HYPNOSIS AND BROAD-SPECTRUM BEHAVIOR THERAPY FOR BLEPHAROSPASM:
A CASE STUDY

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Abstract: This study describes the apparently successful treatment of a case of blepharospasm (severe eye-blink tic). The blepharospasm apparently did not respond to analytic psychotherapy which had previously been attempted. The dynamics and etiology of the symptoms seemed clear to the previous therapist, present therapist, and to the patient. Combining hypnosis and behavior therapy in a manner calculated to strengthen the ego appears to have been the critical therapeutic intervention.

The patient was a small, but chunky, 45-year-old white, divorced female who was referred for hypnotherapy because she had failed to respond to a variety of medications and intensive insight-oriented psychotherapeutic procedures over a 2½ year period. The major presenting symptom, which had stubbornly resisted treatment, was a blepharospasm or severe eye-blink tic. The symptom had started about 2½ years before and it apparently had grown progressively worse. By the time of the referral, the patient could not drive, could not walk outside her home unassisted, and had to be led into the office by a female friend. Apparently, the rate and duration of the blink was so high that the patient's eyes were closed most of the time. She was, for all practical purposes, blind outside her home. The patient explained that she wore dark glasses because the sunlight bothered her eyes. After she was helped into a chair and her female friend had withdrawn, reluctantly at my request, the patient was asked to remove her dark glasses, which she did under protest. In the first two sessions she recounted the following history.

When the patient was a child, her family (mother, one younger brother, and herself) had been abandoned by her father. The patient described her father up to the point of his departure as a "loving" and industrious man. She did not expect him to "take off," and she never found out why he abandoned his family. Because the patient was the

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oldest child, she had to quit high school, which she dearly loved, to support the family by working at a job which she had held until the time of her present symptoms.

At the age of 25, she married a man who was active, as she was, in the youth program of the Fundamentalist Christian Church she attended. Although she was “allowed” to keep her job all through her marriage, her husband dominated their social and recreational life. All her hours away from work and her vacation were spent doing the things he valued with the friends he liked. Their social and sexual relationships were always on his terms. She apparently responded to this situation by becoming increasingly absorbed in her work, in the youth camp, and in scout activities connected with their church. She had recognized during her previous therapy that conflict was very aversive to her and that she avoided it. In retrospect, she recognized that, over the years of marriage, she and her husband had drifted further apart but neither of them had taken the initiative to try to stop the process. She also felt that he blamed her for not becoming pregnant, although they were never certain as to who was the sterile member of the marital unit.

After about 5 years of infertility they decided to raise foster-children, but her husband would permit fostering only of older girls between the ages of 10 and 16. Together they raised several female foster-children. After about 12 years of raising foster-children, the patient refused to have any more of them in her house, mainly because she felt that she and her husband had never had any time together by themselves. She recalled that before the foster-children there were the church and other activities which had kept them apart. At this time, an attractive, young, female adolescent needed a foster home, but the patient was opposed to taking her in. The patient claimed that her husband insisted and told her that, unless she accepted the girl, he would move out and raise the girl himself. At this point, the patient backed off and reluctantly accepted the girl into her house. The patient resented the young girl right from the beginning and never established a close relationship with her as she had done with the previous foster-children, although she recognized that this attitude only drove the foster-child and her husband closer together. She recalled that, over the years, the situation deteriorated to such a point that when she entered a room, frequently her husband and the girl would stop talking, which, of course, made the patient uneasy, uncomfortable and suspicious. She claimed that although she felt uneasy with this situation she did not know what to do to change it. The patient stated that her husband bitterly complained of her indifference to him and the girl. She suspected that her 46-year-old husband and the 16-year-old foster-child were closer than they should
be, but she never suspected that they were sexually intimate. Apparently, her passive resistance only isolated her even more in her own home and drove her husband and foster-child together. She was apparently too insecure to risk open conflict and possibly abandonment by her husband, as her mother had been abandoned by her father.

The patient wanted to think that her husband's interest in the girl was only "fatherly." One evening he told her that the girl was pregnant by him, that the two of them intended to move out of the house the next morning, and that he intended divorcing her and marrying the girl. The patient claimed that she took the "news" in stunned silence but did not try to prevent them from leaving the next morning. After they left, she attempted to kill herself in the garage by starting the motor of the car with the garage door closed. Apparently, she fell forward on the steering wheel and activated the horn, alerting the neighbors. She woke up in the emergency room of a general hospital. Later she was moved to the psychiatric ward, severely depressed, and received a course of electroshock therapy. After her release from the hospital, she attempted to go back to work but was unable to function on the job because she could not keep her eyes open. The blepharospasm became progressively worse until one day, when she was driving to the grocery store, she became involved in a near-fatal accident. She sought psychiatric treatment again (chemotherapy and intensive psychotherapy) without positive outcome. Apparently, she accepted the symptom and developed a close relationship with a young, obese, female neighbor (Linda), on whom she had come to depend more and more to drive and to lead her around outside her house.

In time, she came to have a sexual relationship with Linda, but claimed that she played a passive role in this sexual liaison. At the time when she consulted the therapist, she was deeply into the sexual relationship with the young woman and was also leaning on her for nearly all her excursions outside her house. The patient had no social relationship apart from the one she had with this girl; her church and social activities had also ceased. She claimed that all her neighbors and church members uniformly blamed her ex-husband for the divorce and were full of pity for her. She felt vaguely uncomfortable with this outpouring of sympathy for her, but it did help her during the divorce to strip her husband of "everything" material that they had built together since they were married. It seemed to the therapist that she felt some sense of guilt for the way her marriage had drifted and for the harsh judgment her community had inflicted on her ex-husband, his infant, and young wife.

The patient's job and her friends used to be important to her, but
she was concerned that in the last 2 years so much had changed on the job that she did not know if she could cope with the changes. On two previous occasions, she had tried to go back to work on a full-time basis but her eyes had gotten worse and she had had to quit. I told her during the second session that I, as therapist, agreed with her that the work in the mail room was probably now too difficult for her to comprehend or to cope with but that, if she insisted on going back to work, I would require that it be on a part-time basis, if at all; I added that I would call the medical authorities at the plant and insist that she was too sick to be considered for any full-time employment and that, if she did not cooperate with me in these measures, I would have to terminate her treatment.

One aspect of the patient's non-verbal behavior which attracted my attention, even during her first session, was that the frequency of blinking seemed to increase when the patient was addressed but to decrease when she was addressing me. At the beginning of the third session of treatment the patient was asked what her immediate short-term and long-term goals were. After a few moments of silence, she stated that she wanted to be able to go places outside the home unassisted. Upon being asked if she could be more concrete and specific about what she wanted to be able to accomplish in the next 2 weeks, she stated that she would want to be able to (a) do her own marketing, (b) drive her own car, and (c) walk around her neighborhood unassisted. After a few moments of silence, I asked her what she would like to accomplish in the long run. After some delay and extended verbal self-exploration, she stated that she would like to be able to (a) pick up and complete her high school education at the point she had dropped it 25 years ago and hopefully secure a high school diploma, (b) return to work, and (c) become involved again in youth and social activities in her church. I told her that the idea of securing a high school diploma was a good and sensible one, but since she was on permanent disability insurance and apparently living well on it, I could see no reason why she should even contemplate returning to work. The patient appeared surprised at this response since she apparently expected me to pressure her to go back to work as had her previous therapists and employer. Apparently, there had been quite a bit of pressure to get her off disability status.

The patient again began to tell me how long she had worked at her previous job before her illness, how important it and her friends at work used to be to her, and how much she desired to return to work. It appeared that her anxiety regarding her ability to function on the job if she returned to work was at least one factor delaying her motivation to recover from the blepharospasm and that this avoidance was also
being reinforced by her disability status and checks. I, therefore, tentatively explored with her the possibility of systematically desensitizing her apprehension about returning to work and the work situation. When it became clear to the patient that she would have to learn progressive muscular relaxation, which apparently she regarded as a passive and supine interpersonal posture, she seemed resistant and insisted that she was the type of person who could not sit still in a chair and needed to be active and busy. In view of the clear message that she did not want to sit passively in a chair during systematic desensitization and because I had noticed earlier that activity on my part and passivity on her part seemed to increase the blepharospasm, it seemed that the only effective intervention in the short run would be one in which she played an active role and in which she felt that she was challenged. Of course, there is also material in her background to indicate that men were not to be trusted (her father and her husband) or be allowed much influence over her life.

It was made clear to her that I would not allow her to return to work immediately even if she should recover, thus decreasing the pressure to perform visually, which subjectively seemed very real to her. I decided to use a hypnotic intervention, which was what she had originally expected. Hypnosis was induced with the hand-levitation method and deepened with a procedure in which the patient counted backwards quietly in her mind from 20 to 0. When she appeared to be in about a medium level of trance, I said to her:

I want you now to recall the specific short-term goals you wanted to accomplish in the next 2 weeks. Please recall them now and concentrate on them. I want you to carefully think about each of them and to picture each one in your mind; to notice and to recognize how important it is to you to accomplish these steps you have described to me. I will now be quiet for a while and you can get into concentrating and picturing even more clearly these goals in your head.

After about 3 minutes of silence, I asked her to tell me, while still in the trance, what kinds of things she needed to do, in general, to accomplish the above three goals in the next 2 weeks. She stated that she needed to (a) act more "independently," (b) lean less on Linda, (c) get off the medications which she had been attempting to phase off for 2 years, and (d) forget her past and stop feeling sorry for herself. She was told to pick the easiest one of these four methods and to commit herself right now to implementing it. I told her that if she did so, she would require no help in walking into my office the next Saturday. In fact, each week she might want to commit herself to concentrating on working harder on changing the other three weaknesses in her life.
The patient walked into her fourth session unassisted but still wearing her dark glasses. After she was seated across from me, she removed her glasses spontaneously, sat back in the reclining chair (which she had never done in previous sessions), and smiled broadly at me. She opened the session by saying that her eyes were very much improved since she had decided to stop taking the medication. She stated that the medication had kept her mind “in a fog” and that not only could she see better now, but her mind “was much clearer and sharper.” She felt excited about putting her “brain to work” to secure a high school diploma; she reminded me that in adolescence she had always been a straight-A student and “her mind felt so bright now that she felt almost invincible.” The patient was given the name of the counselor at the local Adult Education Extension Center, and it was suggested that he might be a person who could help her start exploring the possibilities of returning to school. I did not probe into her explanation of her symptomatic improvement, but I closed the session by suggesting that when she was able to drive herself to my office, she would be approaching the point where she would no longer need to consult me. The purpose of this statement was to reinforce a specific treatment-goal and to indicate indirectly to her that I, as therapist, stood ready even now to return to her the influence over her which she had given me. The patient made no mention of hypnosis during this session, and hypnosis was not mentioned hereafter by either of us. We both knew that her medication had been altered and stopped several times before without symptomatic change, but neither of us mentioned this little inconsistency because it seemed we both recognized her need for this rationalization and had tacitly agreed to an innocent pact of mutual ignorance.

In the following 15 sessions, the patient made rapid changes in her life style. She enrolled in a 2-month crash program to prepare herself for the General Education Development test and graduated with the highest score made by anyone in her class. Her relationship with Linda deteriorated slowly as I helped her to focus on its unhealthy aspects and as her own sense of self-reliance and confidence surfaced. She walked into my office one day and told me that she had decided to clean out her closets and that she had found and burnt a lot of old letters from her ex-husband; letters that he had written her during and before their marriage. Christmas was approaching, and she said she felt lonely but had to get rid of these old memories. She was surprised that she did not weep more than she did while looking at the letters.

At Christmas she accepted an expensive gift from Linda and felt very guilty about doing so. After a few sessions of assertive training, she returned the gift to Linda. I noticed that, even though Linda continued
to drive the patient to the sessions, Linda no longer came into the waiting-room but would wait for the patient outside in the car. The patient and Linda shared a part-time job selling cosmetics door-to-door. The patient's role was to sit in the car getting the merchandise together while Linda drove from house-to-house and walked from door-to-door delivering the merchandise. Since the patient's eyes had improved, the therapist asked her if she would be willing to try driving the car on the short trips from house-to-house to give her the feel of being behind the wheel again. Even though the patient was clearly uneasy about trying to drive again because of her previous near-fatal accident, she agreed to try this "in vivo" desensitization procedure. By the twelfth therapy session she was doing all the driving on the cosmetics-selling route.

When the patient was under pressure at school, the blinking would worsen, but only temporarily, and she would complain that her mind felt foggy. Soon after she graduated at the top of her class, she asked me to explore the possibility of getting her back to work on a part-time basis. It was arranged to phase her back into the work situation gradually, and within a month she was again working full-time at her previous job. She now regularly drove herself to the sessions, and, by mutual agreement, it was decided that she would come only on a monthly basis.

The patient continued to make progress vocationally and socially. She was promoted on her job and had returned to social activities at church. The most striking change that occurred was in her attitude toward her ex-husband; her previous bitterness seemed to yield to a sense of real compassion for him and for his family. At this time she terminated treatment and joined an older-adult "social-dating" group.

Follow-ups done 6 months and 1 year after termination indicated the complete absence of the blepharospasm and no evidence of symptom substitution. In fact, the patient's life had expanded into several new social, vocational, and personal dimensions. While the initial therapeutic goal was symptomatic improvement, the focus of treatment shifted rapidly away from her symptom and toward enhancing and expanding the patient's intellectual and social skills, stimulating risk-taking behaviors and generally more self-affirmative behaviors, which enlarged and redefined her capacity for joy. The psychoanalyst who had treated the patient previously had interpreted her blepharospasm as symbolic of her reluctance to confront reality. The interpretation was probably quite accurate, but it seemed highly improbable that the patient would improve symptomatically until she was able to find an alternative resource (e.g., her "mind") around which to rally and concretize (e.g., a high school diploma) her discontent and restlessness.
with the cramped and stifling context of her life. Apparently, in some personally meaningful way, her intellect provided her with a point of reference within herself, which was fundamentally dependable and that enabled her to pick up a thread from her life which she had dropped 25 years ago and to go on to use it to broaden the base of her self-reliance and personal worth. It appeared that hypnosis catalyzed her previous therapeutic learning and focused her attention on her need to evolve alternative strategies of adapting to her loneliness. The behavioristic focus of treatment may have encouraged her to translate her previous therapeutic insights into the concrete and specific substance and shape of actions which behaviorally defined her commitment to intervene in her own life and which concurrently propelled her life forward. Research in psychotherapy has indicated the power of the concrete and specific dimension in therapeutic influence (see Truax & Carkhuff, 1964). The fact that the present therapist was a man, a reasonably dependable and trustworthy one, may have enabled the patient to vicariously complete “unfinished business” (see Perls, Hefferline, & Goodman, 1969) with her husband and father.

References
portementale visant à renforcer le Moi semble avoir été l'intervention thérapeutique décisive.