitted feeling guilty about it, but still preferred to isolate herself in her room each day. On his part, Dylan admitted to being tired of sitting with the boys, while she was lying on her own in their room. Dylan not only had to become mother and father to the boys, but had also lost his sexual partner. Dylan said he found the whole situation stressful and tiring, and he wanted them to be able to do the things they used to do.

Communication

Roy (1989) states that effective communication is not easily achieved in families with chronic pain. The reasons for this are multiple. For one, massive role changes occur and, under these circumstances communication invariably undergoes significant changes. Communication is also affected because of the nature of chronic pain – a vague and ill-defined condition. Is he/she sick? How sick is he/she? This makes direct and clear communication difficult, and family members and patients are seriously compromised in their ability to express their true feelings about each other.

Communication in this family had definitely been affected. Dylan found he could not express negative emotions. He found himself holding back his negative feelings and anger because Mandy was in pain and he didn't want to add to her suffering.

Dylan and the children admitted to finding it hard to know how to relate to Mandy. She had become increasingly absorbed in her problem, and Dylan and the children no longer wanted to talk to her because all she talked about was pain. Mandy agreed that she seemed to have lost her ability to communicate positive feelings.

Affective involvement

Affective involvement encompasses the quality and extent of involvement that family members have with one another. Roy (1984) states that the picture that is likely to emerge in a family with a chronic pain sufferer is complex and

multi-dimensional. Depending on the part of the subsystem under scrutiny, the nature of involvement can vary. Roy (1989) states that chronic pain can induce dependency, anger, frustration and depression.

In this family, Mandy demonstrated a lack of involvement, because of her withdrawal, as well as narcissistic involvement, which Epstein and Bishop (1981) define as involvement where the investment in others is primarily egocentric and there is no feeling of the meaning a particular situation holds for others.

Dylan demonstrated a well-meaning over-involvement towards Mandy, which became evident when he was the one who made the initial contact and made all the arrangements to meet for the first time.

Affective responsiveness

According to Roy (1984), affective responsiveness has two groupings: welfare emotions exemplified by responses such as love, happiness, and joy and, secondly, emergency emotions such as anger, fear, sadness, disappointment and depression. A wide range of emotional responses is desirable for an effectively functioning family.

Mandy shut herself off and, therefore, Dylan and the children found it difficult to express affection and caring for her. Mandy did express emergency emotions such as anger, sadness, disappointment and fear of being

controlled by her pain. Dylan and the children responded with sadness, but tended not to express their emergency emotions.

Problem solving

Problem solving involves the family's ability to resolve problems at a level that maintains effective family functioning.

When does a medical problem become a family problem? Roy (1984) states that with chronic pain, it grows slowly and almost imperceptibly. There is hope initially that a medical cure will be affected. Gradually, however, this optimism sours as the patient begins to recognise, as he/she makes his/her way through the medical mill, that a cure is not at hand. The patient also receives conflicting messages about his/her condition from different physicians.

Roy (1984) believes that repercussions of all this on the family may not be immediately apparent, because the family continues to view the patient in his/her usual role. But as the problems persist and the patient fails to resume normal roles, tensions begin to mount and questions about his/her status begin to be hesitantly and then forcefully raised. Is she sick or not? Some doctors conclude there is nothing wrong. So why does she act so strangely? Is she mentally ill? As the patient becomes more entrenched in the sick role the problems assume serious proportions.

According to Roy (1984), families with a chronic pain patient tend to have considerable difficulty in identifying problems, let alone reaching a consensus.

This problem is attributable to the very nature of the chronic pain syndrome with its gradual onset and the ever-present hope for a medical cure.

Roy (1986) states that problems can be subdivided into instrumental and affective categories. Instrumental problems are the practical ones that people are likely to encounter on a day-to-day basis and may include issues such as social activities and money management. Affective problems are related to relationship issues. The family with a chronic pain patient often has a number of problems in the domain of problem solving, especially as they relate to the affective areas. They tend to explain all problems on the basis of the patient's pain and that, of course, is beyond their solution.

With regard to instrumental problems, both Mandy and Dylan stated they were unhappy with their social life and demonstrated an inability to solve that.
Their social life had been badly affected. They had limited contact with friends and they didn't go out as a family anymore. Dylan said he couldn't remember when they last went to a restaurant and hated that they'd become a "take-a-ways family". Activities they used to enjoy together were now a problem; Dylan stated they used to be "movie people". Mandy admitted that she had also withdrawn from her friends. She became very annoyed when, after no definite cause for the pain could be found, well-meaning friends started to suggest that maybe she was "just a bit tense and anxious". She hated the idea of "supposed friends" starting to think she was just using the pain as an excuse not to do things.

Both Mandy and Dylan perceived their spending their evenings in two separate rooms as a problem. But that is more or less where it stayed. Epstein et al. (1982) describe effective problem solving as a sequence of seven steps:

1. Identifying the problem
2. Communication with appropriate people about the problem
3. Developing a set of possible alternative solutions
4. Deciding on one of the alternatives
5. Carrying out the action required by the alternative
6. Monitoring the action
7. Evaluation of success

Mandy and Dylan did not move beyond the identification step.

With regard to affective problems Mandy realised she had withdrawn from her family. She felt guilty about it, but, again, there was no movement beyond the identification stage. Mandy and Dylan were also unwaveringly focussed on the problem of pain, while finding answers to family problems had a very low priority.

Behaviour control

Behaviour control is the pattern the family adopts for handling behaviour in three types of situations (1) physically dangerous situations (2) situations involving the meeting and expressing of psychobiological needs and drives and (3) situations involving socialising behaviour both inside and outside the family.

The rules in this family had definitely changed. Mandy and her pain now set the rules with regard to aspects such as their sexual life and social life. Flexibility and spontaneity had become replaced by rigidity.

Dylan admitted to feeling controlled by Mandy's pain because the headaches interfered with things like their social plans. He also felt the pain had taken his control away in that he couldn't do anything to help her, even though he really would have liked to. He admitted he was not used to finding himself in situations that he could not control.

The rest of the second session was used to allow Mandy to complete the Brief Pain Inventory (BPI) for the first time (see figure 4.1), and to discuss Mandy and Dylan's expectations of hypnosis.

Brief Pain Inventory

Mandy completed the Brief Pain Inventory for the first time (see figure 4.1 and 4.2). As stated in the research design chapter, with regard to the pain severity items, the pain worst item, rated on a scale of zero to ten bounded by 0 = no pain and 10 = pain as bad as you can imagine, was chosen as the primary response variable. The other three pain severity items served as a check on variability.

With regard to the seven pain interference items, each rated on a scale of zero to ten bounded by 0 = does not interfere and 10 = interferes completely, the mean of these scores was used as a pain interference score.

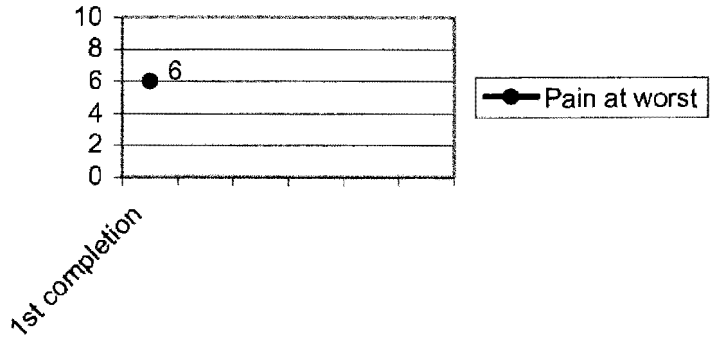

Figure 4.1 First Completion of BPI by Mandy: Pain at worst rating

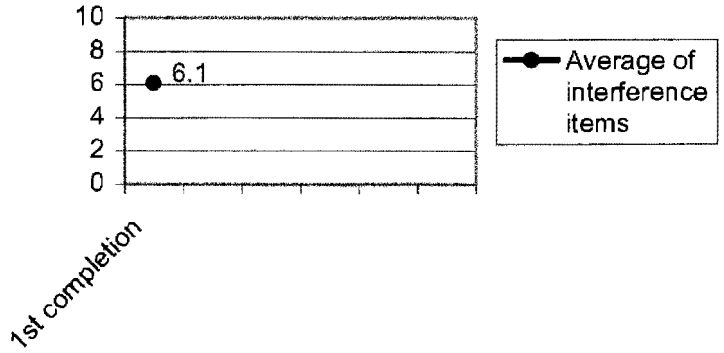

Figure 4.2 First Completion of BPI by Mandy: Pain Interference Score

Expectations of hypnosis

When asked what she believed hypnosis to be and what she expected from it, Mandy's first reaction was that it was a deep form of relaxation that might help her take her mind off the pain. She also stated that it might relieve some of her fear and anticipation of spasms if she could learn to relax her muscles.

Mandy stated that her pain left her feeling helpless and out of control and she desperately wanted to feel some degree of control of her life again. She said she needed to feel that the pain had not taken over her life and who she was. She wanted to feel like she was more than the pain and she didn't entirely want to lose the life she led before the pain began.

Dylan agreed that he thought it might make her relax more and cope better. He wanted to know if he could be involved in some way, because he felt very shut off and very helpless.

In answer to current medications, Mandy indicated a painkiller and anti-inflammatory, but indicated that they gave her no relief. She also indicated that she could not sleep unless she took a sleeping tablet.

It was decided to schedule the third session (first hypnosis session) for the following Saturday in their home, and both Mandy and Dylan agreed to attend.

First hypnosis session

The session started with Mandy commenting on how she had been feeling in the past week. She stated that she felt more positive. She said she was tired of being in a passive position in dealing with her pain. She no longer felt good about simply taking her medicine and following medical advice, and hoping for the best. She felt more willing to believe she could do something to change the situation. Dylan expressed how pleased he was to see a change in her and again stated his need to help and be involved.

Mandy filled in the BPI for the second time (see figure 4.3 and 4.4).

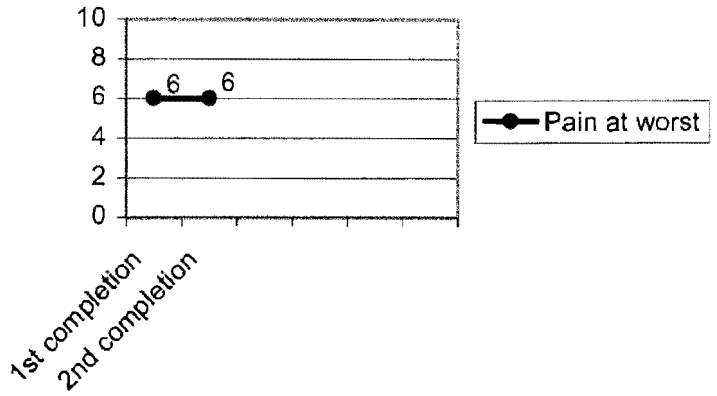

Figure 4.3 Second Completion of BPI by Mandy: Pain at worst rating

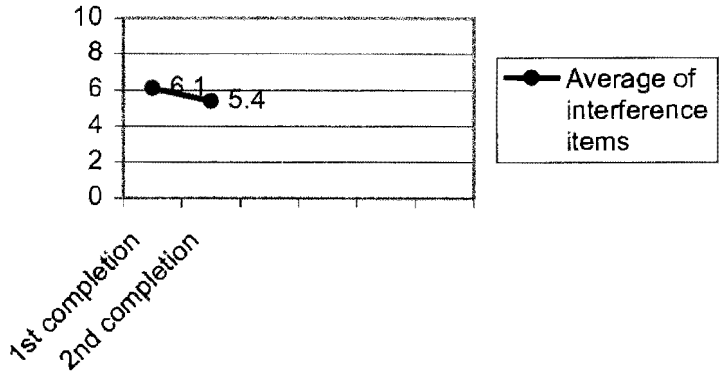

Figure 4.4 Second Completion of BPI by Mandy: Pain Interference Score

Before the session, Dylan had asked Mandy whether she would mind if he were to be hypnotized with her, as he felt a need to be involved in the process. Mandy consented. In this first hypnosis session the induction centered on simple relaxation techniques, as this appeared to fit with their expectations. A progressive relaxation was done and then the couple was asked to imagine going down a flight of stairs to a place that each would like to see as safe, and peaceful and calm. After asking them to take in their special place with all their senses, the couple was instructed to open their eyes in their own time. Dylan opened his eyes almost immediately, but Mandy

remained with her eyes closed for a long period of time. When she finally opened her eyes, each was asked to describe the place they had imagined. Dylan described a beautiful forest, which he imagined walking through. Mandy, who had already mentioned her love of her garden, saw herself walking in a beautiful garden which extended as far as the eye could see in all directions. She described the scene vividly; right down to the white dress she was wearing blowing in the wind. She stated that God was in the garden with her. She stated that she felt very safe and peaceful and protected. She said she believed that if she kept praying God would help to heal her.

Mandy stated she had felt very relaxed and saw herself as very mobile while walking in this garden. She said that for the first time in a long time it was possible to ignore the pain for a while. She stated that she had not wanted to leave the garden.

I commented that Mandy obviously missed going walking a lot and she agreed with that. I asked her what exactly had stopped her walking, as she did not appear to have difficulty walking the few times I had met her. She replied that it was the fear of a back spasm that kept her from walking, her fear of hurting herself. I asked her if she would consider just walking around the block in the coming week with Dylan. In that way he would be there if something happened to her or if she did go into spasm. She agreed to try, and Dylan seemed pleased to have some role to play.

The next appointment was scheduled for the following Saturday in their home.

Second hypnosis session

The session began with Mandy completing the BPI for the third time (see figure 4.5 and 4.6). The Pain Interference Score appeared to be lower due to Interference with Walking Ability being rated a two as opposed to the rating of nine the previous week.

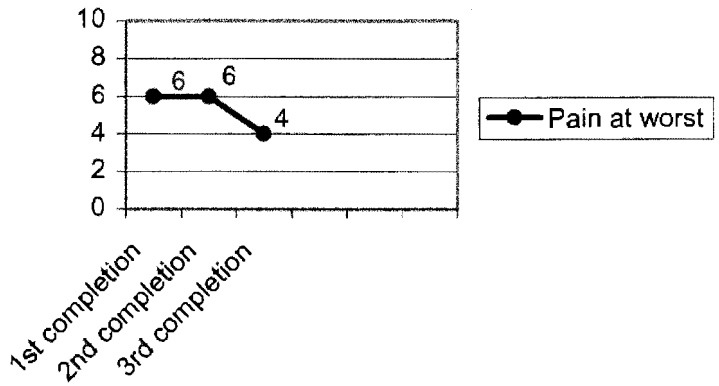

Figure 4.5 Third Completion of BPI by Mandy: Pain at worst rating

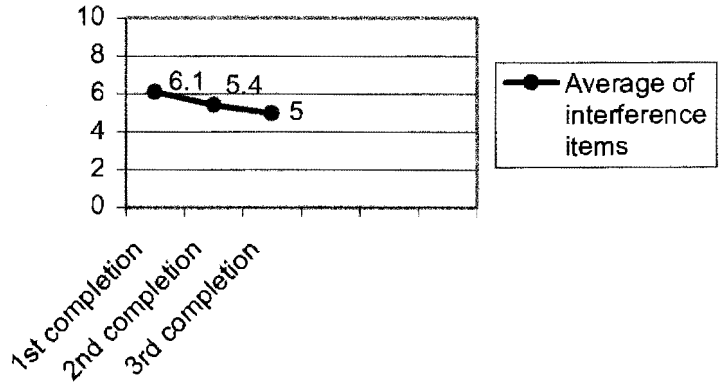

Figure 4.6 Third Completion of BPI by Mandy: Pain Interference Score

When asked to comment on the lower rating for Interference with Walking, Mandy was visibly pleased. She stated that the day after our last session she and Dylan had gone for a walk around the block. It had felt wonderful to be outdoors in the sun and walking in the neighborhood she loved. She felt so good that she went out the next morning on her own, after Dylan went to

work. She said she was amazed to find that her muscles actually felt "looser" and felt less likely to go into spasm. The two of them had also been walking together before the current session. She stated that the walking did make her a little tired, but that she would lie down afterwards and sleep, rather than just lying on the bed feeling sorry for herself. The walking made her feel like her "old self".

Dylan stated how proud he was of her and how good it felt to see her up and about again. He joked that she was still fitter than he was, and that he was the one battling to keep up. Mandy was visibly pleased by this comment. Dylan stated that her mood was "200% better" and that she had mentioned the word "future" for the first time, even if it only related to going walking in the botanical gardens the next week.

Mandy stated that she had felt very relaxed after the previous session. She said that she had been trying to go back to her imagined safe place herself, because it was so pleasant. She expressed a desire to go back there again.

Dylan expressed a desire to be hypnotised with Mandy again; however, she seemed agitated by this request. Mandy stated that she would prefer to be hypnotised on her own, as she wanted to learn to control the pain herself. I pointed out to Dylan that in the same way people relax in different ways they also become hypnotised in different ways and that it was important to find a unique method of hypnosis for each person.

I suggested to Mandy that she appeared to have a lot of "hypnotic talent", as she had been able to go so "deeply" into hypnosis the week before, to the point where she "didn't want to come out". I suggested that we take a chance and try a technique that is only suited to people with a lot of "hypnotic talent", namely glove anaesthesia. I asked her permission for Dylan to help me induce the glove anaesthesia and she agreed.

A progressive relaxation was used once again, as well as imagery of going down a flight of stairs to her imagined safe place. Once she indicated that she felt totally relaxed, I started to give suggestions that her right hand was feeling heavy and numb. I asked her to imagine all the feeling slowly draining out of her right hand. Dylan was asked to aid the process by slowly and steadily stroking her hand from wrist to fingertips, so as to "aid the draining out of feeling". Mandy was instructed to help the process by using the power of her mind to tell her hand to become numb. The couple was instructed to keep doing this until Mandy felt her hand was totally numb. After a few minutes, Mandy said that her hand was heavy and numb.

At this stage Mandy was asked to lift her hand and to place it on her lower abdomen. She replied that she could not move her hand at all and Dylan was then requested to lift her hand and place it on her lower abdomen. Mandy was further instructed to imagine all the numbness draining out of her hand and through to her lower back, until her lower back felt filled with all the numbness that had been present in her hand.

Mandy appeared very relaxed at this stage. I then introduced the image of a healing white light surrounding her body. Mandy immediately started to smile. She was asked to imagine the healing light moving throughout her body, and cleansing and healing her as it did so. Mandy was then asked to open her eyes when she felt ready.

Once Mandy had opened her eyes, Dylan expressed his amazement at how numb her hand had appeared to become. Mandy said that both her hands had actually felt numb, and that her lower back still felt numb even though her eyes were now open and she was "no longer hypnotised". I commended her on how well she was able to control the sensations in her body and noted that very few people were able to exert such control over their bodily sensations. Mandy stated that she was very surprised at her sense of control and said that she had not thought it possible to do such things. Mandy also commented that she had enjoyed the image of the healing, white light and that it made it feel like God was helping to heal her.

As homework, Mandy and Dylan were instructed to keep up the walking. Mandy was again commended on her "obvious natural talent" and instructed to start experimenting with progressive relaxation herself during the coming week. The next session was scheduled for the following Saturday in their home.

Third Hypnosis Session

The session began with Mandy completing the BPI for the fourth time (see figure 4.7 and 4.8)

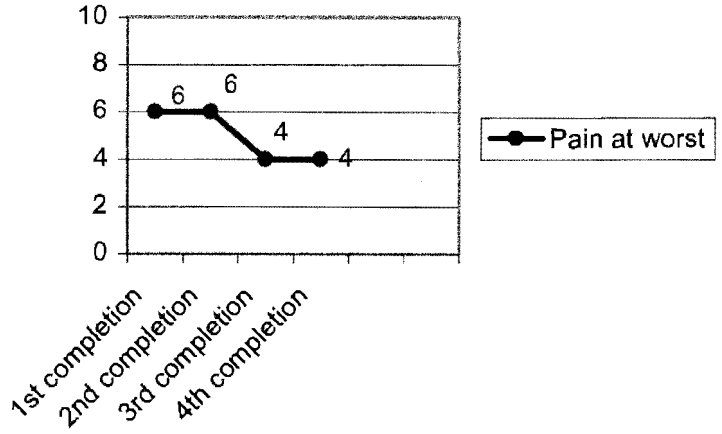

Figure 4.7 Fourth Completion of BPI by Mandy: Pain Severity Items

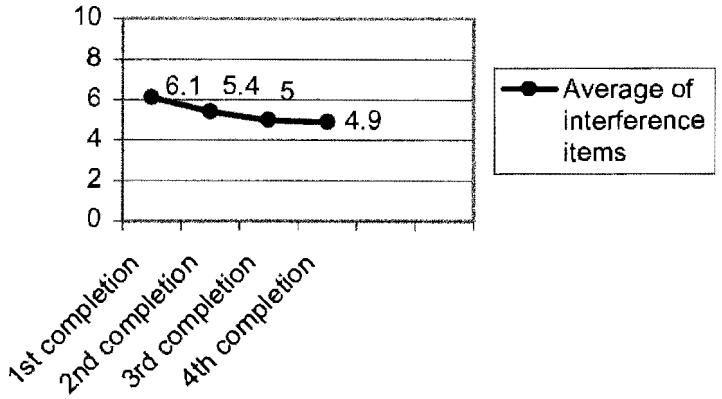

Figure 4.8 Fourth completion of BPI by Mandy: Pain Interference Score

Dylan once more attended the session. Mandy stated that she had had a good week and had been walking every day, with Dylan joining her when he had the time. She said that she had been trying to do the progressive relaxation herself, but found it difficult to talk her way through it. I suggested that perhaps her talent lay in responding to the hypnotic suggestions rather than making them, and asked how she would feel about Dylan talking her

through the relaxation. She agreed it was worth trying. I suggested that Dylan guide Mandy through the relaxation and then introduce the image of the staircase so that she could imagine herself walking down it to her "safe place". I would then "take over from him".

Dylan started to talk to her, using much the same phrasing he had heard me use for the progressive relaxation in previous sessions. He then introduced the image of the staircase and Mandy was able to imagine herself walking down the stairs and to her safe place. The glove anesthesia exercise and the image of the healing white light were then repeated as in the previous session. Mandy reported feeling very good afterwards and reported being quite satisfied with Dylan leading her through the progressive relaxation. She stated that she found his voice quite soothing.

For homework the couple was instructed to keep walking, as well as to practice the progressive relaxation with Dylan guiding Mandy and then introducing the image of the staircase so that she could "reach her safe place". Additionally, I asked Mandy and Dylan to start to think about ways to help Mandy cope better when she went back to work. The next session was scheduled for the following Saturday in their home with Mandy and Dylan to attend.

Fourth hypnosis session

The session began with Mandy completing the BPI for the fifth time (see figure 4.9 and 4.10).

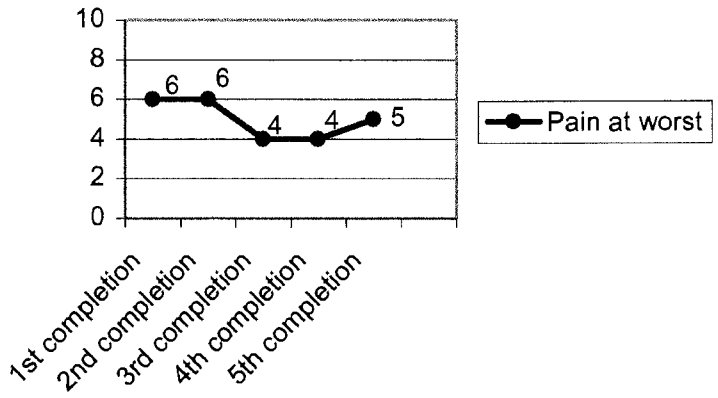

Figure 4.9 Fifth completion of BPI by Mandy: Pain Severity Items

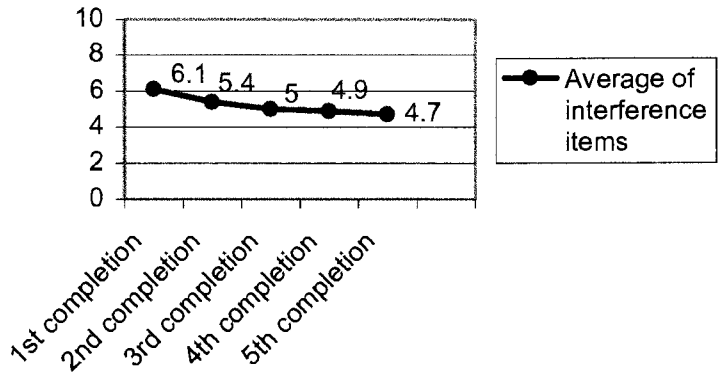

Figure 4.10 Fifth completion of BPI by Mandy: Pain Interference Score

Mandy's rating for Interference with Walking was now down to a one as opposed to the original rating of ten. Mandy and Dylan reported that they were planning to go on a day hike with the boys. Dylan joked that maybe they would become "walking people instead of movie people".

Both reported that practicing the progressive relaxation had been going well and that they enjoyed this quiet and peaceful time together.

Mandy reported that they had spent some time talking about how she would cope once she returned to work. She said she had decided to spend more time teaching the flute, instead of the piano. She had a lot of requests to teach the flute and it was something she enjoyed. She stated that maybe this was a chance to try something new, rather than just trying to force herself back into her old life. If she taught the flute and the piano she could alternate sitting and standing. She stated that her schedule could also be flexible and she wondered whether she could use her self-hypnosis in quiet times between classes. As Dylan would not be present at these times, they asked me about the option of making a tape. I agreed that it was a good idea and suggested that Dylan, therefore, took Mandy through this session, with me there to help him if he "ran out of words or got stuck". We once more did a progressive relaxation, and used the image of descending the staircase so that Mandy could reach her safe place. Once she indicated that she felt relaxed, the couple used the glove anaesthesia exercise and Dylan introduced the image of the healing white light. I commented after the session on what a wonderful team they made and how positively they could tackle this problem together.

For homework the couple were instructed to keep walking and to make their tape and bring it to the next session, scheduled for the following Saturday.

Fifth hypnosis session

The session began with completing the BPI (see figure 4.11 and 4.12).

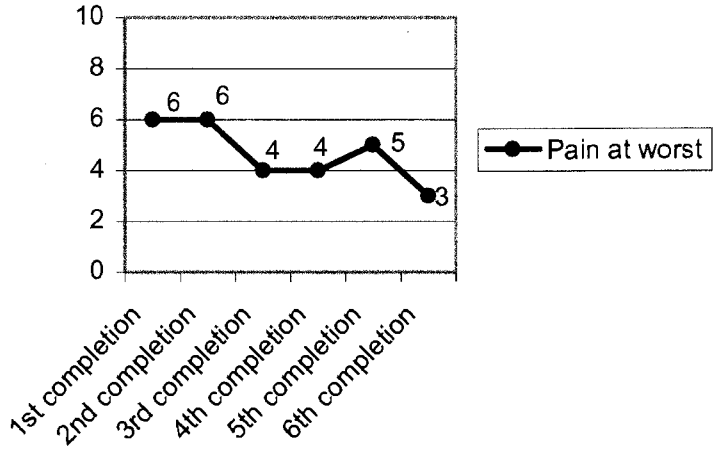

Figure 4.11 Sixth completion of the BPI by Mandy: Pain Severity Score

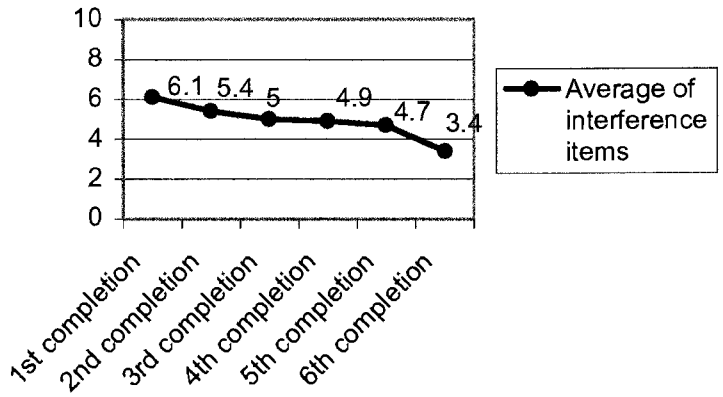

Figure 4.12 Sixth completion of the BPI by Mandy: Pain Interference score

The Pain Interference score was lower on this completion, due to the rating for Interference with sleep decreasing for the first time. Mandy stated that, for the first time in months, she had had a night of sleep without a sleeping tablet.

Mandy was now walking every day and said she felt confident that she would cope when she went back to work. She stated that she had gained a new perspective on pain. She said she no longer expected to be pain-free, but she did now expect to cope and get on with life. She felt she could now live rather than merely survive.

Dylan stated how proud he was of her and how glad he felt for having played some role in helping her.

The couple had made their tape during the week. Mandy stated that she found it effective in helping her to relax and that she was planning to use the tape in her free periods once she was back teaching.

I suggested to Mandy and Dylan that we made this our last session as they were now coping so well and were obviously an effective enough team to take on this battle alone. They agreed that they felt that together they could do this and that we could end our time together. A feedback session was scheduled for two weeks later in their home.

Feedback session

Mandy had by now returned to work. She stated that though she was finding it tiring, she was coping. She kept a foam mattress in her classroom and if she had time off between classes she listened to her tape and relaxed. She stated that she enjoyed feeling like Dylan was there with her. Mandy was now teaching the flute and the piano and found this helpful physically, as she no

longer sat for extended periods of time. Mandy and Dylan continued to walk and the family had been on a day walk the previous weekend.

Mandy felt that she had benefitted from our sessions. She stated that she still experienced pain on a daily basis. However, she felt the pain was no longer the center of her life. It had now become just a little corner, which at times she was not even aware of.

Metaperspective

A feature of ecosystemic therapy is the need to join the with the clients' consensual domain. From our initial conversation it seemed as if the consensual domain within which we were situated adhered to the following ideas: hypnosis can help with relaxation and allow the mind to exert some control over the body. The issue of control appeared central to Mandy. She felt as if her old life was slipping away. Using glove anesthesia could well not have been successful. However, it was worth attempting because it is a technique which sets the client up as having control over his /her bodily sensations. Fortunately, it worked well with Mandy and became a mainstay in her pain artillery. The imagery of a healing white light also appeared to be effective because it joined with Mandy's idea that God could help to heal her.

During the sessions Mandy and Dylan were "taught " to make use of self-hypnosis. From a contextual point of view, an ecosystemic stance seriously questions the usefulness of the concept self-hypnosis (Lifschitz and Fourie, 1985). The notion of self-hypnosis, form an ecosystemic viewpoint, is seen as

an artifact of the state conception in which hypnosis came to have a reality of its own. As Lifschitz and Fourie (1985) state, this does not imply the rejection of the strategic utilization of self-hypnosis in the context of therapy.

From our initial meeting it also became obvious that pain was splitting the family up and isolating members of this family. Mandy's reaction to pain was to isolate herself, but this ignored Dylan's need to be there for her and help her. Dylan was left feeling inadequate and helpless. There was a very real need to unite these two in doing something active and positive to combat the pain, and with their mutual love of the outdoors, walking filled this purpose. Involving Dylan in the hypnosis also helped build this supporting relationship.

Mandy did a lot of talking in our first two sessions about what it meant to be in pain. She had a lot of fear, as well as anger, related to whether people saw her pain as real. Just letting her know that I accepted her pain as real appeared to very helpful to her. She appeared to have a need to feel that someone was paying attention and believed her, and having this need fulfilled appeared to be therapeutic in itself.

With regard to the BPI, Mandy's pain at worst rating had decreased from a six to a three over the course of the sessions. Her pain interference score had decreased from a 6.1 on the first completion of the BPI, to a 3.4 on the last completion of the inventory.

4.2 DUDU

Dudu, her husband and their daughter, Lindy (20), were present at our first session, which was held in their home on a Sunday afternoon. Dudu's husband had made a special effort to attend, as he normally was busy with work on weekends. Dudu also has two sons, but both were away at university.

Dudu had been suffering from low back pain for three years. She had already had surgery twice. The second operation, a spinal fusion, was performed eleven months prior to our first session. Dudu stated that her reaction to pain was not to slow down, but rather to "put the pain in the back of my mind and carry on". She stated that she still tried to be as active as before and didn't relax much.

Dudu stated that she hated her children to see her in pain and that she hated to see them upset when they visited her in hospital after her two operations. She was in hospital for a month both times and then at home for three months after each operation. She admitted to getting very depressed when she was bedridden, but said that she did not want her family to know how she felt. Her husband expressed surprise at this and said that they had all believed she was coping just fine.

MMFF Assessment

The MMFF was used to determine the level of family functioning in the six areas. The MMFF was started during the first session and completed a week later in the second session.

Roles

With regard to instrumental roles, Dudu's occupational role was initially affected by the time spent in hospital and then at home recovering after each operation. At the time of these sessions, however, Dudu was working a full day and refused to let her pain interfere with her work, to the point where she at times was in danger of hurting herself because she did too much.

With regard to instrumental roles, it appeared that Dudu was still very nurturing towards and supportive of both her husband and children. The marital relationship also seemed to be characterized by love and affection. Dudu remained an active participant in all aspects of family life and still took joint responsibility for making sure the family was well provided for.

Communication

Dudu's daughter, Lindy, stated that even when Dudu was in pain she and her brothers found her very approachable and they were not afraid to share their problems with her. Dudu's husband agreed that, even when she was in pain, she communicated support and encouragement to him and the children.

What did appear to be problematic with regard to communication was that Dudu did not share emergency emotions, as she felt the need to protect her family's feelings.

Affective involvement

This family appeared to demonstrate empathic involvement. Epstein and Bishop (1981) believe this to be the most effective type of affective involvement and define it as an emotional involvement in other family members in which each member cares deeply about the significant activities and involvement of the others. This family appeared to demonstrate true affective concern for the interests of others in the family.

Affective responsiveness

A lot of welfare feelings were expressed in this family. However, Dudu did not express emergency emotions, even though other members of the family felt free to express their emergency emotions. Dudu kept her sadness and depression to herself.

Problem solving

This family effectively dealt with practical, day-to-day instrumental problems. Notably, areas such as social activities and money management had not been very affected by Dudu's pain problem.

The affective domain was, however, problematic. Dudu's need to protect her family from her pain was not even identified as a problem, let alone dealt with. Tunks (1990, p.245) discusses the problem of "the patient who copes well". These patients present an image of strength or are seen as admirable. The disadvantage is that more appropriate behavioral repertoires in line with their problems have not been developed. They seem to feel an obligation to be

immune to their problem and not to impose their difficulties on the family. Tunks (1990) states that these patients need to learn more appropriate adaptive responses. They need to learn to ventilate feelings rather than push themselves to the point of breakdown, and they need to set limits on themselves and others.

Dudu appeared to negate her need to share not only positive, but also vulnerable feelings. Dudu also needed to inform the family when she was pain and not simply leave it to their imagination or powers of observation to find out.

Behavior control

This family appeared to be well organized with clear family rules. Behaviour control was fairly rigid though in that there appeared to have been very little change in behavior control since the onset of Dudu's pain. The family still stuck to the same rules of who did what. There should perhaps have been an opening up, with more of a give and take situation and a moving in by other family members to take up the slack.

The rest of the second session was used to discuss the family's expectations of hypnosis and to allow Dudu to complete the BPI for the first time.

Expectations of hypnosis

Both Dudu's husband and daughter thought that hypnosis might help Dudu relax and, therefore, feel less pain. Dudu stated that she "hoped" it was about

relaxation. She said she didn't think hypnosis could remove the pain, but that it could maybe make it something she could cope with.

Brief Pain Inventory

Dudu completed the BPI for the first time (see figure 4.13 and 4.14). Her Pain Interference score was only 2.6, which was consistent with her reporting that she did not let her pain interfere with her life.

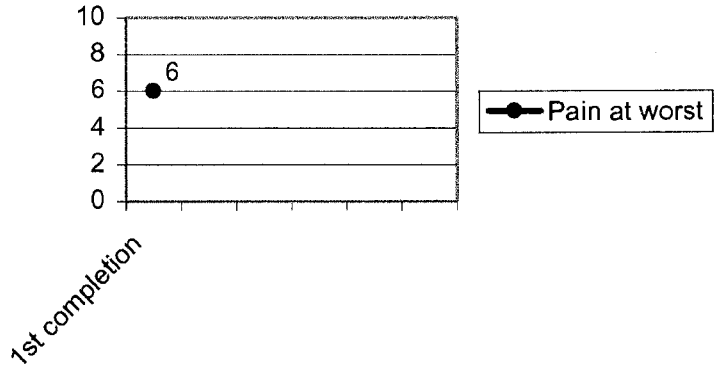

Figure 4.13 First completion of the BPI by Dudu: Pain at worst rating

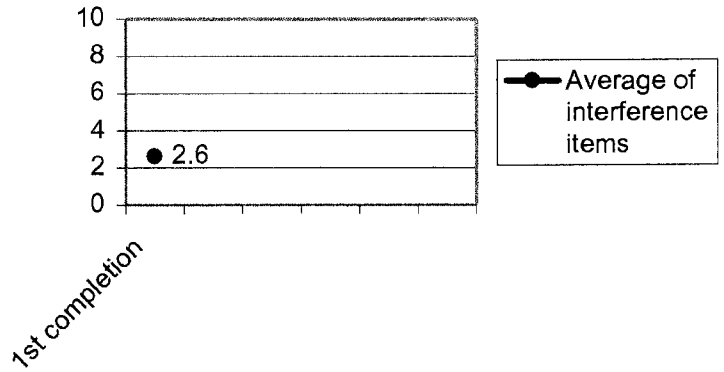

Figure 4.14 First completion of the BPI by Dudu: Pain Interference score

The idea was introduced to the family that perhaps Dudu would appreciate someone attending the sessions with her, so as to encourage and support her. Her daughter immediately indicated that she would like to remain

involved in the process. She stated that her father had to work on weekends, but that she would like to "help mom out".

It was decided to schedule the third session (first hypnosis session) for the following Sunday in their home, with Dudu and Lindy to attend.

First hypnosis session

The session began with Dudu completing the BPI for the second time (see figure 4.15 and 4.16)

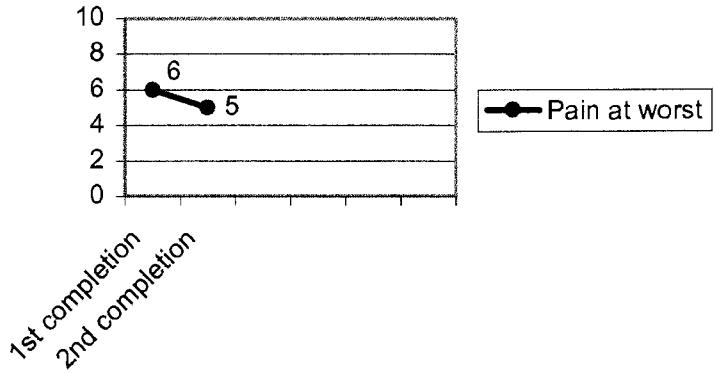

Figure 4.15 Second completion of the BPI by Dudu: Pain at worst rating

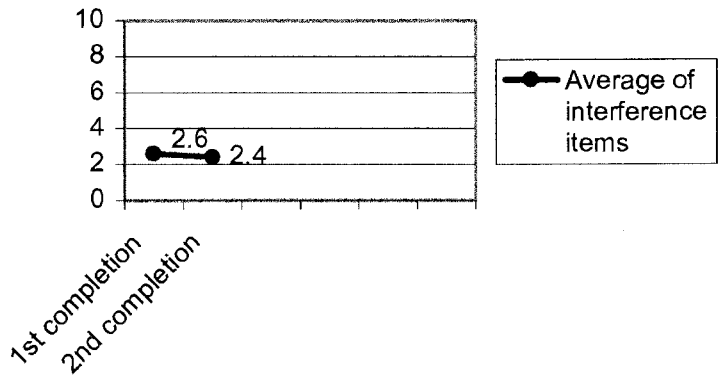

Figure 4.16 Second completion of the BPI by Dudu: Pain Interference Score

Dudu reported that she had a good week. Her daughter stated that she was looking forward to "being there" for her mother as "she's always there for me." Dudu made herself comfortable on the couch. She asked if she should close her eyes and I told her to do whatever came naturally to her. She then closed her eyes. Dudu was instructed to breathe deeply and to focus on her breathing. I then began to metacommunicate with her daughter. I pointed out that Dudu's breathing seemed to be getting deeper and slower and Lindy remarked that Dudu's facial expression was relaxing too. I took hold of Dudu's right wrist, lifted it above the arm of chair and commented on its heaviness. It was noted to Lindy that this was a clear indication of the depth of relaxation Dudu had achieved. Lindy was then asked to lift Dudu's wrist herself to also verify the heaviness.

Dudu was then asked her to imagine herself in a very peaceful and relaxing place and to indicate by nodding her head when she felt totally relaxed. At this stage the reframe was introduced that, while it was admirable for her to be a loving mother who felt responsible for her children and husband, she was ignoring her own needs and feelings. It was suggested that by placing the needs of others before her own, she was losing touch with herself and that she needed to be a complete person if she was to be there for her family. I suggested that it was crucial that she learn to accept and fulfil her own needs if she was to help others. I commented that she needed to let others help her and listen to her.

Dudu was instructed to rouse herself by counting up from ten to zero silently, and then opening her eyes. Dudu opened her eyes and reported feeling very relaxed.

Lindy stated that her mother had looked "incredibly at peace" and said that she too would like to "experience hypnosis". I suggested that hypnosis might be something that Lindy could "do for Dudu". It was agreed that Lindy and Dudu would be hypnotized together in the next session.

For homework Dudu was instructed to ask her family for help with at least one household task each day, no matter how small the task. The next session was scheduled for the following Sunday in their home, with Dudu and Lindy to attend.

Second hypnosis session

The session began with Dudu completing the BPI for the third time (see figure 4.17 and 4.18).

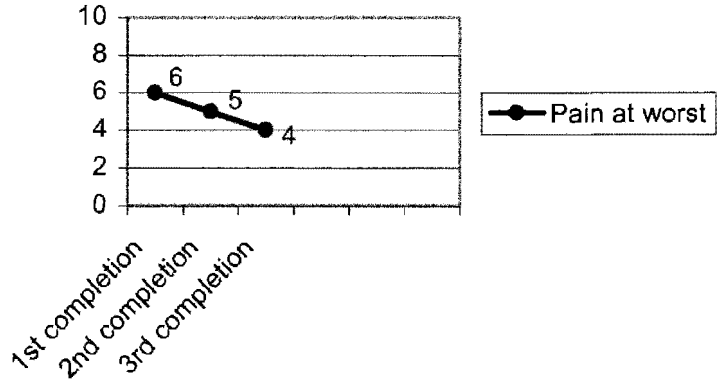

Figure 4.17 Third completion of the BPI by Dudu: Pain at worst rating

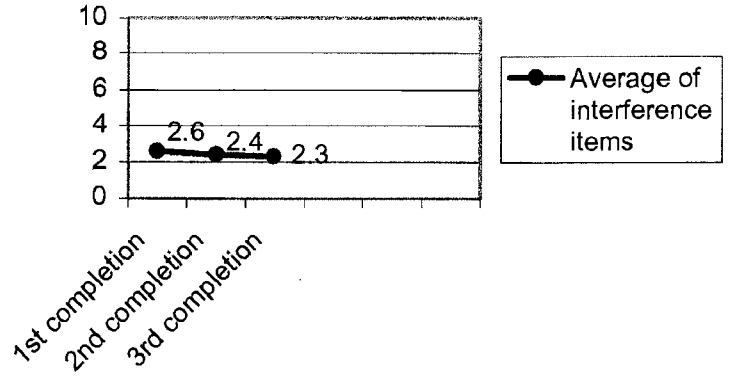

Figure 4.18 Third completion of the BPI by Dudu: Pain Interference score

Dudu reported that she had a good week. Lindy said that Dudu had asked for help during the week and, in response, Lindy had cooked supper on two occasions. She stated that she quite enjoyed the cooking and that she liked the time it gave her parents to relax, as they both worked very hard. Dudu stated that it had been good to relax a little more than usual.

It had been agreed in the previous session that Dudu and Lindy would be hypnotised together. In order to punctuate what was about to happen as hypnosis, we set them up in two chairs facing each other. I asked them who they thought would "go into hypnosis" first. Both agreed that, because of her previous experience, Dudu would. At this point Dudu closed her eyes. Lindy closed her eyes a minute or so later. I began to speak softly to them, asking them to breathe slowly and deeply, and then took them through a progressive relaxation exercise. The pair was then asked to imagine a staircase consisting of ten stairs and to imagine descending those stairs, in their own time, to a place they felt safe and comfortable in. Once they had reached their imagined

safe place they were asked to "take in the place with all their senses" and then to ascend the stairs again when each felt ready and open their eyes.

Once both the women had opened their eyes, Dudu reported feeling very relaxed and pain free. She stated that the safe place she had imagined was the ocean. Lindy stated she had felt very connected to her mother even though her eyes were closed. Dudu and Lindy were instructed to practice the breathing and relaxation exercise, as used in the session, at home. Dudu was also instructed to keep asking for help with household tasks, although she could decide how frequently she did so. In addition, she was instructed to tell her family when she was experiencing pain, not so that they felt they had to do something about it, but so that they would know how she was feeling.

The next session was scheduled for the following Sunday in their home, with Dudu and Lindy to attend.

Third Hypnosis Session

The session began with Dudu completing the BPI for the fourth time (see figure 4.19 and 4.20).

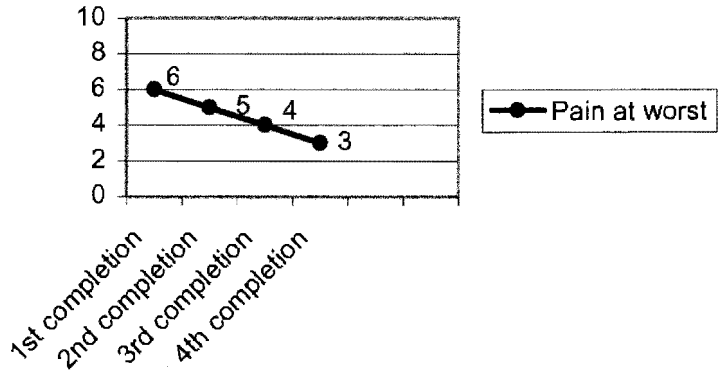

Figure 4.19 Fourth completion of the BPI by Dudu: Pain at worst rating

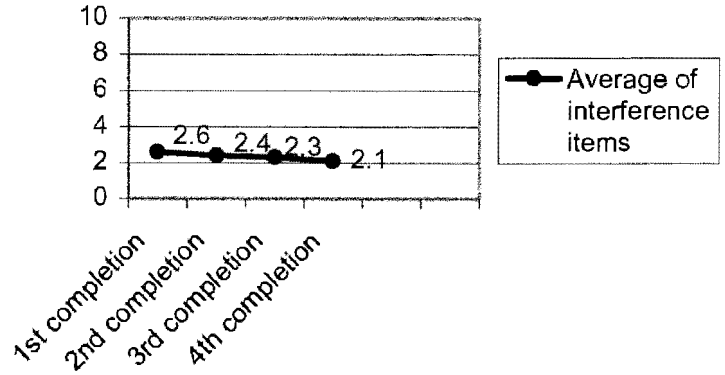

Figure 4.20 Fourth completion of the BPI by Dudu: Pain Interference score

Dudu and Lindy reported that they had practiced "with great success". Lindy stated that Dudu had admitted to being in pain on two occasions during the week. On both occasions they had used the breathing and relaxation and Dudu had felt better afterwards. Lindy stated that she was continuing to help out in the house, even if Dudu did not ask for help each day.

I asked Lindy if she would be willing to hypnotize Dudu, out of her experience of the previous week and their practicing at home. Lindy agreed to try and Dudu made herself comfortable on the couch. Lindy started to speak to her mother in a soft voice, suggesting that she was feeling relaxed and peaceful. She asked her to focus on her breathing and kept repeating words like "calm" and "quiet". Dudu's eyes then closed. I mentioned to Lindy that Dudu's hand was twitching and suggested this might be a sign of her muscles relaxing. Dudu's head began to move to the left and Lindy noticed this and pointed it out. At this stage Dudu nodded her head to indicate that she was totally relaxed.

I suggested to Dudu that it might be good if she could attempt to transform her pain "into something else" and in that way make it something she could cope with better. Dudu was asked to visualize her pain and to "give it a form". She reported seeing her pain as a solid red block. Dudu was then asked to imagine the form of her pain changing. Firstly, she was asked to imagine the edges of the block softening and losing their rigidity and becoming almost fluid. She was then asked to imagine the colour changing from red to purple and then to blue, until the colour resembled that of waves. It was suggested that rather than discomfort she now felt coolness and refreshment. Dudu was instructed to enjoy the sensation for as long as she needed and then to open her eyes in her own time.

In the discussion of her experience, Dudu stated that she enjoyed the exercise and that it had reduced her pain and left her feeling relaxed and calm. Dudu was instructed to continue practicing her breathing exercises. In addition she was to continue letting her family know how she felt and ask for help when she needed it.

The next session was scheduled for the following Sunday in their home with Dudu and Lindy to attend.

Fourth hypnosis session

The session began with Dudu completing the BPI for the fifth time (see figure 4.21 and 4.22).

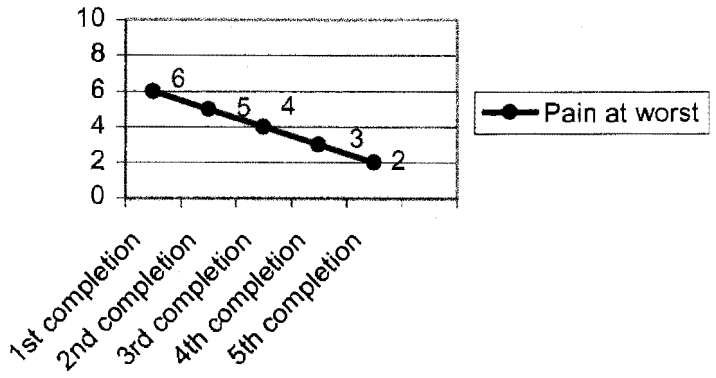

Figure 4.21 Fifth completion of the BPI by Dudu: Pain at worst rating

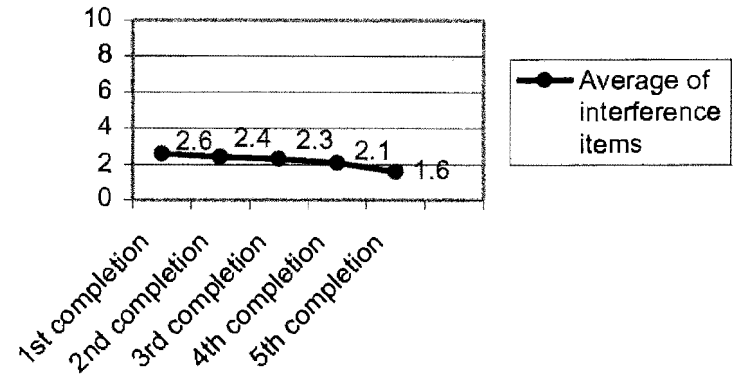

Figure 4.22 Fifth completion of the BPI by Dudu: Pain Interference score

The average of the Interference items was lower due to Interference with Sleep now being rated a three as opposed to a six the previous week. Dudu attributed this to her having more help in the evenings and, therefore, being in less pain when she went to bed at night.

Dudu was instructed to relax herself, with Lindy assisting in the process by speaking in a soft tone of voice and by directing her attention to relaxing each

group of muscles in turn. Once Dudu indicated she was relaxed, the previous session's "transformation of the pain" exercise was used again. I then commented to Dudu that she was now in a "sufficiently deep state of hypnotic relaxation" so as to be able to present herself with a number of hypnotic suggestions, which would aid her in overcoming her pain. The following suggestions were presented to her: (1) that she could "transform" her pain whenever feeling stressed or overwhelmed by pain and (2) that it was okay to tell others when you are in pain and to ask them to help. Dudu was asked to indicate her acceptance of the suggestions and her commitment to their fulfillment. She was instructed to terminate the session by opening her eyes when she felt ready.

Dudu was instructed to practice her breathing and the "transformation" exercise at home each day. She remarked she felt very relaxed and "very positive about trying it in my daily life".

The next session was scheduled for the following Sunday in their home with Dudu and Lindy to attend.

Fifth hypnosis session

The session began with Dudu completing the BPI for the sixth time (see figure 4.23 and 4.24).

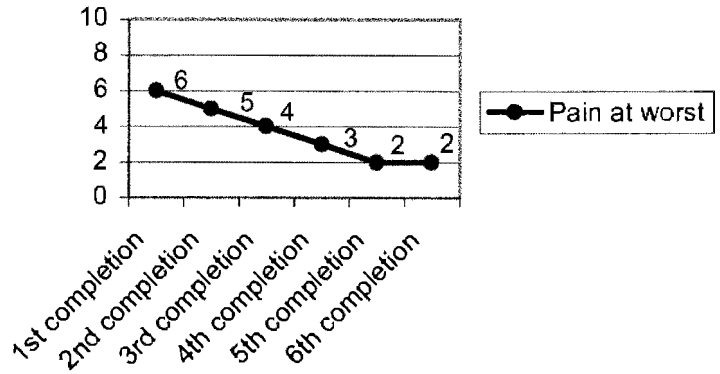

Figure 4.23 Sixth completion of the BPI by Dudu: Pain at worst rating

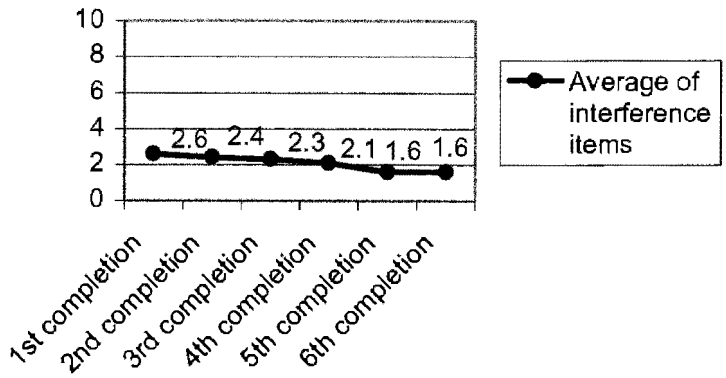

Figure 4.24 Sixth Completion of the BPI by Dudu: Pain Interference Score

Dudu reported "great success" with her "self-hypnosis". She said that she had been very tired one night and didn't want to "talk herself through". She had then asked her daughter for help. Dudu reported a "definite decrease" in pain and stated she found it very effective to "transform" her pain. I congratulated her on her success, but stated that it was exactly what was expected because of her strong will and determination to succeed.

It was agreed that this be the final session. A feedback session was scheduled for two weeks time in their home with Dudu, her husband and Lindy to attend.

Feedback session

Dudu appeared very relaxed at this meeting and stated she was "feeling good". She reported practicing each evening before she went to sleep. She stated that using her self-hypnosis before going to sleep, coupled with the extra help in the house, was helping her to sleep better than she had in years.

Lindy stated that she was still enjoying being able to do something for her mother. Dudu's husband stated he enjoyed the extra bit of time they got to spend together, now that Dudu didn't feel she had to do everything herself. He also enjoyed that Dudu appeared to be more relaxed.

Metaperspective

From the first session it appeared that the consensual domain we were operating in was that hypnosis could help with relaxation and that, rather than taking the pain away, it could help transform the pain experience into something Dudu could cope with. Therefore, an approach was adopted that would fit with these ideas. Relaxation was used from the first session and in the later sessions externalization was introduced. The problem was made a separate entity and external to Dudu, so that she could change its fixed qualities. In this way Dudu's pain was not taken away, but changed into something she could better cope with. The transforming of the pain appeared to be made more effective by transforming it into a wave, which is associated with Dudu's chosen "safe place", the ocean.

The MMFF assessment revealed that, although this family functioned relatively successfully, Dudu was placing an unnecessary burden on herself by insisting on coping with the pain on her own. The members of this family did appear to care a lot for each other and, therefore, the researcher introduced the idea that someone who cared for her became involved in the therapy. A lot of the gains made by Dudu appeared to be related to her realization that she didn't have to cope alone and that someone else could understand the problem. Dudu needed to, and did appear to, accept the requirement to depend appropriately on others.

With regard to the BPI, Dudu's Pain at Worst rating had dropped to two as opposed to the first rating of six. The mean for the Pain Interference items had dropped from the original 2.6 to 1.6.

4.3 EVE

Eve's first session was held on a Saturday afternoon in her home. Eve's husband and two teenage sons (13 and 19) also attended. Eve had been suffering from chronic lower back pain for six years. She described her pain as sharp and burning. Her doctor, however, could not find a definite cause for the pain on any X-rays, and told her he believed the pain was caused mostly by muscle spasm. Sitting for a long period of time, climbing stairs and driving long distances were all problematic for Eve. Eve stated that having her back rubbed helped her, but that she did not often have the time to get to a physiotherapist. As a result, Eve's husband and children were always getting called on to rub her back. Eve's husband admitted that he was starting to find

this annoying: "We get little enough time together, and every time I do see her, she wants me to rub her back." Eve's sons also admitted to "making a run for it" whenever they saw her with her tube of anti-inflammatory gel. Eve admitted that she had now taken to making the housekeeper rub her back for her. Eve stated that if the pain could be taken away she could be more independent, because she wouldn't always be looking for someone to rub her back and she would be less irritable.

MMFF Assessment

The MMFF was used to determine the level of family functioning in the six areas. The MMFF was started in the first session and completed in the second session on the following Saturday.

Roles

With regard to instrumental roles, Eve's work life had been affected very little and she stated that she had very rarely missed work due to her pain. Eve and her husband both had very demanding jobs, which involved long hours and a fair amount of traveling. Eve stated that she refused to limit what she did and admitted that she sometimes did too much and hurt herself.

Affective roles also appeared to be unaffected and, despite her pain, Eve remained invested in maintaining a caring and supportive relationship with her husband and children.

Eve appeared to still be an active participant in all aspects of family life. She and husband took joint responsibility for making sure the family was well provided for.

Communication

Eve stated that she would tell her family "quite openly" when her back was sore. However, she tried not to take her pain out on others and preferred to communicate "positive and supportive ideas" to her family. Her husband and children agreed that she didn't tend to get "depressed or irritable" when in pain and that they always found her approachable.

Affective involvement

Although both parents worked long hours, this family appeared to demonstrate empathic involvement, with each member caring deeply about the significant activities and interest of the others. Eve and her husband remained concerned and interested in each other's welfare. The couple also took an active interest in and supported all their sons' activities. This family liked to be seen as a team and members appeared to be very loyal to each other.

Affective responsiveness

This family appeared to have a wide range of emotional responses and welfare emotions and emergency emotions appeared to be freely expressed.

Problem solving

The family appeared to deal effectively with practical, day-to-day instrumental problems. Notably, areas such as social activities and money management had not been affected by Eve's pain problem.

This family also did not appear to have difficulty with solving affective problems. The family members were genuinely interested in and involved with each other. They liked to see themselves as a team and tried to deal with affective problems as a family: "If one of us is unhappy, we will try to figure out why, and what we can do about it."

Behavior control

This family appeared to be well organized with clear family rules. Behaviour control was flexible in that family members "pick up the slack" for each other. For example, if Eve was traveling, her husband and the boys would help out more.

The rest of the second session was used to discuss expectations of hypnosis and to allow Eve to complete the BPI for the first time.

Expectations of hypnosis

Eve's expectations were that hypnosis would teach her to relax and, therefore, cope better with the pain. This was important to her because her doctor believed her pain was related to muscle spasm. Eve's husband agreed that relaxation was important, especially as she appeared to have more pain at times when she was under stress or feeling anxious. Eve stated that she thought hypnosis might also involve some sort of visualization and that she had heard that the "deeper you went" the more effective hypnosis could be.

Brief Pain Inventory

Eve completed the BPI for the first time (see figure 4.25 and 4.26).

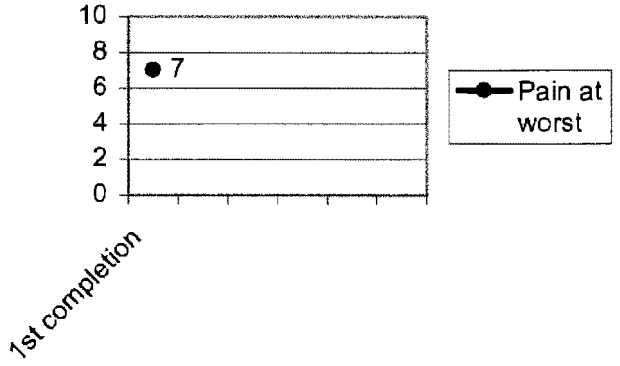

Figure 4.25 First completion of the BPI by Eve: Pain at worst rating

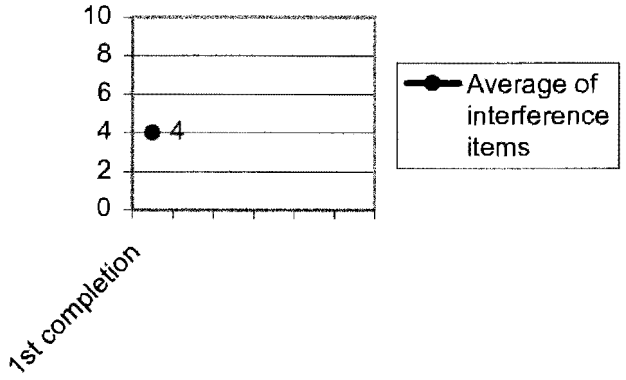

Figure 4.26 First completion of the BPI by Eve: Pain Interference Score

Pain's overall influence over this family appeared to have been kept to a minimum. Therefore, only Eve was scheduled to attend the third session (first hypnosis session) to be held in their home the following Saturday.

First hypnosis session

The session began with Eve completing the BPI for the second time (see figure 4.27 and 4.28).

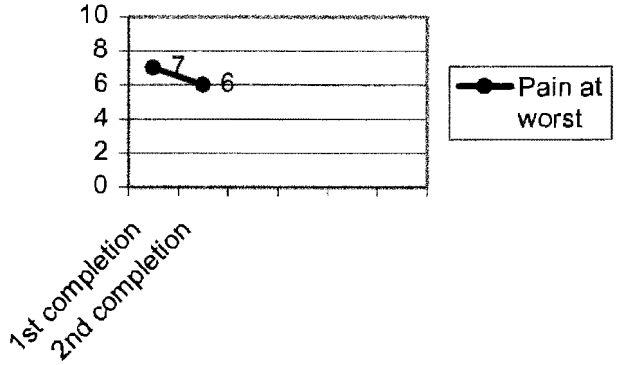

Figure 4.27 Second completion of the BPI by Eve: Pain at worst rating

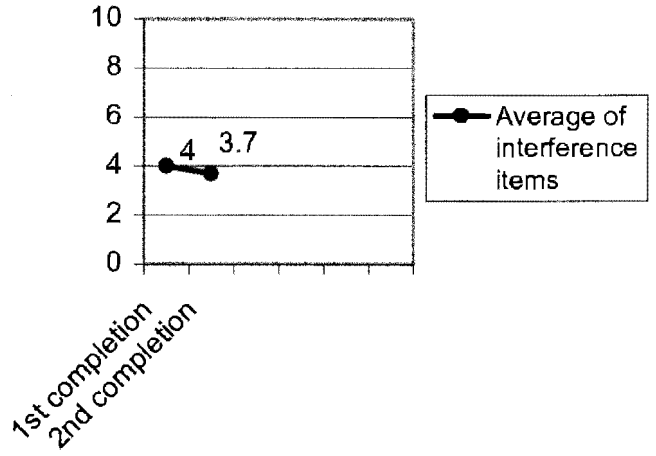

Figure 4.28 Second completion of the BPI by Eve: Pain Interference Score

Eve stated that she was feeling excited and "very positive". Eve was asked to make herself as comfortable as possible to increase the likelihood that she would "relax completely". She felt she should lie on the couch and, once she had made herself comfortable, she closed her eyes without being asked to. I asked her to concentrate on her breathing and notice how this was connected to any movement she might feel in the rest of her body. It was suggested that, as she breathed in, her shoulders might begin to feel lighter. I then mentioned that her shoulders were connected to her arms and hands. I suggested that we wait for changes and suggested that perhaps her hands might begin to feel lighter. I started to wonder aloud whether her left or right hand might start to feel lighter first. At this stage her right index finger started to twitch. I remarked on this, and suggested that her finger might continue to move on it's own, and added that it might even begin to feel as if her whole hand wanted to lift. I commented that it would be best not to make her hand lift, but to wait for it to feel like it wanted to lift. I pointed out that her right thumb seemed to be getting lighter and I continued in this vein, until her right hand had completely levitated. I instructed her not to be afraid of this. I also asked her to notice how

it felt and then, when she was focused enough and felt ready, to open her eyes and watch her hand. She opened her eyes and I suggested that when she had seen enough she should close her eyes again and bring her hand down under her own control. She was instructed to terminate the hypnosis by slowly opening her eyes in her own time.

Eve stated on opening her eyes that the movement of her hand had surprised her. She said that at first she had not been sure that she was hypnotized, and that she had not thought she was that "deep" until she saw her hand. She felt the experience had been very different to what she expected, and she had enjoyed the "very unusual sensations" she had experienced. She stated her body had "felt different" in trance. I commented that perhaps that "different feeling" was preferable to the pain she normally felt and she agreed with this.

The next session with Eve was scheduled for the following Saturday in her home.

Second hypnosis session

The session began with Eve completing the BPI for the third time (see figure 4.29 and 4.30).

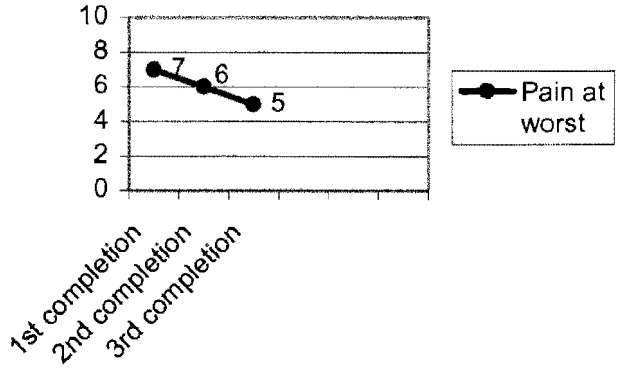

Figure 4.29 Third completion of the BPI by Eve: Pain at worst rating

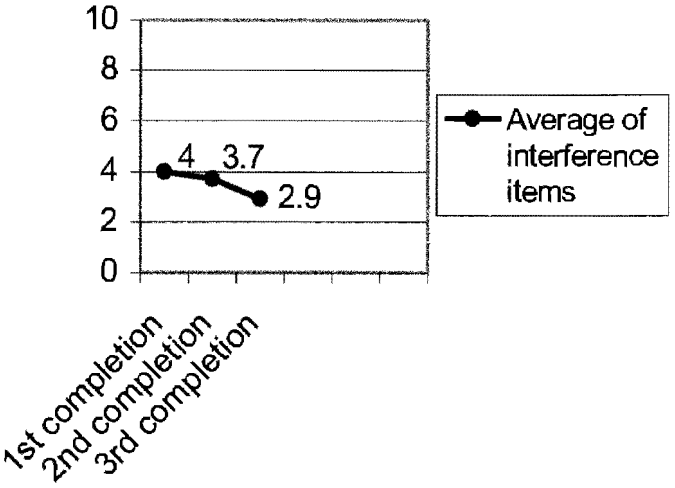

Figure 4.30 Third completion of the BPI by Eve: Pain Interference score

Eve was asked to make herself comfortable and to concentrate on her breathing, which then became progressively slower and shallower. Shortly thereafter she indicated by nodding her head that she was completely relaxed.

Eve was then asked to imagine herself in a large, airy lift, which descended slowly to an imagined place that represented safety and comfort for her. Once

Eve indicated that she was in this imagined safe place, she was asked to become aware of any pain present in her lower back and to focus her attention on it. Eve had stated in the very first session that her pain tended to be a burning pain. She was now asked to visualize her pain as a large, red, burning ball of energy like the sun. She was asked to focus on it and to imagine it slowly start to become smaller and smaller as she watched it. As the ball appeared to become smaller, Eve was asked to imagine it beginning to lighten and change colours from red to a soft pink to a pale blue. She was asked to indicate when the imagined ball had become so small and pale that it had disappeared completely. Once Eve indicated that it had, she was asked to slowly lift her head and open her eyes.

Eve commented that she "felt very different again". She described it as a pleasant and comfortable feeling. I suggested that by making her pain feel different, it might make it possible for her to cope with it. Eve was instructed to "hold onto" that feeling. I commented that she could now look to her imagined special place to find that feeling and in that way cope with her pain independently, instead of having to rely on someone being around to rub her back. I suggested that now that she had had this experience she could access it whenever she wanted to.

Third Hypnosis Session

The session began with Eve completing the BPI for the fourth time (see figure 4.31 and 4.32).

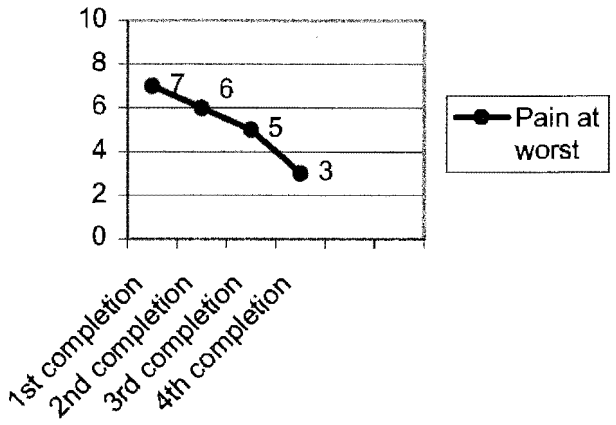

Figure 4.31 Fourth completion of the BPI by Eve: Pain at worst rating

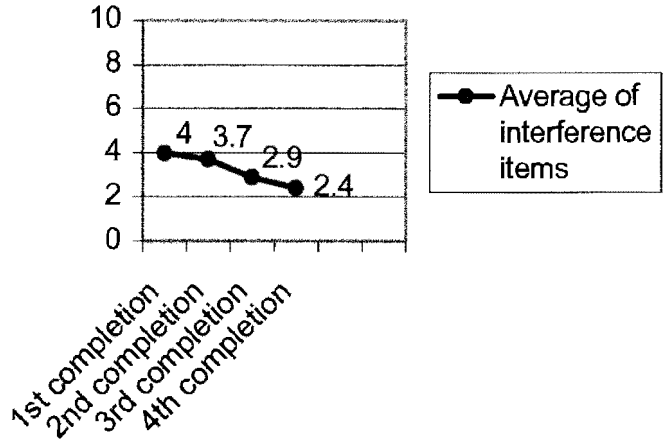

Figure 4.32 Fourth completion of the BPI by Eve: Pain Interference score

Eve was asked to relax herself in the presence of the researcher by closing her eyes, focusing on her breathing and allowing a sense of heaviness to develop throughout her body. She was told that "at the appropriate moment" she would be aided in extending the relaxation into hypnosis. Eve closed her eyes and began to breathe slowly. After a few minutes, she indicated by nodding her head that she was relaxed. At this point the image of descending in a lift to her imagined safe place was introduced. Once Eve indicated she was in her safe place, the visualization exercise of the sun was employed as

in the previous session. On completion of the exercise, Eve was requested to present the following suggestion to herself: that during the coming week, whenever the pain was particularly bothersome, she would at any time be able to use this image of the sun during self-hypnosis. Eve was then asked to imagine ascending in the elevator and instructed to open her eyes in her own time.

Eve was instructed to practice "self-hypnosis" every day, incorporating the suggestion given to her.

The next session with Eve was scheduled for the following Saturday in her home.

Fourth hypnosis session

The session began with Eve completing the BPI for the fifth time (see figure 4.33 and 4.34).

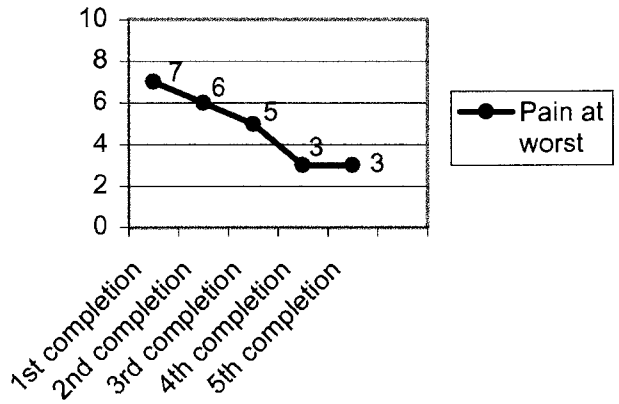

Figure 4.33 Fifth completion of the BPI by Eve: Pain at worst rating

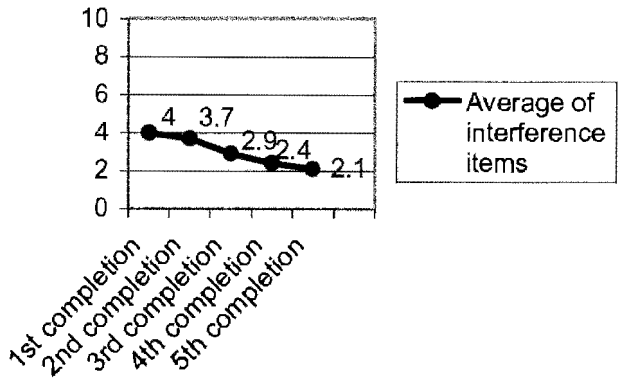

Figure 4.34 Fifth completion of the BPI by Eve: Pain Interference score

Eve's Pain Right Now rating had dropped to a rating of one, as opposed to the original rating of six. Eve stated that this was because she felt relaxed in anticipation of the session. Eve reported that she had practiced successfully and that she was feeling "more relaxed in general". She noted that someone at work had commented that she looked years younger.

Eve again "hypnotized herself" in the researcher's presence and used the sun visualization exercise. She was complimented on the ease with which she had learnt to hypnotize herself and instructed to persist with her self-hypnosis exercises, which would increase her ability to relax more quickly and deeply.

The next session with Eve was scheduled for the following Saturday in her home.

Fifth hypnosis session

The session began with Eve completing the BPI for the sixth time (see figure 4.35 and 4.36). Eve's Pain Interference score had dropped, mostly due to her rating for Interference with Sleep dropping from an eight on the first completion to a rating of four on this completion.

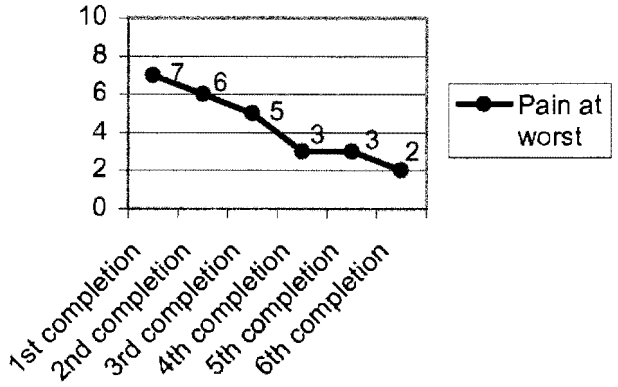

Figure 4.35 Sixth completion of the BPI by Eve: Pain at worst rating

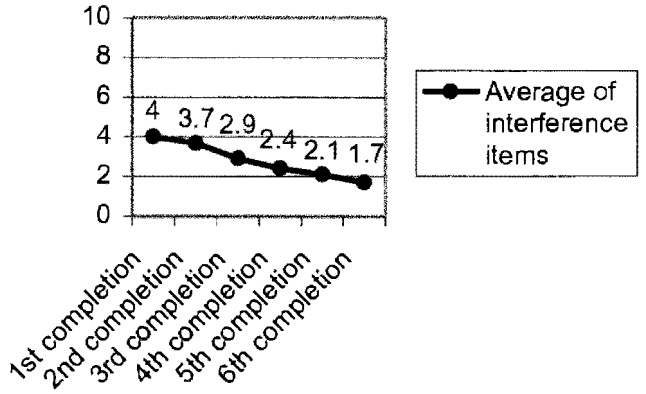

Figure 4.36 Sixth completion of the BPI by Eve: Pain Interference Score

Eve stated that her practicing went well. Eve hypnotized herself as in the previous session. She stated afterwards that the "self-hypnosis" was having a positive impact on her whole life because she felt more relaxed. I commented that it was a skill that could be used whenever needed and complimented her

on her inner strength and determination, which would ensure that she coped with the pain in the future.

It was agreed that this be our last hypnosis session. A feedback session was scheduled for two weeks time with Eve and her husband in their home.

Feedback session

Eve reported still "feeling wonderful" and said she owed it all to her "self-hypnosis". Eve stated that she had just been promoted at work and felt confident that she would cope because her back was "feeling great". Her husband agreed with her work colleague that Eve was "looking great". He said he appreciated no longer being roped in to rub her back and instead having that time to do something pleasant together.

Metaperspective

From an ecosystemic viewpoint, it was necessary to create a hypnotic experience that would be congruent with Eve's expectations and fit with these, rather than forcing her experience into a pre-conceived framework. For example she believed that the "deeper" one went, the more powerful hypnosis would be. Therefore, arm levitation was used to prove to her how "deeply she was hypnotized". The image of going down in a lift was also used in response to her request for depth. Although from an ecosystemic perspective no credence is given to reified concepts such as "depth" of hypnosis, this term was used because it linked with the conceptions of the client. As Fourie (1991a, p.475) states, an "implication of an ecosystemic approach to

hypnosis, and one following from the idea that it is possible to capitalize on peoples' conceptions of hypnosis, is that the language of operation often differs from the language of conception".

The consensual domain within which we were situated appeared to adhere to the ideas that hypnosis could help with relaxation and that hypnosis involved imagery and visualization. Relaxation did play an important part in these sessions because Eve's pain appears to be related to muscle spasm. Turner and Chapman (1982) state that relaxation's primary purpose is to relax tense muscles believed to cause musculoskeletal pain. The idea that hypnosis involves visualization was capitalized on through the use of the metaphor of the sun. Eve's pain was likened to the sun because burning is the primary sensation she associated with her pain.

Eve had not expected the pain to disappear, but wanted to be able to cope with it. The researcher, therefore, linked with the idea that hypnosis made her feel unusual and suggested that this unusual feeling evoked by the hypnosis might be easier to cope with than the pain.

With regard to the BPI, Eve's Pain at Worst rating had dropped from a seven on the first completion to a two on the final completion. Her Pain Interference score had dropped to a 1.7 on the final completion of the BPI, as opposed to her score of four on the first completion.

4.4 MIKE

Mike, his wife (Kate) and their son and daughter attended the first session, held in their home on a Thursday evening. Mike had already had three lower back operations, the last of them five months before the first session. He stated that he still experienced pain on a daily basis.

Mike had been back at work for two months. Mike was in the construction industry and found it difficult to confine himself to just supervising his men. His doctor recommended that, if he was going to insist on still being active on site, he should work half-day for a few months so as to allow his back to heal completely from the surgery. Mike felt very frustrated by this and stated he hated "hanging around the house like a spare part." He admitted that he was very irritable and impatient with his wife and children because he found it hard to explain how he was feeling: "how could they understand anyway".

Mike's wife, Kate, was angry that he had been through so many operations and felt the medical profession had failed to help him effectively. She admitted she found Mike difficult to deal with and very demanding. Mike's son said that Mike always been very approachable, but now he felt like he had lost his father's friendship. Mike's daughter agreed and said they now went to Kate with all their problems. The children found him unreasonable, impatient and difficult to please.

MMFF Assessment

The MMFF was used to determine the level of family functioning in the six areas. The MMFF was started during the first session and completed a week later in the second session.

Roles

Mike's occupational role had been affected as he was only working half-day at the time of the sessions, and Kate had become for the moment the primary breadwinner. As he subscribed to fairly traditional views on masculine roles, he battled to accept this change in role. Mike compensated by being dictatorial with his wife and children. Kate had taken on the major share of responsibility in running the family, including listening to the children's concerns, shopping, and mediating between her husband and children.

With regard to affective roles, Mike no longer provided nurturance or support for his wife or kids. Mike was moody most of the time and had lost interest in their sexual relationship. Kate stated that she still cared deeply for him but was "afraid of touching him". Kate believed that Mike was no longer supporting her emotionally and felt she was not always able to respond to the increased demands of her children for love and attention.

Communication

As Mike became increasingly absorbed in the frustration of his pain problem, he manifested many of the characteristics of chronic pain patients, such as anger and irritability. The children felt that when he did speak it was usually to

express frustration, anger or criticism, directed mainly at them. As a result, the children found it difficult to talk to him and no longer went to him for help and advice. Kate was angry with him for not keeping up his end of responsibility, but she did not express her anger. Her silence led to a sense of resentment mixed with hopelessness. Silence and an avoidance of emotional issues appeared to be the main features of this family's style of communication.

Affective involvement

Kate attempted to maintain an empathic involvement with the children, but there appeared be to a lack of involvement between Mike and Kate. They no longer had sexual contact, and had very little positive communication. There also appeared to be a lack of positive involvement between the children and Mike.

This family appeared to be characterized by the members feeling a lack of understanding and support. Kate and the children felt that Mike did not understand how they felt and Mike complained of the same thing.

Affective responsiveness

Mike expressed a lot of emergency emotions. The family withdrew from him and found it hard to express concern and caring because of his outbursts of anger and frustration. The only welfare feelings expressed were between Kate and the children. Kate felt sorry for the children. She stated that she felt sorry for Mike, but also angry with him. She felt it was pointless to for Mike to say

that no one understood how he felt when he made it so difficult to talk to him about it.

Problem solving

Mike was aware that the quality of his relationships with other members of the family had suffered a decline following the onset of his pain problem. He was ready to accept that the pain problem was not only his personal problem, but also a family problem, because of the deterioration in the way family members normally interacted with each other. At this stage, however, the problem solving process had not moved past the identification phase.

Behaviour control

This family appeared to be characterized by chaotic behaviour control, because rules did not remain consistent and were subject to repeated change. As he was no longer the primary breadwinner, Mike's self esteem had suffered a blow. He no longer held the same position of power in the household and he appeared to compensate by making unreasonable demands on the children and being overly strict. At other times he would feel guilty about his outbursts and then let them do what they liked. Kate tried to maintain order in the house, but this was made difficult by Mike's unpredictability. She stated that at times the way she did things was accepted, but at other times he would openly contradict her.

The remainder of the second session was used to discuss the family's expectations of hypnosis and to allow Mike to complete the BPI for the first time.

Expectations of Hypnosis

Mike believed that hypnosis might help him gain some form of control over his pain so that he would not be so irritable. He hoped that it would "calm him down" somehow so that he wouldn't be "so short-fused" with his family. Kate agreed that she would like it to help him relax so that it would be easier for all of them to be around him.

Brief Pain Inventory

Mike completed the BPI for the first time (see figure 4.37 and 4.38).

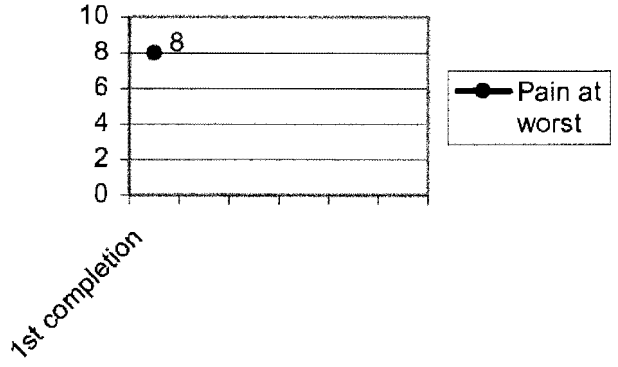

Figure 4.37 First completion of the BPI by Mike: Pain at worst rating

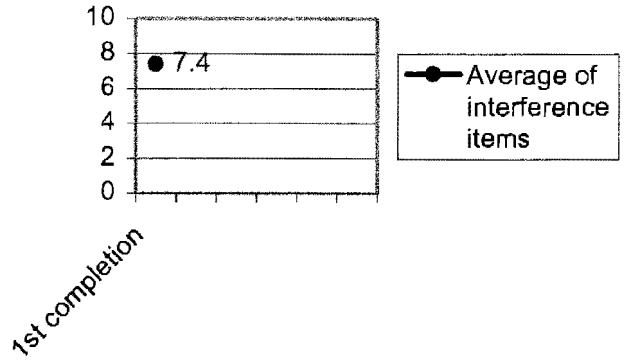

Figure 4.38 First completion of the BPI by Mike: Pain Interference score

Mike reported that he used analgesics even though they had a negligible effect on the pain. He also took sleeping tablets to help him cope, because by sleeping at night he felt he could get through the day.

Before scheduling the next session, a reframe of the family's interaction with Mike was introduced. It was suggested that perhaps they were not intolerant of him, but rather frustrated that he was no longer the person they knew. I suggested that perhaps they were just as frustrated as he was: frustrated by what pain had done to him and frustrated by their inability to help him overcome pain. All members of the family readily accepted this reframe. The third session (first hypnosis session) was scheduled for the following Thursday evening in their home, with Mike and Kate to attend.

First Hypnosis Session

The session began with Mike completing the BPI for the second time (see figure 4.39 and 4.40).

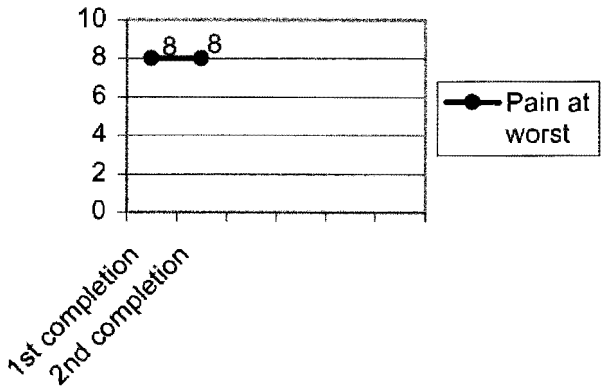

Figure 4.39 Second completion of the BPI by Mike: Pain at worst rating

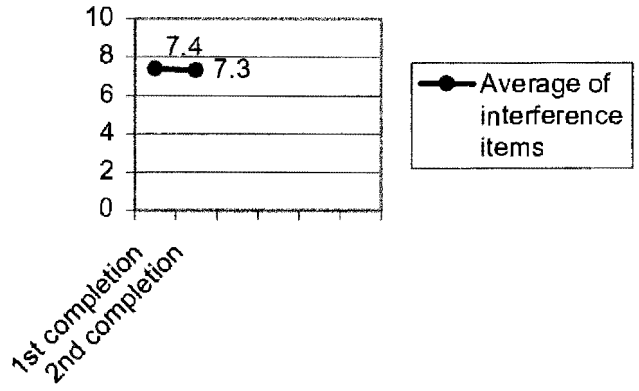

Figure 4.40 Second completion of the BPI by Mike: Pain Interference score

A suggestion was made to the couple at this stage that, as they were both feeling a lack of understanding and support, hypnosis could be used to help them get in touch with themselves and their needs. I commented that this could also help them communicate their needs to each other. It was

suggested that closeness, breathing together and hypnosis could also become associated with less pain.

Mike and Kate set up two chairs facing each other. They made themselves comfortable and I asked them whether they would prefer to go into hypnosis with their eyes open or closed. They both elected to close their eyes and did so at this stage. I began to speak softly to them, asking them to breathe slowly and deeply, and then took them through a joint guided relaxation exercise. The pair was then asked to imagine a staircase consisting of ten stairs and to imagine descending those stairs, each in their own time and each to a place they felt safe and comfortable in. Once they had reached their imagined safe place, they were asked to "take in the place with all their senses" and then to ascend the stairs again, when each felt ready, and open their eyes.

Mike described the experience as very relaxing and peaceful and Kate agreed with this. Mike stated that he had felt "more connected" to Kate than he had "in a long time". For homework Mike was instructed to relax himself, with Kate assisting in the process by speaking in a soft tone of voice and by directing his attention to relaxing each group of muscles in turn. Once Mike indicated to Kate that he was relaxed by nodding his head, she was to instruct him to descend the imaginary stairs to his "safe place".

In addition the couple was instructed to set aside 15 minutes a day after supper, as a family, to talk about good things. The next session was scheduled for the following Thursday in their home.

Second hypnosis session

The session began with Mike completing the BPI for the third time (see figure 4.41 and 4.42).

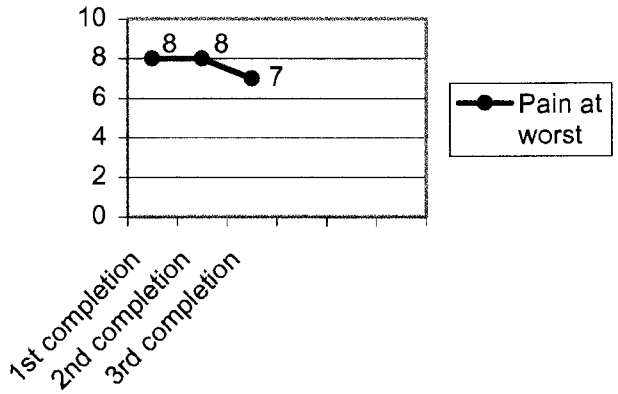

Figure 4.41 Third completion of the BPI by Mike: Pain at worst rating

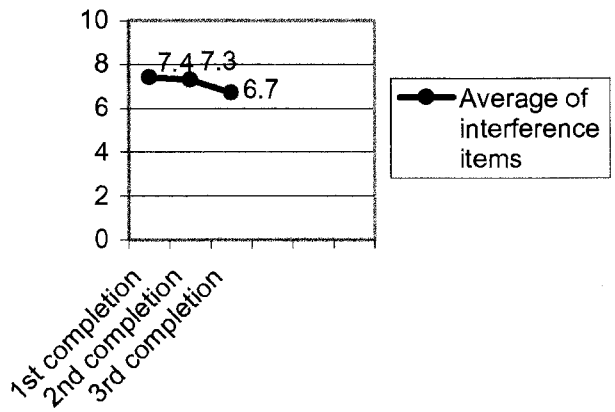

Figure 4.42 Third completion of the BPI by Mike: Pain Interference score

The average for the Interference items was lower on this completion, mainly because the rating for Interference with Relations with Other People had dropped. Mike attributed this to making time to spend "positive time" together as a family: "we actually laughed together about something". He stated that his rating for Interference with Mood had not improved, however, as they had found practicing to be frustrating. The couple reported that they had problems achieving the same degree of relaxation, and that Mike had found it difficult to go to his imagined safe place. They had felt separated and not connected like during the previous session. They asked for guidance on how to practice more effectively.

I suggested that perhaps they needed some physical connection to help them. The couple was instructed to sit next to each other on the couch and hold hands.

The couple made themselves comfortable and closed their eyes. They were guided through a joint relaxation exercise and it was then suggested that they create a third special place together by building on each other's images. Mike introduced the initial image of walking through long grass in the sun. Kate said that reminded her of a weekend a few years back when she and Mike went away to the mountains. The two of them built up an image of walking in the mountains together. Once the couple agreed their safe place was "real" to them and "fixed in their minds", they were instructed to open their eyes in their own time.

For homework, the couple was instructed to continue practising. In addition the couple were instructed to go out on a "date" in the coming week. It was suggested that if pain didn't stop Mike going to work, it should not stop him taking part in social activities with his wife or children.

The next session was scheduled for the following Thursday in their home.

Third Hypnosis Session

The session began with Mike completing the BPI for the fourth time (see figure 4.43 and 4.44). Mike's Pain Interference score was lower, as the rating for Interference with Mood had dropped from a seven the previous week to a four on this completion. His rating for Interference with Enjoyment of Life had dropped from a seven the previous week, to a five on this completion.

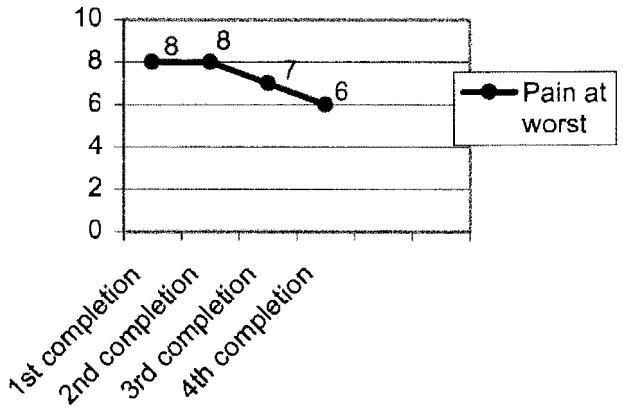

Figure 4.43 Fourth completion of the BPI by Mike: Pain at worst rating

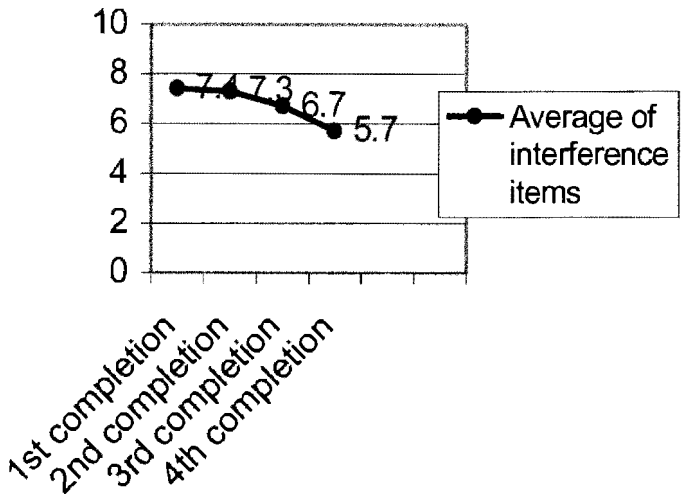

Figure 4.44 Fourth completion of the BPI by Mike: Pain Interference score

Mike reported that he and his wife had carried out their homework assignment by going out for lunch. They had both enjoyed it, particularly Kate who said that for the first time in ages she felt like Mike's partner instead of his mother. Mike had also started to help out more by collecting the children from school. He stated it gave him "a reason to leave work" rather than "forcing" himself to leave in the afternoon.

The couple reported that their practicing had been more successful. They found it quite easy to use their "mutual safe place" as Kate knew what it looked like and could help create it for Mike. I suggested that the practice was strengthening their connection and suggested that hypnosis was becoming part of their relationship.

Kate was asked if she would be willing to hypnotize Mike, out of her experience of the previous week and their practising at home. Kate agreed to try and she and Mike made themselves comfortable on the couch. They joined hands and both closed their eyes. Kate started to speak to Mike in a soft voice, suggesting that he was feeling relaxed and peaceful. She asked him to focus on his breathing and kept repeating words like "calm" and "quiet". I commented on how they appeared to be breathing in time with each other, and suggested that perhaps this was because of their connection.

Kate then directed his attention to relaxing each group of muscles in turn. When Mike indicated to her verbally that he was totally relaxed, Kate called up the image of the staircase and instructed him to go to their imagined safe place. Once both indicated that they had reached this imagined place, they were asked to concentrate on the connection between them. I suggested to them that this connection could make it easier for them to understand each other and know what the other was thinking and commented that it might even be possible for Kate to use this connection to take some of Mike's pain away.

Mike was now asked to become aware of any pain present in his lower back. Mike then was asked to imagine a control room in his head filled with a number of machines, each controlling certain processes in his body. It was suggested to Mike that, as he was a man who worked with machinery on a daily basis, it would not be too difficult for him to recognize the machine that controlled the flow of pain in his body. I asked Mike to indicate to me when he had found this imagined machine. Mike was then asked to notice that the

machine had a dial on it that enabled the pain to be turned up or down. Mike was asked to imagine reaching out and turning the dial ever so slightly to the right, so that the pain in his lower back became slightly worse. Mike indicated when this had happened. Mike was then asked to imagine turning that same dial to the left and feeling a corresponding decrease in pain. He was instructed to imagine turning the dial down as far as he could get it to go. It was suggested that Mike draw on the strength provided by his connection to Kate to help him achieve this. At this, Mike visibly held her hand tighter.

On completion of the exercise, Mike was requested to present the following suggestion to himself: that during the coming week, whenever the pain was particularly bothersome, he would at any time be able to use this image of the dial during self-hypnosis. Mike and Kate were then asked to imagine ascending the staircase and instructed to open their eyes in their own time, stressing that the connection that had been established would not be lost.

Mike reported that his pain had definitely diminished and that he "could feel Kate helping". He stated that he felt very connected to her and felt "a wave of support and understanding from her".

Mike was instructed to practice "self-hypnosis" every day, incorporating the suggestion given to him. In addition, it was suggested that a family outing be planned for the coming week.

The next session was scheduled for the following Thursday in their home with Mike and Kate to attend.

Fourth hypnosis session

The session began with Mike completing the BPI for the fifth time (see figure 4.45 and 4.46).

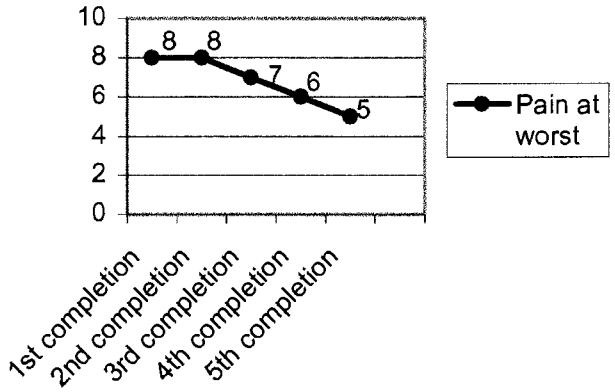

Figure 4.45 Fifth completion of the BPI by Mike: Pain at worst rating

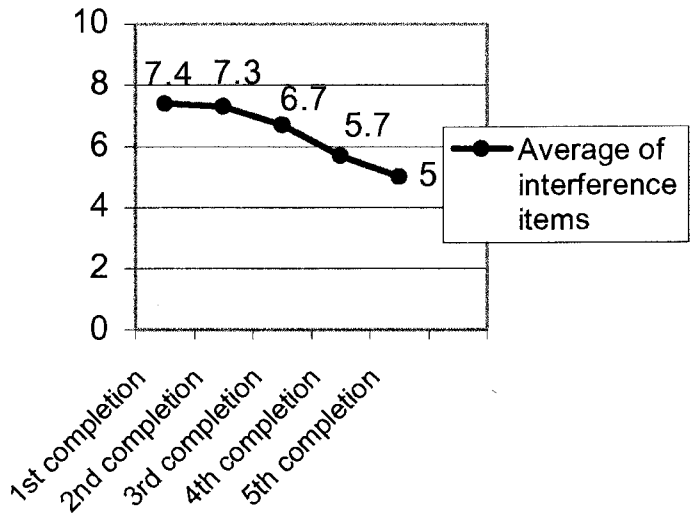

Figure 4.46 Fifth completion of the BPI by Mike: Pain Interference score

Mike stated that the family had gone to the drive-in on the weekend, as Mike could not sit through a whole movie. They had taken blankets along and had a "huge picnic" on the ground next to the car. Mike said he had stopped seeing his enforced time at home as "a punishment", but rather as time to spend with his family before he was "back at it till all hours".

Mike had experimented with the image of the control dial. He said the exercise was most effective when holding Kate's hands as could "draw strength from her". He felt a very deep connection to her when practicing. I suggested that this type of connection could be strengthened even more, and that the more they practiced the more the connection would be strengthened, even when they were not hypnotized.

Mike was asked to relax himself in the presence of the researcher by closing his eyes, focusing on his breathing and allowing a sense of heaviness to develop throughout his body. He then used the dial visualization exercise. Mike was complimented on the ease with which he had learnt to hypnotize himself and instructed to persist with his self-hypnosis exercises. I commented on how well they are doing without me, and encouraged them to experiment more. The next session was scheduled for the following Thursday.

Fifth hypnosis session

The session began with Mike completing the BPI for the sixth time (see figure 4.47 and 4.48).

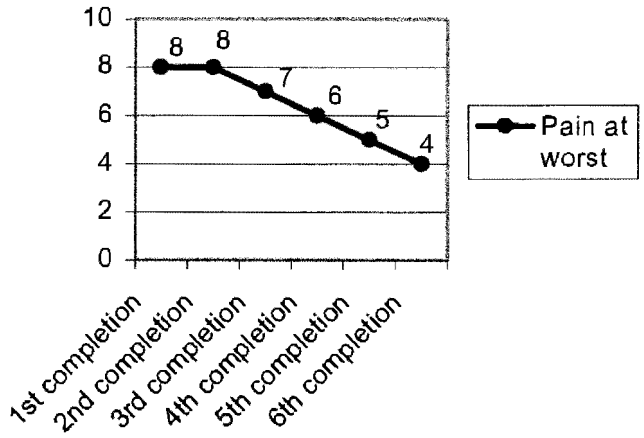

Figure 4.47 Sixth completion of the BPI by Mike: Pain at worst rating

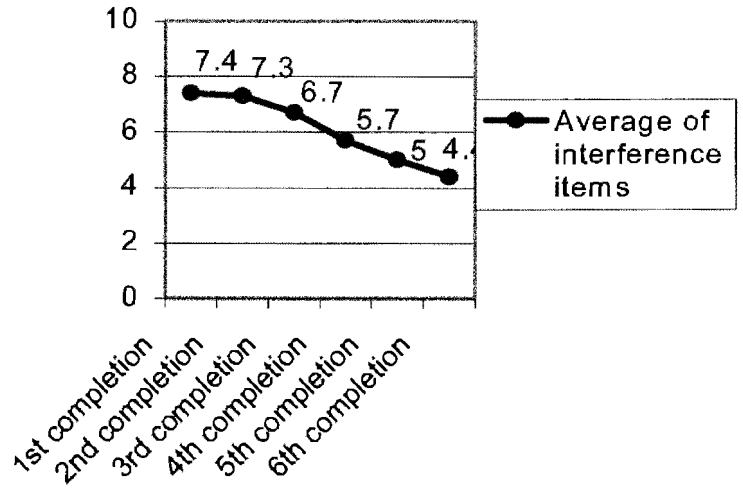

Figure 4.48 Sixth completion of the BPI by Mike: Pain Interference score

Mike stated that his practicing went well. Mike hypnotized himself as in the previous session. He stated afterwards that the "self-hypnosis" was having a positive impact on their life as a family and that it had "helped us through a difficult time". I commented that it was a skill that could be used whenever needed and complimented both of them on their inner strength and determination, which would ensure that they coped with the pain in the future.

It was agreed that this be our last hypnosis session. A feedback session was scheduled for two weeks time with Mike and Kate in their home.

Feedback session

Mike reported "feeling good" and stated that he was going back to work in two weeks. He stated that the hypnosis had worked for him because it focussed his attention away from the pain and onto his wife. He felt it created a bond between them and he felt a great deal more understanding from her. Mike believed it helped their relationship through a difficult time. Kate stated she was "just happy to have more of the old Mike back".

Metaperspective

From the MMFF assessment it was clear that Mike was experiencing a feeling of lack of support. Mike felt that no one understood how he was feeling and this opened up the therapeutic possibility that an experience of more support would help him deal more effectively with his perception of pain. Kate wanted to support him, but did not know how to approach him. Hypnosis could give her a tool to do so.

From the start the hypnotic experience was designed to create a feeling of increased closeness. The breathing homework created a context in which Mike and his wife had to spend more time with one another. Joint guided relaxation exercises were used and the couple created a combined image of a

safe place. The additional exercises were also designed to ensure that the couple and family spent positive time together.

The image of a control dial joined with Mike's idea that he would like to use hypnosis to control his pain. The image appeared to be effective because Mike worked with machinery and could relate to the idea of a mechanism controlling things.

With regard to the BPI, Mike's Pain at Worst rating had dropped from a rating of eight on the first completion to a four on the final completion. His Pain Interference score had dropped from an initial 7.4 to 4.4. Mike still rated Interference with Sleep as a ten and Interference with Normal Work as an eight on the final completion, as he was still at that stage confined to working half-day.

4.5 NICK

Nick and his wife, Pam, attended our first session, held in their home on a Tuesday evening. The couple's daughter was only three years old and it was decided not to include her in the session. Nick had a spinal fusion two years prior to the time of these sessions, but had been left with some permanent nerve damage, which caused him to continue to feel some pain in his lower back as well as referred pain in his right leg. He stated that he tried not to let the pain interfere with his life. His approach was to have "as many weapons in my arsenal as possible". A year prior to these sessions he had been on an exercise course designed for patients with chronic back pain and he

religiously stuck to the routine that had been worked out for him. He felt he had a neurosurgeon and physiotherapist that he trusted and he referred to his exercise routine, doctor and physiotherapist as his "team".

MMFF Assessment

The MMFF was used to determine the level of family functioning in the six areas. The MMFF was started during the first session and completed a week later in the second session.

Roles

At the time of these sessions, Nick's occupational role was unaffected and he remained the primary provider. Nick very rarely missed work because of his pain problem.

Nick was still an active participant in all aspects of family life. He and wife still shared responsibility for family budgeting, shopping and even cooking. Even "on a bad day", Nick still took an active interest in his daughter.

Affective roles had also been little affected. The couple appeared to be very nurturing and supportive of each other. The marital relationship appeared to be characterized by love and affection, give and take, and much caring for each other.

Communication

This family did not appear to demonstrate any problems related to communication. Pam appeared to engage in supportive and encouraging communication, rather than pain-reinforcing messages. She had a matter-of-fact attitude to his illness and Nick was equally determined to get over his pain problem. Given that match it is not surprising that this couple engaged in direct and clear communication. In spite of the pain, they retained their stance of sharing their negative and positive thoughts and feelings with each other.

Affective involvement

This family appeared to demonstrate empathic involvement. They appeared to have a true affective concern for each other and had the ability to take an interest in each other's pursuits, even if those pursuits were not of interest to them personally. Both parents were very involved in the daughter's upbringing and showed an equal concern for her well-being.

Affective responsiveness

Neither spouse appeared to hold back on their welfare or emergency emotions. Both believed that they expressed their "true feelings" towards each other and "felt the freedom to do so".

Problem solving

Nick and Pam stated that they did not avoid disputes or arguments. They tried to make all major decisions together and tried to resolve differences through

discussion. They also tried to always be open to seeing the other's point of view.

The concern and affection they had for each other was evident in their problem solving. They mentioned that Mike had recently been offered an opportunity to relocate. This problem had involved thorough discussion and they had to look at the situation from all angles, even their daughter's. Although the offer was a good one for Nick and he was the primary breadwinner, other factors "swung their decision". Pam was particularly happy in her present job and they were living close to both sets of their daughter's grandparents. As a result, they decided to stay where they were.

Behavior control

This family appeared to demonstrate flexible behaviour control, which, according to Epstein and Bishop (1981), is the most desirable form of behaviour control. Family rules were clear, but the couple had the flexibility to modify family rules and, at times, even change them depending on what the situation demanded. Nick was involved in all aspects of family life and had an intimate relationship with his family. His periodic withdrawal was almost expected and predicted and Pam happily moved in to fill the vacuum. The couple exhibited the capacity to pitch in for each other without much fuss and was happy to move in and out of their respective roles. Pam had no problem with taking over some of Nick's usual activities if he was in pain. Similarly, when Pam was busy he would assume some of her tasks.

The remainder of the second session was used to discuss the family's expectations of hypnosis and to allow Nick to complete the BPI for the first time.

Expectations of hypnosis

Nick made it clear at our first meeting that it was important for him to have as many skills as possible to cope with the pain, and this is the reason he wanted to try hypnosis. He tended to cope with pain by not thinking about it and by focussing on something else. He stated that ignoring the pain sometimes became tiring and he hoped that through hypnosis he could achieve some type of control over the pain so that he didn't have to avoid it. Nick stated that he was very interested in learning self-hypnosis because he believed that it might be a skill to add to his "arsenal".

Brief Pain Inventory

Nick completed the BPI for the first time (see figure 4.49 and 4.50). Nick's Pain Interference score appeared consistent with Nick's reports of the limited effect pain had on his life. Interference with Sleep did, however, obtain a rating of ten.

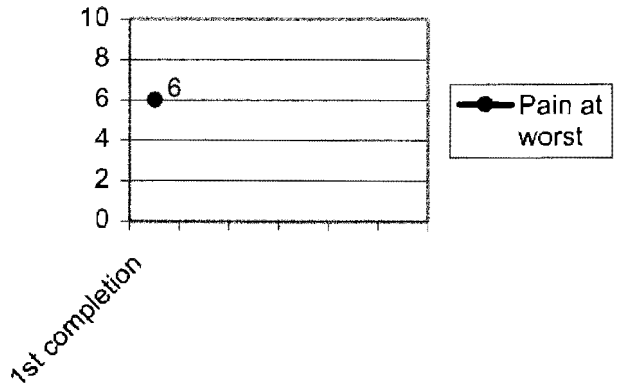

Figure 4.49 First completion of the BPI by Nick: Pain at worst rating

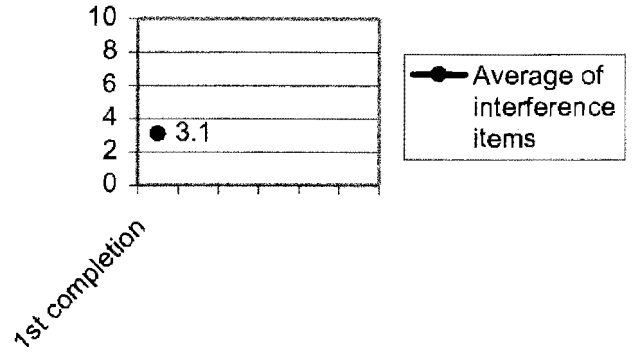

Figure 4.50 First completion of the BPI by Nick: Pain Interference score

Pain's overall influence over this family appeared to have been kept to a minimum. Therefore, only Nick was scheduled to attend the third session (first hypnosis session) to be held in their home the following Tuesday evening.

First hypnosis session

The session began with Nick completing the BPI for the second time (see figure 4.51 and 4.52).

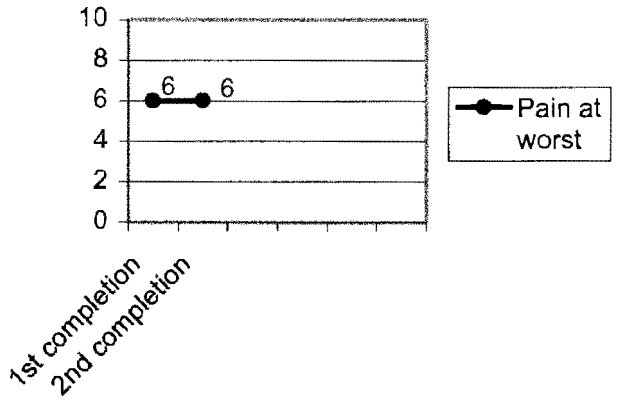

Figure 4.51 Second completion of the BPI by Nick: Pain at worst rating

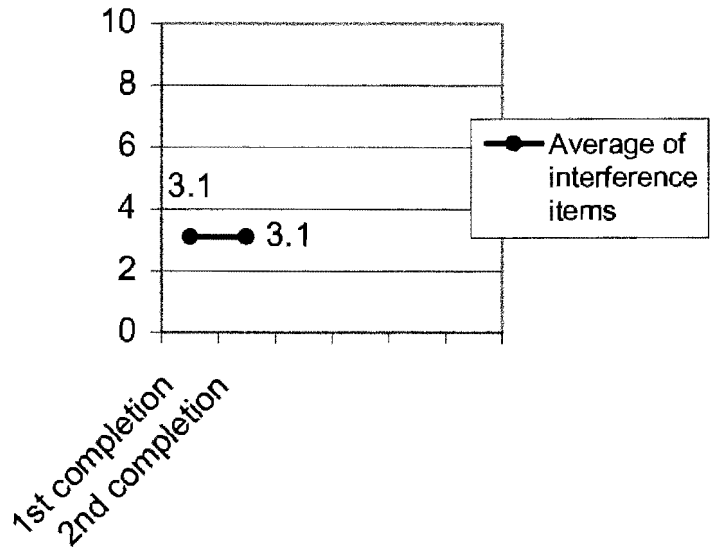

Figure 4.52 Second completion of the BPI by Nick: Pain Interference score

Nick was asked to make himself comfortable and to concentrate on his breathing. I suggested that his eyes appeared to be getting heavier and, at this stage, he closed them. It was suggested that he should "become unaware of the chair" he was sitting on and allow himself to become more and more relaxed. I pointed out that his head was moving slightly and commented that

maybe his head felt heavy. His head then dropped slowly. I pointed out that his arms might begin to feel heavy too. After a few moments, I picked his right arm up and commented on how heavy it felt.

Nick was asked to imagine a staircase and to imagine descending the staircase to a place he imagined to be safe and comforting. Nick indicated by nodding his head that he had reached this imagined place. I commented on how relaxed he appeared to be and asked him to focus and to notice the details of how he felt at that moment and to be very aware of what it was like to be in this state. He was instructed to try and find a name or word that applied to how he was feeling at that moment. I asked him to raise his right index finger when he had found a name and felt ready to come out of trance. His breathing became lighter and quicker and that appeared to be an indication that he was ready to come out. I suggested that he walk back up the stairs and that when he reached the top he should open his eyes in his own time. He was asked to remember the name he had given to what he felt, so that we would be able to evoke that feeling again in his body.

The next session with Nick was scheduled for the following Tuesday evening in their home.

Second hypnosis session

The session began with Nick completing the BPI for the third time (see figure 4.53 and 4.54).

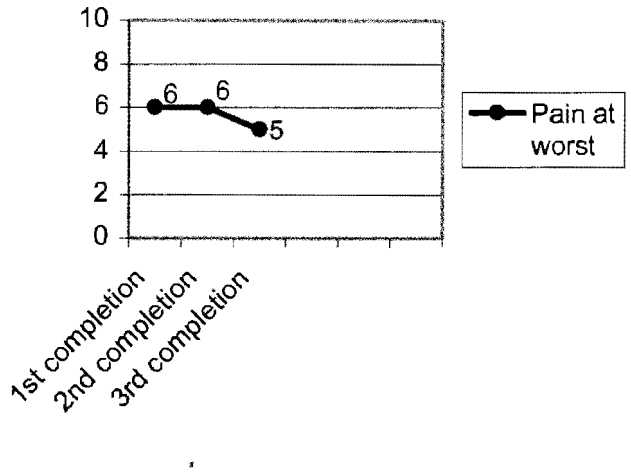

Figure 4.53 Third completion of the BPI by Nick: Pain at worst rating

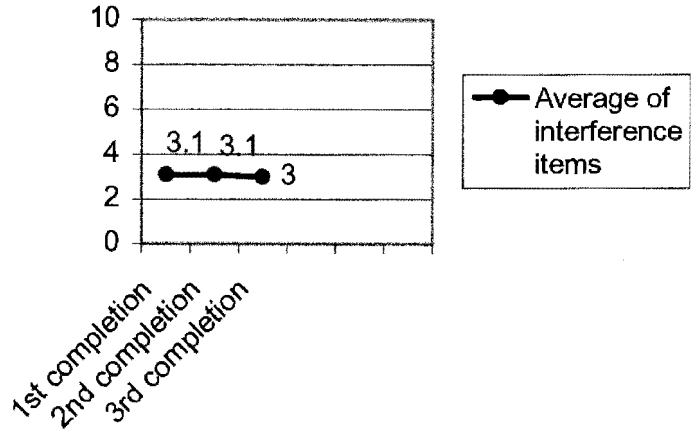

Figure 4.54 Third completion of the BPI by Nick: Pain Interference score

Nick spoke about his experience of the previous week. He stated that he had felt very relaxed and "very removed". He had named what he was feeling "release". Nick said it felt strange to let go, but he also felt "relieved".

Nick was instructed to make himself comfortable. He was then asked to relax himself by closing his eyes, focusing on his breathing and allowing a sense of heaviness to develop throughout his body. He was told that "at the

appropriate moment" he would be aided in extending the relaxation into hypnosis.

Once Nick indicated that he was relaxed, he was instructed to use the name he had found during the hypnosis the week before to "go to his special place". Once Nick indicated he has reached this imagined place he was instructed to focus his attention on his lower back. Nick was asked to become very aware of any pain present in his back and to focus his attention on it, instead of away from it as he usually did. I suggested that Nick "give the pain a colour" so that it would be "easier to focus on it". Nick stated that the pain was red.

I commented to Nick that he was aware that pain could move in your body, as a lot of the pain he suffered was referred pain in his leg. I commented that maybe we could use the "fact" that pain could move to his benefit. Nick was asked to imagine the pain in his back starting to move and to visualize the redness start to move up along his spine, carrying all the pain with it. Nick was asked to visualize the pain moving up his spine, into his right shoulder and then down his right arm. He was asked to visualize the pain flowing into his right hand and, as it did so, to physically form a fist around it. Nick was asked to imagine gathering all the pain into that hand and to "hold it tight".

Once Nick indicated that he had "collected all the pain" in his right fist, he was instructed to open the fist and visualize all the redness flowing out of the hand, carrying the pain with it.

On completion of the exercise, Nick was requested to present the following suggestion to himself: that during the coming week, whenever the pain was particularly bothersome, he would at any time be able to use this image of the clenched fist during self-hypnosis. Nick was then asked to open his eyes in his own time.

Nick's breathing became shallower and he opened his eyes. He was instructed just to sit quietly for a moment and notice how he felt different. He stated that his major feeling was again one of release and relief.

Nick was instructed to work on his breathing, going to his imagined safe place by using "his word" and the clenched fist exercise at home. He was instructed to notice through the week how he felt different and how the pain felt different.

The next session with Nick was scheduled for the following Tuesday evening in their home.

Third Hypnosis Session

The session began with Nick completing the BPI for the fourth time (see figure 4.55 and 4.56).

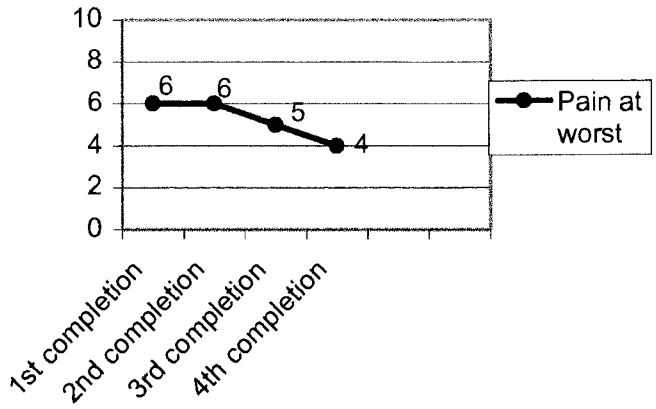

Figure 4.55 Fourth completion of the BPI by Nick: Pain at worst rating

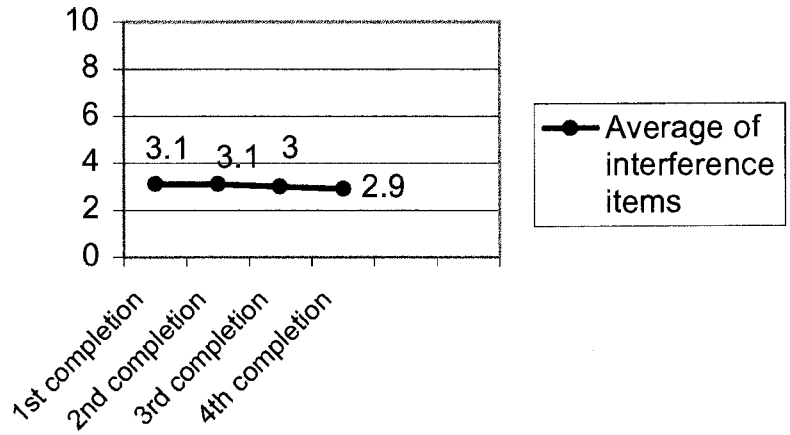

Figure 4.56 Fourth completion of the BPI by Nick: Pain Interference score

Nick reported that the practicing had been very successful and that he was sleeping slightly better due to his practicing just before going to bed at night. He experienced the same feeling of release each time he practiced. He stated that it was a different feeling for him as the feeling he normally associated with the pain was one of fighting it off and keeping it at bay. He felt he could now rather face it and release it. This left him feeling calm instead of tired.

Nick "hypnotized himself" as in the previous session and used the clenched fist exercise. He was complimented on the ease with which he had learnt to hypnotize himself and instructed to persist with his self-hypnosis exercises, which would increase his ability to relax more quickly and deeply.

The next session with Nick was scheduled for the following Tuesday evening in their home.

Fourth hypnosis session

The session began with Nick completing the BPI for the fifth time (see figure 4.57 and 4.58). He stated that he had one particularly good day when he had experienced almost no pain. The average for the Interference items was lower due to Interference with Sleep dropping from a ten on the first completion to a rating of six on this completion.

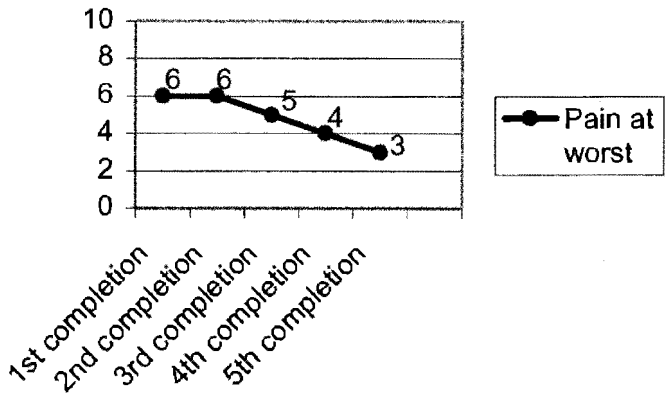

Figure 4.57 Fifth completion of the BPI by Nick: Pain at worst rating

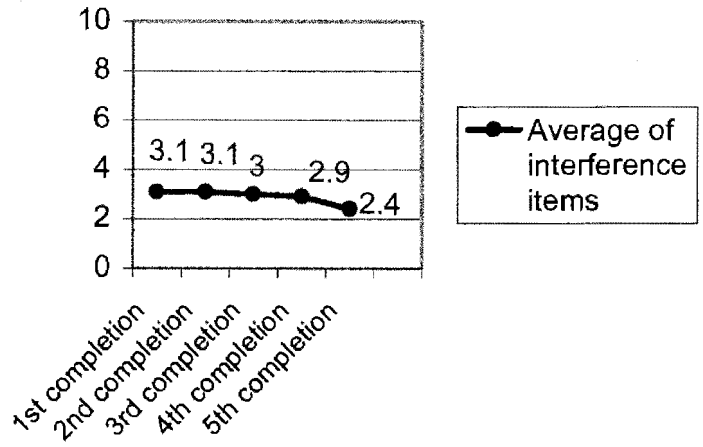

Figure 4.58 Fifth completion of the BPI by Nick: Pain Interference score

Nick hypnotized himself as in the previous session. I commented afterwards that "self-hypnosis" was a skill that he could use whenever he needed and complimented him on his inner strength and determination, which would ensure that he continued to cope with the pain in the future. It was agreed that this be our last hypnosis session. A feedback session was scheduled for two weeks time with Nick in their home.

Feedback session

Nick reported that he was still practicing daily. He stated he had become as addicted to "self-hypnosis" as he was to his exercise routine. He felt that "self-hypnosis" was a worthy skill to have "in his arsenal" and that it had definitely become part of his "team".

Metaperspective

From an ecosystemic viewpoint, it was necessary to create a hypnotic experience that would be congruent with Nick's expectations and fit with

these. In this context, breathing and eye closure seemed to be agreed to be appropriate induction behaviors and served as a punctuating ritual. In the same way a return to natural breathing and opened eyes seemed to serve as a waking-up ritual. The post-hypnotic discussions about the hypnotic experience further served to confirm the experience as hypnotic.

Nick's interest in hypnosis was to acquire a skill and, therefore, the sessions concentrated on "teaching him" the skill of "self-hypnosis". Nick also wanted to be able to face his pain, instead of avoiding it. He, therefore, needed to focus on and become aware of any pain present in his body and then "do" something about it. In the first hypnosis session, Nick associated the word "release" with what he was feeling. This opened up the therapeutic possibility of introducing an image to help him "release" the pain. As a result, the clenched fist exercise was used, and proved to be very effective.

With regard to the BPI, Nick's Pain at Worst rating had dropped from a six on the first completion to a three on the final completion. His Pain Interference score had dropped from a 3.1 to a 2.4.

4.6 HANNES

Hannes had been suffering from lower back pain for just over seven months at the time of the first session. His neurosurgeon was unable to find a definite cause for the pain and was advocating conservative treatment, which included a week in hospital for traction. Hannes expressed anger at the doctor and felt he was "not taking my problem seriously enough" and that the doctor was "not

doing enough". Hannes's primary treatment at the time of the first session consisted of medication and physiotherapy. Hannes admitted in the first phone call that was only "doing this" because his wife felt he was "doing nothing to get well".

Hannes and his wife, Elize, attended the first session held in their home on a Wednesday evening. Although the whole family had been requested to attend the first session, Hannes stated he didn't see why their teenage son had to be there, as his pain had "nothing to do with him".

MMFF Assessment

The MMFF was used to determine the level of family functioning in the six areas. The MMFF was started during the first session and completed the following Wednesday evening in the second session.

Roles

Hannes's occupational role had not been affected beyond the week he spent in hospital in traction. What was problematic was that he would go to work, but then arrive home and withdraw and engage in protective behaviour. He complained that he was "too sore" to do anything in house, or go shopping, or take his son anywhere.

With regard to life skills development, Hannes appeared to have lost interest in his son and his son's education. Elize appeared to carry the major

responsibility for their son, with Hannes appearing to only step in when she insisted upon it, and then without enthusiasm.

With regard to affective roles, Hannes appeared to have withdrawn from family life. Elize complained that he was "extremely distant" and hardly ever spoke to her or their son anymore. Hannes had taken to sleeping in the spare bedroom when his back was sore and Elize felt he had lost all interest in their intimate life. She stated that she found it disturbing that he seemed to have so little interest in their welfare. Hannes did not seem perturbed by this statement and made no effort to contradict it.

This family appeared to be characterized by a major shifting of responsibilities from the husband to the wife. Hannes was so preoccupied by his own misfortune that he has seemed incapable of fulfilling any affective function in the family. Elize appeared to be finding it difficult to respond to the increased demands of her son for love and attention.

Communication

Elize had already stated that Hannes had all but stopped speaking to her and their son. As Hannes had withdrawn so much, she and her son had also stopped making the effort to speak to him. Elize stated that she felt like she was speaking "at" Hannes, instead of "to" him, and that it was like "one-way communication".

Elize found herself in the situation of wondering whether Hannes was sick or not. The doctor was unable to find a definite cause for the pain and he was always well enough to go to work, but not well enough to do anything at home. Her doubts were, however, never verbalized and she felt guilty about even having such doubts. Elize also did not express her anger at having to take over so many responsibilities from Hannes. She appeared to live in silent resentment toward Hannes.

Prior to this session no discussion about Hannes's back pain and its negative consequences on their relationship had taken place. Hannes spoke little during the completion of the MMFF and it was Elize who answered most of the questions. Elize appeared to enjoy being able to express how she felt and the difficulties they were encountering.

Affective involvement

The relationship between Hannes and his family appeared to be characterized by an absence of involvement. Hannes continued to be the primary provider, but other than that appeared to only eat and sleep in the house, often in a separate room to Elize.

Affective responsiveness

Elize found it difficult to express caring or concern for Hannes because he "shut himself off" from her. She also felt that he demonstrated little affection and concern for her. Elize stated that she felt "pushed away" and had taken to "keeping her distance" from him.

Problem solving

Although this family appeared to be experiencing problems in the instrumental and affective areas, Hannes blamed all his current problems on the pain. He felt that "everything would be better at home if the pain could be taken away". Roy (1984) states that this attitude acts as a deterrent against the family's willingness to engage in therapy, because the patient insists that if the pain could be removed, the family problems would evaporate. Such patients deny family problems, yet the continuing and unresolved difficulties in the families of such patients are evident.

Hannes appeared to be firmly entrenched in the sick role and was no longer involved in the decision-making process. The onus of problem solving appeared to rest squarely on Elize's shoulders. Elize found herself forced into making an increasing number of decisions, without the benefit of his counsel and without him seemingly caring one way or another.

Behaviour control

This family appeared to demonstrate chaotic behaviour control with family rules subject to change. Elize tried her best to maintain order in the household, with no support from Hannes. She realized that at times she was overly strict with their son, but at other times she felt sorry for him and was overly indulgent with him.

The remainder of the second session was used to discuss the couple's expectations of hypnosis and to allow Hannes to complete the BPI for the first time.

Expectations of hypnosis

Hannes stated that he wasn't sure hypnosis could do anything for him and repeated that he was attempting hypnosis to "make Elize happy". If anything, he hoped that it would "take the pain away".

Brief Pain Inventory

Hannes completed the BPI for the first time (see figure 4.59 and 4.60).

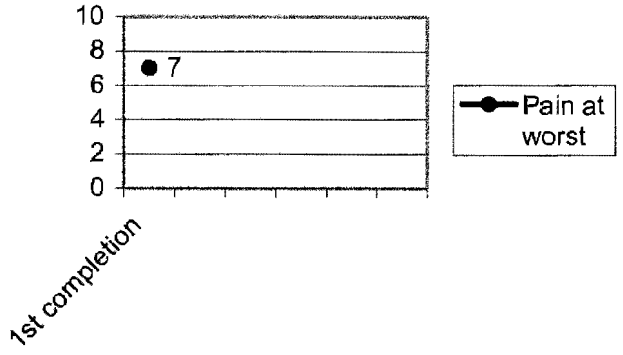

Figure 4.59 First completion of the BPI by Hannes: Pain at worst rating

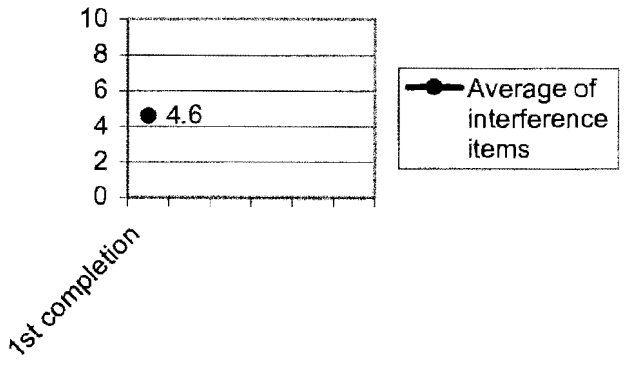

Figure 4.60 First completion of the BPI by Hannes: Pain Interference score

The third session (first hypnosis session) was scheduled for the following Wednesday with Hannes and Elize. However, on the Monday morning, Hannes opted to withdraw from the study. He stated that he had not enjoyed the first two sessions and said: "I don't see what my back pain has to do with any other difficulties I may be experiencing in my life." Hannes stated that he had decided that hypnosis might not be an "appropriate" form of treatment for him.

This case study was retained as it illustrates one of the possible problems identified in the research design stage, namely the possibility that the chronic pain sufferer would be unwilling to see the need for a psychological solution. Roy's 1989 study with 32 headache and backache patients, found that backache sufferers in particular were less inclined to accept that their pain problem could be linked to underlying psychological factors. Roy (1989) believes that by defining these patients' pain problems in psychological terms they may feel their problem is somehow being trivialised and not believed. Hannes already felt the medical community was not taking his problem

seriously enough and possibly felt that a psychological solution would only serve to confirm that his problem was not "real".

4.7 CONCLUSION

The first five cases reported above represent a sample of what is possible in ecosystemic hypnosis. The illustrations are presented not as "proof" of the effectiveness of ecosystemic hypnotherapy, but simply to illustrate this way of thinking and it's practical application in the treatment of chronic lower back pain problems. It is conceivable that a more experienced therapist might have conducted the therapy in different manner than that employed in the current study and might have obtained different, although not necessarily better, results. Although a feedback session was held, no claims can be made about the permanence of the therapeutic gains achieved. However, barring a sudden or dramatic relapse it would appear that an ecosystemically oriented approach to chronic lower back pain might have a wider application.

The following and final chapter sets out the implications that follow from the use of ecosystemic hypnosis as a treatment for chronic pain.

CHAPTER 5

CONCLUSION

Capra (1983) states that to understand and deal effectively with pain it must be viewed in its wider social context. The current study described the impact of chronic low back pain on each participant and his/her family system. From an ecosystemic perspective it is vital to examine how chronic pain is embedded in each individual participant's total ecology and to consider the possible meaning of and function served by each participant's pain before embarking on treatment. The MMFF provided an ideal preliminary basis for conducting an ecosystemic diagnosis of each subject's pain problem and it appeared to be helpful to administer it in the subject's natural environment. The Brief Pain Inventory proved invaluable for keeping track of treatment progress.

A number of possible problems were identified in the research design stage. The current study did not encounter any problems in getting the spouse of the chronic pain sufferer to attend. However, the possibility that the chronic pain sufferer would be unwilling to see the need for a psychological solution was found in Hannes's case.

All case studies showed the importance of using an approach that fits best with all involved. The current study attempted to take the context of each participant into account, including the subject's attributions, expectations,

belief systems, life circumstances and relationships. This is one of the current study's strengths. Had a quantitative approach been employed, individual's attributions of meaning would either have been lost or would have assumed statistical importance and the findings could have differed considerably from those of the current study. The subjects would also not have had the opportunity to make sense of their pain in their total circumstances.

In each case study the researcher spent time trying to understand the conceptualisations of hypnosis, held by the subject and his/her family member/s, as treatment had to fit with these conceptualisations. If the system expected hypnosis to involve relaxation, then that idea was capitalised on. Once hypnosis had been experienced, the researcher had to work with each system's experience thereof so as to perturb the consensual domain around pain.

The flexibility of the ecosystemic approach allows it to be compatible with more conventional forms of treatment. It will be noted that many of the techniques used in traditional hypnosis were employed in the presented case studies, such as hand levitation, eye closure and imagery. However, the thinking behind the use of these techniques represents the point of departure from traditional hypnosis. For example, hypnosis was used in this study to establish an experience of support, as in Dudu and Mike's case. Hypnosis was also something that the spouse or a relative of the subject could do, as in the case Dylan, Lindy and Kate, in order not to feel helpless or cut off. During

the entire process, the experiences of all individuals were incorporated into the therapeutic rationale through the use of feedback.

The current study appeared to have a number of shortcomings. Firstly, due to the limited sample size, no significant gender differences in the experience of chronic low back pain could be discerned.

As this study emphasised unique and personal contextual factors and used a descriptive, qualitative method, the study's second shortcoming is that the findings cannot be "proved" or verified by future replication. However, from a perspective that seeks to understand rather than prove, this is not considered problematic.

A further limitation of qualitative research is that the human mind tends to select data that fit with working hypotheses and initial impressions (Moon et al., 1990). The implication of this is that the themes and meanings elucidated by the researcher are not the only possible distinctions that could be made. Hence the meanings that readers attribute to the case studies may well differ from the researcher's meanings.

A further limitation of this study is that member checks were not conducted formally (Lincoln & Guba, 1985). This means that the participants were not provided with the research report to comment on. However, as meaning and outcomes were continuously negotiated in the sessions, informal member

checks did occur and were believed to be adequate in a study of this limited scope.

There exists an absence of published material documenting the use of ecosystemic hypnosis for chronic pain patients and, therefore, the acceptability of this approach is also a problem. The issue of acceptability is also complicated by the lack of specific therapeutic techniques or a plan of action, and there being no objective evaluation of treatment.

The current study appeared, however, also to have a number of strengths. Firstly, the current study was not interested in the etiology of pain. As Capra (1983) states, in practice it is frequently impossible to know which sources of pain are physical and which psychological. The advantage of using an ecosystemic approach is that it does not emphasize the origin of the subject's pain. An ecosystemically oriented approach allows for the development of an appropriate context wherein some degree of pain relief may be achieved regardless of the origin of such pain.

Each subject's pain complaint was, therefore, regarded as "real" and legitimate. This stance appeared to make it easier for the participants to talk about their pain problems. In many cases it appeared that the researcher was the first person to ever listen to a detailed account of the subject's pain in terms of where it began, perceived causes and possible solutions, the reactions of different family members to the problem, coping behaviours etc. This in itself appeared to be therapeutic. Each patient's pain story needs to be

taken seriously and be explored thoroughly. An ecosystemic approach may also capitalise on the client's ideas surrounding his/her pain. Information may be forthcoming in areas such as the subject's interpretation of the presumed cause and nature of his/her pain, possible reasons why he/she did not respond to previous treatment, and his/her outlook on the future regarding the pain problem.

A second strength of this study was that realistic treatment objectives were set. The permanent relief of chronic pain symptoms is rarely reported in the literature. In many cases, adjustment to continuing pain is a more attainable treatment goal than pain alleviation (Spinhoven & Linssen, 1989). The success of ecosystemic hypnosis in this study was not decided by its bringing about complete and permanent pain relief for the chronic low back pain sufferer. Ultimately, the effectiveness and viability of any ecosystemically oriented therapy for the chronic pain syndrome is determined solely in terms of whether or not it has facilitated the development of more functional patterns of interaction and relationships in the participant's ecology. The feedback sessions held with the families were important in this regard to gauge the individual attributions made by each person who came into contact with the research. Each participant needed to determine the relevance of the experience for him or herself, rather than the relevance being predetermined by a set of rigid research principles such as sample methods, data collection methods etc.

A further advantage of an ecosystemic approach is the attempt to fit treatment to the participant's ecology. No attempt was made in this study to impose a treatment solution in a linear manner and no attempt was made to force the participant's and his/her family's ideas into a particular conceptual framework. The researcher attempted to link with the participant's ideas about him/herself and about his/her specific problems. An ecosystemic approach to hypnosis is, as far as is known, the only approach which actively aims at utilising the family's attributions regarding hypnosis and no attributions are viewed as misconceptions (Fourie, 1992). An ecosystemic approach recognizes only conceptions and attempts to utilize these attributions in arriving at different and acceptable ways of viewing the problem.

Many chronic low back pain patients run the gamut of conventional treatment and are left frustrated because they have failed to respond to it. An advantage of an ecosystemic approach is that some form of therapeutic change is inevitable once more functional patterns of interaction have been initiated in the subject's ecology. As a result, the subject could be spared some of the costs and risks frequently associated with other forms of medical examination and treatment.

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APPENDIX A

Letter to Physiotherapists

Dear

I am presently conducting research for my Master's degree in Research Psychology on chronic low back pain.

I am seeking patients who are suffering from chronic low back pain to take part in this study. The proposed treatment consists essentially of hypnotherapy and/or guided relaxation techniques. Treatment sessions will consist of once-weekly meetings with the patient for a period of about eight weeks. Patients will, of course, be under no financial obligation whatsoever and, as I would prefer to see them at their homes, they will not even have to travel. Patients will also be free to withdraw from the study at any time.

If you have any suitable patients on your records that may be interested in participating in this project and you have no objection to such participation, I would greatly appreciate it if you could contact me at the telephone number or e-mail address listed below:

I thank you in anticipation of your assistance.

Yours sincerely

APPENDIX B

Letter of consent

Dear

Your cooperation in my Master's research project will be greatly appreciated. I am interested in finding out what effect your pain has on your day-to-day living, as well as on your family and others with whom you come into regular contact.

In exchange for your time and effort (which simply involves (a) seeing me once weekly for about one hour and (b) completing a short questionnaire each time), I hope to be able to help you to gradually gain some degree of relief from your suffering through the use of hypnosis.

Please note:

1. This is a genuine research project. Your physiotherapist would not have consented to your participation if this were not the case.
2. There is absolutely no financial commitment or obligation on your part
3. All information requested from you will be treated with the strictest of confidence. Your name will not be used for purpose whatsoever, nor will it be communicated to anyone not directly involved in the project
4. You are free to withdraw from the project at any time, although please bear in mind that your cooperation may someday help other pain sufferers such as yourself.

Please note that your signature below (a) frees me, as the researcher, from any liability regarding the outcome of treatment and (b) grants me permission to consult your physiotherapist in connection with your medical condition.

I look forward to meeting you and I hope our short association will be mutually rewarding.

Yours sincerely

I agree to participate in this research project.

NAME (Please print):_____ **DATE** _____

ADDRESS _____

TELEPHONE NUMBER _____ **SIGNATURE** _____

STUDY ID# _____ HOSPITAL # _____

DO NOT WRITE ABOVE THIS LINE

Brief Pain Inventory (Short Form)

Date: ____/____/____ Time: ____

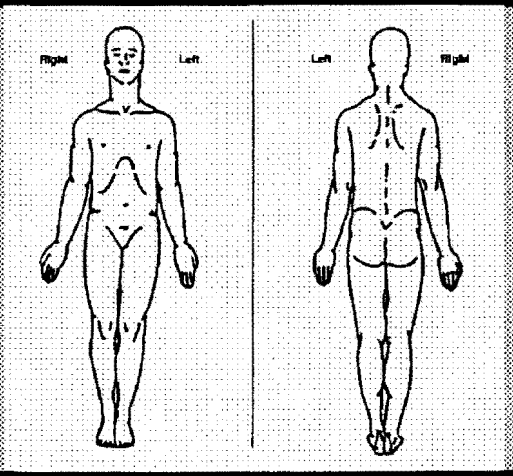
Name: _____ _____ _____

Last First Middle Initial

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these every-day kinds of pain today?

1. Yes 2. No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

4. Please rate your pain by circling the one nuimber that best describes your pain at its least in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

5. Please rate your pain by circling the one number that best describes your pain on the average.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

6. Please rate your pain by circling the one number that tells how much pain you have right now.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Pain as bad as you can imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No Relief										Complete Relief

9. Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

B. Mood

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

C. Walking Ability

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

D. Normal Work (includes both work outside the home and housework)

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

E. Relations with other people

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

F. Sleep

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes

G. Enjoyment of life

0	1	2	3	4	5	6	7	8	9	10
Does not Interfere										Completely Interferes