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AN INCOMING EDITORIAL

It was with a sense of great honour and considerable trepidation that I accepted the invitation to take over the role of Editor of *Contemporary Hypnosis* from Brian Fellows. Ever since its inception as the *Bulletin of the British Society of Experimental and Clinical Hypnosis* in 1979, Brian and the journal have been virtually synonymous. As a result of his hard work I have inherited a journal that is in very good shape, with a powerful and eminent international team of Editors and, as I have discovered, a considerate and supportive publisher. Brian is a very difficult act to follow, but I will try.

My first and most welcome task as incoming editor is to offer thanks and appreciation to my predecessor on behalf of the BSECH and the hypnosis community at large for his excellent and unstinting work, well beyond any reasonable call of duty, for the journal and the society. We are particularly pleased that Brian has agreed to continue to serve the journal as one of the UK Associate Editors. On a personal level, I value greatly the various helpful, and at times inspiring, contacts with Brian over the years. Not the least of these was my introduction to hypnosis via a demonstration by him at a BSECH workshop in the early 1980s, which he mentioned in his outgoing editorial. As I recall it, though, it was of an age progression, rather than the more traditional age regression, which for me made the demonstration all the more striking as it was unexpected. Overturning expectations and confronting orthodoxy have been constant themes and from the outset Brian has been an untiring campaigner for a non-state, or socio-cognitive, view of hypnosis. This has been reflected in the flavour of the journal and no doubt accounts for why so many non-state writers, notably Nick Spanos, have felt so at home in its pages. I hope they will continue to do so, though sadly Nick will no longer be one of their number.

A BRIEF LOOK FORWARDS

Whilst it would be difficult to overestimate the beneficial influence of the socio-cognitive perspective in sharpening up our understanding of hypnosis and the way in which we investigate its phenomena, we should not ignore other important movements. For example, there have been significant advances in what we know of the neuropsychophysiology of hypnosis, and in particular of hypnotizability (e.g., Crawford and Gruzelier, 1992); advances that might herald the emergence of a 'neo-state' movement in hypnosis. Just how far Chevreul's pendulum will swing remains to be seen. What is most important though is that there is a growing realization that, as in all good dichotomies, the truth lies somewhere between the two extremes. In the state versus non-state (or special process versus socio-cognitive) debate, as with the broader dichotomy of nature versus nurture, we are all really interactionists at heart, though we may argue over the emphasis we should place on the two constituent processes. Where we place the emphasis, and to what degree, is dependent on our own predilection and also on the particular phenomenon we are attempting to understand. The view that we should abandon dichotomies and speak instead of points on a

continuum has been very ably articulated by Irving Kirsch and Steven Lynn (1995) and I will not pursue it further here. Instead, I will use this as an appropriate point to underline the journal's commitment to all points on the continuum and, with that in mind, to welcome John Gruzelier as a UK Associate Editor.

When something is working well it is best not to try to fix it, and my major commitment to the future of *Contemporary Hypnosis* is to maintain and build on what has been already achieved rather than to tinker with the basic machinery. The journal receives a regular flow of strong academic and research papers from international authors. I look to the UK Editors, the American and Australian Editors and to the Consultant Editors to continue their excellent work in maintaining that flow. In addition to Main Papers I shall continue to encourage the publication of well-documented Clinical Reports, Book Reviews, Comments, Tributes and Brief Reports of various sorts, as well as maintaining the tradition of inviting Discussion Commentaries from reviewers and other experts on the Main Papers. More recent innovations such as publishing regular Abstracts of Current Literature and the Proceedings of the BSECH Annual Conference in the journal will also continue. The first set of proceedings published in the journal were of the 1994 conference and were edited by John Warren and myself as Volume 12, Issue number 2 (1995). It is an interesting coincidence, if it is a coincidence, that my first editorial should accompany the second set of conference proceedings to be published here. In connection with the latter, I would like to thank the reviewing panel for all their hard work in refereeing and commenting on the papers included in these proceedings. I would also like to take this opportunity to extend a vote of thanks to all the other reviewers who have worked for the journal over the years. I propose to publish an annual list of the names of everyone who has reviewed papers in that year – in the past, many of you have worked without public recognition, but be assured your efforts have been much appreciated.

Finally, the journal depends for the future on material submitted by you for publication. I look forward to hearing from you.

David Oakley

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OPTOMETRIC USES OF HYPNOSIS

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ABSTRACT

The literature on optometric uses of hypnosis is reviewed. Probably, the most common uses are for patients with contact lens phobias and for those with intractable diplopia. This is double vision that does not respond to treatment and usually results from paresis of eye muscle(s) following trauma, a neurological lesion, or unsuccessful surgery. Attempts have also been made to use hypnosis to treat other optometric conditions, including refractive error, strabismus, amblyopia, and nystagmus. Only a few optometrists practise hypnosis and clearly such work should be confined to areas of their own expertise.

INTRODUCTION

Optometry is the largest eye-care profession in the UK and most optometrists work as primary health-care practitioners carrying out eye examinations in the community. These examinations aim to: detect ocular pathology, determine refractive errors, correct refractive errors with spectacles or contact lenses, and detect and correct orthoptic anomalies. Only qualified practitioners who are registered with the General Optical Council can practise as optometrists and disciplinary procedures analogous to those for the General Medical Council and General Dental Council apply.

For many years, imagery has been a prominent feature of the treatment of strabismus by eye exercises (Cantonnet & Fillozat, 1938; Giles, 1943). Pattie (1936) reported attempts to produce uniocular blindness by hypnotic suggestion and Way (1958) described the first use of hypnosis for contact lenses by Milton Erickson.

A detailed review of the literature (Haas, 1981) stresses the need for a thorough assessment of the optometric status with a full eye examination before hypnosis. If a 'psychological overlay' is suspected then the optometrist should refer the patient. The literature shows that many varied methods of induction and deepening have been used in the treatment of visual problems.

ORTHOPTIC ANOMALIES

Orthoptics is the study, diagnosis and non-operative treatment of anomalies of binocular vision (poor co-ordination between the two eyes). Orthoptics is practised by optometrists in primary care and also by hospital orthoptists who usually work with ophthalmologists in secondary and tertiary care centres.

Strabismus (squint) occurs when the lines of sight of the two eyes are not directed towards the object of regard. Strabismus can be caused by a weak eye muscle (incomitant), or may be concomitant (the same in all positions of gaze).

The development of strabismus in an adult is usually associated with double vision (diplopia). Young children generally make sensory adaptations to a strabismus, which prevent diplopia but also have the undesirable effect of causing the strabismic eye to become 'lazy' (amblyopic). An amblyopic eye is one that has poor vision without any apparent lesion of the eye or visual pathway and which cannot be corrected by optical means. Rarely, strabismus can be a sign of ocular pathology and this possibility must always be excluded. Spectacles, eye exercises, and surgery are all used to treat motor fusion (to correct the deviation) in strabismus and exercises are frequently used to treat sensory fusion (e.g., to alleviate diplopia and suppression).

Uses of hypnosis in orthoptics

Sowden (1952) used post-hypnotic suggestions (PHS) to encourage patients to concentrate and take more interest in their exercises. Rusk (1955) suggested that hypnosis helped through enhancing 'mental effort'.

In cases of strabismus that are caused by a contraction of the ciliary muscle, which focuses the eyes (accommodative strabismus), some authors have used hypnosis to suggest paralysis of the ciliary muscle and hence to control the strabismus (Sowden, 1961; Wheatcroft, 1937). Wheatcroft (1937) used hypnosis to inhibit or reactivate sensory fusion and Sowden (1952) claimed that motor fusion was enhanced in the hypnotic state. Both Rusk (1955) and Browning, Quinn and Crasilneck (1958) used hypnosis to treat amblyopia.

The method that was adopted by Sowden (1952, 1961) was, following a detailed eye examination, to see patients weekly for up to 20 weeks for hypnosis. For patients who could open their eyes whilst hypnotized he used a mirror to demonstrate to patients under hypnosis that they could make their eyes appear straight. Sometimes he regressed the patient to a time before the strabismus. To treat amblyopia, Sowden (1961) used several deepening techniques including itching of the hand, limb catalepsy, and anaesthesia. He would then promote an amblyopia of the 'good eye' to demonstrate that hypnosis can cause 'mental suppression'. He would explain that the amblyopia in the strabismic eye was also the result of mental suppression and would suggest that the hypnosis would alleviate this. Although Sowden (1961) believed that there was a direct relationship between the depth of hypnosis and the speed of cure, Wheatcroft (1937) believed that a light trance was as effective as a deep trance.

More recently, Lask (personal communication) used hypnosis at the Institute of Optometry, most commonly to treat patients with intractable diplopia. He preconditioned patients to believe that only a few visits were necessary and created the PHS that the unwanted image can be suppressed. Sometimes he eliminated the diplopia with the eyes open when hypnotized and also occasionally used age regression.

CONTACT LENSES

Optometrists commonly use comforting suggestions to relax potential contact lens patients and several authorities have gone further and advocated the use of hypnosis to relax and motivate patients (Barnard, 1989). Kroger (1977) used hypnosis to misdirect patients' attention away from a lens being placed on their eyes (e.g., 'you will feel your watch on your wrist'). Bair (1972) used hypnosis to relax patients with a history of fainting, as did Farkas and Kassalow (1971) to reduce excessive watering of the eyes. Hypnosis can be used to create corneal anaesthesia (Sowden, 1961), although this could mask a lens-induced adverse effect (Farkas and Kassalow, 1976).

Whilst positive suggestions without formal hypnosis are often adequate (Barber and Malin, 1977), a deep hypnotic state may be necessary if patients are to practise lens insertion under hypnosis (Farkas and Kassalow, 1969). Vics (1960) felt that patients needed to be intelligent, willing, imaginative, and 'free from fear'. Contrastingly, Farkas and Kassalow (1971) felt that hypnosis was useful for patients who had a phobia about having contact lenses inserted. Vics (1960) argued that the optometrist should be the 'sole operator', whilst Farkas (1974) advocated hypnosis as an aid to transferring control to a clinical assistant.

Cohen (1968) described several case histories, including a patient with blepharospasm (a spasm of the muscles in the eyelids). Another patient, who had discontinued contact lens wear after scratching the eye, was able to resume contact lens wear after three sessions of hypnosis. Paris (1975) described a 26-year-old female who wanted contact lenses but who had a phobia about touching her eyes. She was reminded under hypnosis of how unpleasant her thick glasses were and how much she wanted contact lenses. PHS referred to how resilient her eyes were and how she would have no trouble wearing and handling the lenses. The patient returned in a week, rapidly learnt handling, and successfully wore contact lenses.

REFRACTIVE CORRECTION

Bates (1920) proposed a method for correcting refractive errors without spectacles. He believed that long- and short-sightedness were due to a change in the shape of the eye caused by the stress of focusing on near or distant objects. His system of treatment places considerable emphasis on methods of relaxation and LeCron (1951) used hypnosis to enhance this relaxation. However, research has failed to consistently support the hypothesis that accommodation (focusing) is involved in the aetiology of myopia (Rosenfeld, 1994).

Although there have been many studies investigating whether myopia can be treated by hypnosis, these have generally been poorly controlled (Haas, 1981). Although some studies have found an improvement in the subjective variable of visual acuity there is no evidence of a positive effect on the actual refractive error. Harwood (1970, 1971), in a controlled study, found that subjects generally showed a small improvement in visual acuity of about 15%, which he attributed to increased motivation and concentration. At times, subjects also demonstrated a marked improvement in acuity. Harwood attributed this to 'shifting of the perceptual mechanism to a different set of clues for the discovery of the essential information which leads to the identification of the target'.

More research is needed on genuine cases of myopia, and placebo-controlled trials using automated refracting instruments would be useful. One review noted that there has been an increased interest in the application of behaviour modification to disorders of vision and also reviewed some studies on hypnosis (Rosen, Schiffman & Cohen, 1984).

OTHER OCULAR USES OF HYPNOSIS

Kenitz and Van Scotter (1958) and Erickson (1965) used hypnosis to dilate pupils, which is necessary for some types of ocular examination. Chase (1963) attempted to treat a case of nystagmus (a regular, repetitive, involuntary movement of the eyes) with hypnosis. Hypnosis altered the form of the eye movements, but failed to improve the visual acuity. Erickson (1954) and others have used hypnosis to treat

hysterical blindness, and Sackeim, Nordlie and Gur (1979) put forward a model linking hysterical and hypnotic blindness. In view of the possibility of psychological factors causing this condition, such cases should not be treated by optometrists but should be referred to appropriate specialists. Many authors have used hypnosis in the control of pain during eye surgery (Lewenstein, Iwamoto & Schwantz, 1981), and Barnard (1989) used hypnosis instead of anaesthetic drops in applanation tonometry (a test to measure the pressure in the eye). Hypnosis has also been used in the control of headache by many practitioners (Haas, 1981), although in view of the possibility of an ocular aetiology it is advisable to have a full eye examination first.

CONCLUSIONS

Clearly, there is a place for hypnosis in optometric practice, but it is probably not needed by many patients. Optometrists should only treat cases that are within the scope of their own expertise and should exclude the possibility of active pathology and refer patients with any signs of psychological abnormalities (e.g., neuroses).

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