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SPECIAL ISSUE
HYPNOSIS IN AUSTRALIA:
A SAMPLING OF APPLIED CASE STUDIES FROM A
VARIETY OF PROFESSIONS

Nadine Pelling

Clinical psychologist, University of South Australia

The Australian Society of Hypnosis (ASH) is a not-for-profit organization open to all registered health professionals regulated by the Australian Health Practitioner Regulation Agency (AHPRA) as well as counsellors, speech pathologists, and social workers registered with one of their appropriate professional associations. Candidates for full membership with ASH must meet various criteria. One criterion involves demonstrating the ability to appropriately apply hypnosis in their specific professional context. Often this proficiency in hypnotic application is demonstrated via the submission of case studies or reports. This special issue presents a number of case studies that exemplify the use of applied hypnosis in various professional contexts in Australia. Most of the case studies presented were submitted by the authors to ASH in support of their membership applications. However, a few case studies have been provided by current members of ASH and/or other professionals familiar with hypnotic applications. Thus, some of the case studies presented are offered by professionals highly experienced in hypnosis while others are offered by professionals relatively new to the application of hypnosis in their professional area. Regardless, the variety of cases presented represents the diversity of how hypnosis is being applied across many contexts and addressing many different therapeutic areas in Australia.

Keywords: hypnosis, Australia, case study, case report, membership.

AUSTRALIAN SOCIETY OF HYPNOSIS

The Australian Society of Hypnosis (ASH) is a not-for-profit organization open to all registered health professionals regulated by the Australian Health Practitioner Regulation Agency (AHPRA) as well as counsellors, speech

pathologists, and social workers registered with their appropriate professional association. Specifically, those non-AHPRA regulated professionals listed on the Australian Register of Counsellors and Psychotherapists or having membership with the Australian Association of Social Workers or Speech Pathology Australia.

Candidates for full membership with ASH must meet various criteria and pay a fee. Criteria involve demonstrating being in receipt of appropriate hypnosis training, having obtained supervision of one's application of hypnosis, and being able to demonstrate proficiency in the application of hypnosis. Specifically, one criterion involves demonstrating the ability to appropriately apply hypnosis in their specific professional context.

ASH provides training courses in hypnosis throughout Australia. Since 1982 ASH has offered a Diploma in Clinical Hypnosis (Australian Society of Hypnosis, 2016). Other training providers similarly offer training ASH considers fulfils the training requirement for full membership. Correspondingly, various hypnosis practitioners are approved to provide supervision of applied hypnosis. Often the proficiency in hypnotic application in one's professional context is demonstrated via the submission of case studies or reports. It is the Australian application of hypnosis in various professional contexts that is the subject of this special issue.

Specifically, this special issue highlights a number of case studies that exemplify the use of applied hypnosis in various professional contexts in Australia. Some of the case studies presented are offered by professionals highly experienced in hypnosis while others are offered by professionals relatively new to the application of hypnosis in their professional area. Regardless, the following case studies are a sampling of how hypnosis is being applied in Australia to benefit the lives and functioning of clients and patients.

In the following special issue, the reader will explore hypnosis cases presented by psychologists, nurses, counsellors, and social workers. Johanna Saltis presents her work on analgesia with a severely depressed client while Catherine Mahoney describes how hypnosis was used to aid in treating exam related anxiety. How hypnosis using religious imagery can be used in repeated childhood nightmares is presented by myself and a colleague Travis Gee. Lisa McCall-Strafford then presents how hypnosis was used in pain relief in a client with multiple sclerosis. Paula Bonney notes healing via hypnosis with an adult child sexual abuse survivor. The use of hypnosis as an adjunctive treatment in metastatic cancer by Sally Swift is noted and Kokkwang Lim presents two cases involving academic anxiety and panic disorder, respectively.

Alpana Baruah discusses hypnosis as a support in a Clozapine cessation regime. Joseph Randolph Bowers discusses the use of hypnotic imagery in a culturally appropriate manner for Indigenous healing from transgenerational colonization trauma. Finally, James Auld reviews a book on self-hypnosis thus inviting various clients and patients to be the author of their own personal case study in the application of hypnosis. Together the articles published in this special issue present a “snapshot” of how hypnosis is being used across various professions and areas in Australia showing diversity in professional registration, context, and client related foci. Hypnosis is indeed a widely applicable and useful tool in treating clients and patients (Cowen, 2016) in use in various contexts across Australia and this is demonstrated in the current special issue.

CASE STUDY PUBLICATION RELATED INFORMATION

The Australian Society of Hypnosis’s journal, the *Australian Journal of Clinical and Experimental Hypnosis*, semi-regularly publishes case studies illustrating the use of hypnosis in various contexts and by various professionals. Case studies will only be considered for publication if they are de-identified, where the author can confirm that informed consent was gained from the client/s involved, and permission for publication from the client/s involved has been gained. Alternatively, composite cases are also sometimes presented for illustrative purposes. Cases noting the use of hypnosis for “entertainment” purposes will not be considered for publication. Thus, the publication of case studies in the journal conforms to various ethical standards across various professions in Australia and especially those held by ASH. If you wish to have a case study reviewed for publication and can assert that the standards of the society and journal have been upheld, please feel free to submit same for peer review. The society aims to publish a special case issue on a semi-annual basis.

REFERENCES

- Australian Society of Hypnosis. (2016). *Training courses*. Available <http://www.hypnosisaustralia.org.au/training-courses/>
- Cowen, L.W. (2016). Literature review into the effectiveness of hypnotherapy. *Australian Counselling Research Journal*, 10, 1–55.

THREE SESSION MINDFUL SELF-HYPNOSIS TRAINING FOR ANALGESIA IN A SEVERELY DEPRESSED CLIENT

Johanna Saltis

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This case study is of a 65-year-old man, Stuart, who was referred to the pain unit at a major public hospital in Adelaide, by his treating psychiatrist, requesting management strategies for chronic foot pain. His psychiatrist was treating comorbid symptoms of severe depression, requiring electroconvulsive therapy (ECT). Given the huge demand and long waitlists for pain clinic services, the benefits of developing a 3-session approach integrating self-hypnosis training with mindfulness practices was explored with Stuart's consent. The clinical findings from this case study indicate that integrating hypnosis with mindfulness practices may have a similar additive effect to that found when combining hypnosis with cognitive-behaviour therapy (CBT). Stuart reported surprise that he was able to generate a number of pain-free days, never experienced before. An additional unexpected and welcomed benefit was the emergence of imagery that appeared to assist Stuart in processing emotions associated with a past traumatic incident. Stuart reported that he could continue this new development with a psychologist in the private setting.

Keywords: hypnosis, chronic pain, self-hypnosis, mindfulness, hypnoanalgesia, automaticity, trauma recovery, major depression.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

Stuart was referred to a hospital-based pain unit by his inpatient psychiatrist. He had recently received ECT treatment for chronic depression which had its onset 10 years earlier. The psychiatrist requested pain management support for Stuart's four-year history of foot pain. At the time, the pain unit was offering three psychology treatment sessions to introduce patients to strategies such as: CBT, progressive muscle relaxation (PMR), mindfulness-based exercises (MBE), and self-hypnosis training. This enabled patients to pursue their most

favoured approach with an external provider. The following case study details Stuart's experience of three sessions that combined mindfulness exercises with self-hypnosis training for analgesia. The patient's name and any personally identifying features have been changed to maintain privacy.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Stuart presented as a casually dressed 65-year-old man, who was overweight. He maintained good eye contact and spoke gently with a pleasant manner. He reported having constant, unrelenting stabbing pain in both feet. He said that 10 years earlier an operation to repair torn tendons in both feet had successfully resolved the pain. Regrettably the pain had returned 6–7 years later and he was now requesting strategies to cope with the pain, if not eliminate it.

Stuart said he was living harmoniously with his 56-year-old wife of 30 years, denying any issues. They had two adult children in their twenties, both single and living away from home. He was one of three brothers. His mother was a healthy 88-year-old living independently. His father passed away 10 years earlier, aged 78, from complications of what was believed to be a suicide attempt. Stuart said that it appeared that his father had allowed a heavy bookshelf to fall on him. Although he reported that his family had since recovered from their grief, it is noted that his symptoms of depression emerged soon after the death of his father. Also around this time he had volunteered for an overseas managerial placement in a disaster zone and as a result had witnessed much loss of life, particularly of children. On his return to Australia, he worked as a manager in a drought-affected area. He was not aware of any intensification in his mood until an incident occurred in the workplace a few years later in which his supervisor recommended that he seek counselling for anger management. At this point, Stuart described experiencing intense disappointment at the level of disrespect he experienced in the workplace and feeling undermined by his supervisor, despite the loyalty he had shown to his job for the previous 15–20 years. He sought counselling and went on to resign from this position. Stuart reported that he had previously managed his 10-year history of depression with antidepressant medication and only recently had required ECT treatments to manage the intensification of symptoms. Although he continued to experience suicidal thoughts (with no intent), he was subsequently able to get out of bed and continued seeing his

psychiatrist. Despite reporting a lack of energy, he continued to exercise 30 minutes/day even though it did not generate the usual euphoria attributed to exercise. Regarding his burning foot pain, Stuart reported that physiotherapy had provided some relief which regrettably was not sustained. Stuart was a consistent historian and described how the chronic foot pain emerged after the onset of his symptoms of depression. Despite these challenges, Stuart reported retaining a close social network and an interest in a number of hobbies.

At the time of his referral to the pain unit, Stuart's subscale scores on the Depression Anxiety Stress Scale Scores-21 (Lovibond & Lovibond, 1995) fell into the moderately depressed and anxious range, and severely stressed range. Although Stuart denied any symptoms of psychosis or obsessive compulsive disorder, he reported a history of hearing the constant sound of comforting music in his head from the age of five. After the workplace incident, he started to hear a persistent and unpleasant Morse code in his head.

Stuart reported experiencing discomfort at the smell of water-logged material or rotting vegetables, which triggered flashbacks to the images of children whose lives were lost in the disaster zone a decade earlier. He denied having nightmares or abusing substances and a diagnosis of post-traumatic stress disorder could not be reached, at this stage, on the M.I.N.I. (a comprehensive DSM-IV based International Neuropsychiatric Interview; Sheehan et al., 2006). In the past four months he had noticed numerous worry thoughts, but considered these to be about "trivial" day-to-day matters. Completing the M.I.N.I. indicated symptoms consistent with:

- Major depression (onset 10 years ago; partial remission with recent ECT)
- Dysthymia (current)
- Agoraphobia (onset in childhood) and
- Generalised anxiety disorder (onset in the previous six-months)

Stuart rated his Present Pain Intensity on the McGill Pain Questionnaire (Melzack, 1987) as 6/10 and Overall Intensity in the feet as 3/5. He said that he no longer used Panadeine Forte as it was ineffective. His score on the Pain Self-Efficacy Questionnaire (Nicholas, 2007) fell into the suboptimal range, indicative of requiring pain management support. His Pain Anxiety Symptom Scale scores (McCracken, Zayfert, & Gross, 1992) fell into the normal range.

Therefore, Stuart's presentation appeared to be consistent with major depression, emerging after several stressors 10 years earlier. It appears that a recent workplace incident, combined with intrusions of disturbing recollections from time spent in a disaster zone 10 years earlier, had triggered unresolved

schemas around fairness and possible unresolved grief. This may have reduced his capacity to manage increasing foot pain, which led to an intensification of his depressive symptoms. A differential diagnosis of adjustment disorder with mixed depressed and anxious mood in the context of a delayed post-traumatic stress reaction to working in a disaster zone was also considered.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

The condition being targeted for a hypnotically based treatment in this case study is chronic pain, as it has been used with positive effect in a number of chronic pain conditions (Elkins, Jensen, & Patterson, 2007). Certainly, the use of hypnotic suggestions has been found to be more effective than relaxation alone in managing chronic pain (Dillworth & Jenson, 2010; Elkins et al., 2007). In addition, prevalence studies indicate that 12–35% of people with chronic pain also have a depressive disorder complicating its treatment (Holmes, Christelis, & Arnold, 2012; Miller & Cano, 2009). Integrating hypnosis with CBT has been reported to have an additive effect when treating depression (Alladin & Alibhai, 2007). It is thought that hypnosis can be used to disrupt old patterns of thinking that play an important role in the development of severe depression, as well as to consolidate the learning of new skills designed to increase a sense of self-efficacy and reduce the risk of self-harm (Yapko, 2010). Although some report that this additive effect is not seen when treating chronic pain (Edelson & Fitzpatrick, 1989), others have proposed that the CBT methodology being used in those studies has incorporated “hypnotic components”, for example, reframing pain sensations using terms such as “numbness” (Elkins et al., 2007). Furthermore, neuroimaging studies have shown that different hypnotic suggestions which lead to different subjective experiences in pain management are mediated by different brain regions (see review Saltis, Tan, & Cyna, in press).

Consequently, given the growing number of studies applying MBE to managing chronic pain and depression (Song, Lu, Chan, Geng, & Wang, 2014; Veehof, Oskam, Schreure, & Bohlmeijer, 2011), it was of interest to explore the effect of integrating hypnosis with these when treating Stuart’s chronic pain condition. This appealed to Stuart as he had planned to learn self-hypnosis from his anger management therapist prior to being admitted to hospital for ECT. During his admission, he had learnt a number of MBE and completed an on-line course. He went on to show a similar interest in

learning self-hypnosis while at the pain unit. Completing a variation of the Creative Imagination Scale (Wilson & Barber, 1978), Stuart demonstrated significant capacity for imagery and hypnotizability. It was proposed that the three sessions being provided by the pain unit could be used to build Stuart's capacity to become absorbed in both pain-related and non-pain related hypnotic suggestions for analgesia (Elkins et al., 2007).

TREATMENT PROGRESSION

Stuart welcomed the possibility of learning self-hypnosis to generate analgesia. The definition of hypnosis was provided as being a highly focused or *absorbed* state, in which a person is receptive to verbal *suggestions* made by another person (e.g., therapist) or oneself (e.g., self-hypnosis; Rainville & Price, 2003). As MBE was to be incorporated into the *focus* training sessions, Stuart was also provided with a definition of mindfulness as “paying attention on purpose, in the present moment, and nonjudgmentally” (Kabat-Zinn, 2003, p. 145). He was informed that both practices have been shown to stimulate neuronal plasticity and a reduction in the pain experience. He agreed to pursue the proposed self-hypnosis training program.

To create an exception to Stuart's experience of constant and unrelenting foot pain, the following therapy goals were set. The first goal was to engage in focusing exercises. Stuart was taught three brief MBE to assist with building his capacity for interoceptive awareness. These were the Slow Breathing Exercise, the Five Pleasant Senses Exercise (designed by the author and detailed in next section) and the Three Minute Breathing Space (Segal, Williams, & Teasdale, 2002). The second goal was to apply the interoceptive awareness skills to generate self-hypnosis. Concentrative focus (e.g., on the breath) and receptive focus exercises (e.g., PMR) were used, followed by an invitation to recall a memory of a beautiful place in nature and a deepening of this experience by inviting an exploration of the five senses in this memory. The third goal was to generate or deepen the hypnotic state by eliciting the hypnotic phenomenon of analgesia. This was achieved through either non-pain related hypnotic suggestion (i.e., PMR) or pain-specific hypnotic suggestion (e.g., the Dial Technique). The Dial Technique was modelled on the details provided by Elkins et al. (2007) which had its origins in Carich (1990), who developed the approach for clients with an eating disorder. In this approach, the client is asked to imagine a dial or lever (e.g., an oven or volume slide bar) showing a range of sensation intensity from zero (0) to ten (10), and allows the client to

progressively lower or increase the intensity through suggestion. The fourth goal was to generate a post-hypnotic suggestion (PHS), facilitating future access to these self-hypnosis skills. By generating the hypnotic phenomenon of *age progression*, Stuart was invited to imagine a future time when he could harness the Dial Technique to successfully generate analgesia outside of sessions.

Sessional content was structured around building Stuart's focusing skills. This was prompted by research studies that show the importance of focus and suggestion in managing chronic pain. These mechanisms would appear to be mediated through altering automaticity and interoceptive awareness. Studies have identified two types of focus: (a) concentrative and (b) receptive. The first requires a specific focus on the breath and extraneous stimuli are seen as distractions. The second refers to focus on the present moment-to-moment experience in sensations, thoughts, emotions and memories, including distractions (Jha, Krompinger, & Baime, 2007). Yapko (2011) has noted the experiential parallels between hypnosis and MBE, such as (a) orienting the client to their capacity to shift focus, (b) focusing attention from the general to the specific, and (c) generalizing statements that encourage continued daily practice akin to PHS. Furthermore, neuroimaging studies would indicate that the two approaches are mediated by the same systems (Grant, Courtemanche, & Rainville, 2011; Grant & Rainville, 2005), but not in all cases (Dumont, Martin, & Broer, 2012).

As noted earlier, shifting one's focus to pain-specific and non-pain related hypnotic suggestions would appear to be more effective than using relaxation alone for pain management (Dillworth & Jensen, 2010; Elkins et al., 2007). Integrating hypnotic suggestion with CBT (Alladin & Alibhai, 2007; Yapko, 2001), improves outcomes for 70–90% of clients (Kirsch, Montgomery, & Sapirstein, 1995). With mindfulness-based strategies being the current treatment of choice for managing chronic pain (Kabat-Zinn, 2003), there would appear to be no similar studies reporting the effect of integrating hypnosis with mindfulness practices (see also review by Lynn, Malktaris, Maxwell, Mellinger, & van der Kloet, 2015).

It has been suggested that receptive focus inhibits the tendency to respond automatically to stimuli, leading to improved "self-regulation of attention and emotion" (Bishop et al., 2004). The right anterior insula is activated during interoceptive awareness tasks (Critchley, 2005) and with hypnotic suggestion, leads to a moderated reaction to painful stimuli (Rainville, Duncan, Price,

Carrier, & Bushnell, 1997). Just as PHS (Linden, 2006; Raz, Fan, & Posner, 2005) and meditation (Kozasa et al., 2012) can inhibit the automaticity of word reading, mindful breathing can reduce the automaticity of a roving mind (Mrazek, Smallwood, & Schooler, 2012). In the present case study, the Slow Breathing Exercise, the Five Pleasant Senses Exercise and the Three-Minute Breathing Space, most likely facilitate the client's capacity to bypass the phenomenon of automaticity, in addition to stimulating neuronal plasticity during the learning process (Halsband, Mueller, Hinterberger, & Strickner, 2009). Neuroimaging studies indicate that regular *focus* practice leads to a more active (and thicker) prefrontal cortex (Lazar et al., 2005), along with a decreased sensitivity to pain (Grant, Countermanche, Duerden, Duncan, & Rainville, 2010).

Consequently, extrapolating from the research findings, it would appear that encouraging Stuart to learn sensory focusing exercises and self-hypnosis inductions will most likely stimulate neuronal plasticity. This has the capacity to reduce the automaticity of his roving mind and consequently reduce his sensitivity to pain. Integrating hypnosis with MBE is reminiscent of studies integrating hypnosis with CBT. The model presented here aims to produce a viable three-session training program for generating self-hypnotic analgesia.

ENGAGING IN HYPNOSIS

Initial Assessment Session

The first goal of engaging in a focus exercise was commenced at the end of Stuart's initial assessment session. In learning the Slow Breathing Exercise, Stuart was invited to breathe in to the count of three, hold to the count of three and breathe out to the count of three and repeat this cycle for one minute. He was then invited to practise this twice a day, between sessions. This exercise is reminiscent of the mindful breathing exercise (Mrazek et al., 2012) that has the capacity to reduce the automaticity of a roving mind.

Treatment Session 1

Stuart reflected on the Slow Breathing Exercise and indicated that it had had a "really calming" effect on him. His capacity to become absorbed in the moment was consolidated with the following two MBE: (a) Five Pleasant Senses Exercise (Saltis, developed in 2002), and (b) Three Minute Breathing Space (Segal et al., 2002):

1. The Five Pleasant Senses Exercise is an interoceptive awareness exercise that is reminiscent of the 5-4-3-2-1 Technique (see Appendix). It deliberately evokes the image of the Ancient Greek thinker Aristotle (384–322 BC), who proposed that we can know our world through our five senses (i.e., sight, smell, hearing, taste and touch). However, modern neuroscience research has shown that we have many more senses than this including information processed by the vestibular system. Vestibular sense organs, residing in the inner ear, assess our body position as it moves through space. Given that body movement impacts positively on wellbeing (Penedo & Dahn, 2005), the author included this sixth sense in the Five Pleasant Sense Exercise.

The client was invited to identify pleasant objects or activities for each of the senses, including the sixth sense of movement. This approach introduced opportunities for humour, but also a confusional technique (see Yapko, 2012, p. 337) that Erickson used to deepen a person's hypnotic state. Stuart's feedback on this process was both positive and enlightening. While practising in session, Stuart reported great difficulty in identifying pleasant objects/activities for the sense of touch. We explored how his experience of chronic pain may have reduced his capacity to be aware of pleasant experiences through this modality. Consequently, he was encouraged to explore this sense further, at home.

3. The Three Minute Breathing Space exercise is reminiscent of the concentrative focus exercise of mindful breathing. While practising this in session, Stuart expressed his surprise that "being non-judgemental or neutral does not prevent relaxation." He was informed that the exercise was not intended primarily for relaxation, although many people report this outcome.

Stuart was invited to practise the two MBE between sessions and observe his experience.

Treatment Session 2

Stuart reflected that he had become quite absorbed in the Five Pleasant Senses Exercise and learnt, to his surprise, that massage was a pleasant touch. He said that despite having a challenging week with his mother-in-law passing away and his brother being unwell, he had noticed fewer "raging thoughts" and longer periods without them. He attributed this to the interoceptive awareness exercises he had been practising between sessions.

Stuart was subsequently taught to generate self-hypnosis and the hypnotic phenomenon of analgesia through a non-pain related hypnotic suggestion. Stuart was taken through the permissive (and informal) hypnotic induction of PMR. Using a confusional technique known to deepen the hypnotic state (see Hammond, 1990, p. 56), he was invited to notice whether his left and right side felt the same or different, and that there was “no right or wrong way” to feel (i.e., suggesting neutral, non-judgmental awareness). If he noticed areas that were not so comfortable, the direct suggestion was made that he could be confident that he was learning a technique to change this experience for the better (i.e., implied PHS). This was followed by a guided visualization of a beautiful place in nature and the invitation to build interoceptive awareness through either concentrative focus (e.g., Slow Breathing Exercise) or receptive focus (e.g., Five Pleasant Senses Exercise). He was invited to speak (i.e., an ideomotor signal) while in hypnosis and to notice how the sound of his own voice took him even deeper into hypnosis. During this deepening strategy, he reported a sense of heaviness followed by lightness and weightlessness. To complete the hypnotic session, Stuart was invited to imagine a future time (i.e., age progression) that he could access along a path that extended into the future and one that that forked. One road supported “building calmness, cradling calmness, connecting with calmness,” while the other was not so effective at this. Stuart was invited to notice what supported a more relaxed way of being. He said he was able to follow the path to a place of “warmth and felt a nice rosy glow.” Before starting the reorienting phase, a PHS was provided, suggesting that he would be pleasantly surprised to discover where he encountered comfort and calmness.

Out of hypnosis, Stuart said that he had not been aware of his feet “at all” during hypnosis (i.e., dissociation). His pain-rating pre-hypnosis was 8/10; during hypnosis less than 4/10 and post-hypnosis 7/10. His relaxation rating was 4/10 pre-hypnosis and 8/10 post-hypnosis. Stuart was invited to listen to the CD recording made of the self-hypnosis training session.

Treatment Session 3

In the third and last session, Stuart reported that he had listened to the CD six times a day. He said that he had the new experience of being pain-free for two days. Surprisingly, this did not occur immediately after our session, but two hours later. This significantly challenged his previous expectation that the pain would “remain constant and unrelenting”.

Stuart's heightened sense of self-efficacy for generating analgesia was consolidated on this occasion through a pain-specific hypnotic suggestion (Elkins et al., 2007). This was a variation of the Dial Technique designed by Carich (1990) for clients with an eating disorder. In hypnosis, he rated his foot pain at 8/10 and likened the dial to that seen on his oven at home. On turning the dial, he indicated with his right pointer finger (i.e., ideomotor signal) when he had reached the lowest level, stating it was down to 2.5/10. To consolidate new procedural learning and increase a sense of self-efficacy, he was invited to elevate it back to 8/10, and then back down towards zero. Again stopping at 2.5/10, he stated that the slight warmth of the oven brought comfort to his feet. An age progression was incorporated to weave in a PHS, encouraging the future use of this strategy wherever he might find himself needing this support.

Out of hypnosis, Stuart was perplexed that he had experienced the heat from the oven as comforting to his feet. As this was our last session at the pain unit, I encouraged Stuart to pursue this approach with a psychologist in private practice.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

Two-weeks later, Stuart was provided an opportunity to provide feedback over the phone on how he had been progressing. He reported that he had practised the Dial Technique twice. He noticed a relaxing effect, rather than an analgesic one, that lasted 24 hours. He said that his image of the dial turned into a tap. It was as if his “emotions were flowing from the tap” and he felt calmer in himself. He said that he was very happy with these outcomes and rather than pursuing pain management with a private therapist he had arranged to attend couples' therapy with his wife.

Consequently, in reflecting on the two types of hypnotic suggestions paradoxically, the non-pain related suggestions (explored in Treatment Session 2), had a greater analgesic effect (n.b., pain-free for two days) than the pain-specific suggestions. The non-pain related hypnotic suggestions augmented mindfulness-based practices that engaged both concentrative focus (e.g., Slow Breathing Exercise) and receptive focus (e.g., Five Pleasant Senses Exercise). Indeed, Stuart reported a high sense of self-efficacy in replicating these at home and described how this had been integral in challenging his prior expectations that the pain would “remain constant and unrelenting.”

However, in reflecting on Stuart's experience of the Dial Technique (i.e., the pain-specific suggestion explored in Treatment Session 3), curious *oven* themes emerged, such as the *oven* dial and the "warmth" of the oven brought comfort to his feet with the pain rating never going below 2.5/10. Perhaps his increased sense of self-efficacy in the area of pain management enabled a greater capacity to address interpersonal issues now being identified within his marriage. Alternatively, incorporating interoceptive awareness skills into self-hypnosis training may have built emotion-regulation skills as suggested by Bishop et al. (2004), placing Stuart in a better position to address underlying interpersonal stressors, that may have led to the original intensification of his chronic depression and chronic pain.

In this case study, the essence of hypnosis, that is, *focus* and *suggestion*, were harnessed to build interoceptive awareness skills and bypass the phenomenon of automaticity for generating analgesia within a three-session hypnosis-training program. Stuart was able to generate analgesia lasting for two days by utilizing a non-pain related hypnotic suggestion. This experience of hypnosis assisted Stuart in challenging his prior expectations that the pain would "remain constant and unrelenting." In retrospect, more sessions would be advisable to build on his capacity to generate analgesia during home practice. The possibility remains for expediting a brief self-hypnosis training program by distinguishing which individuals might benefit from non-pain related hypnotic suggestions versus pain-specific hypnotic suggestions. Further studies would be required to clarify whether this approach has had an additive effect.

REFERENCES

- Alladin, A., & Alibhai, A. (2007). Cognitive hypnotherapy for depression: An empirical investigation. *International Journal of Clinical and Experimental Hypnosis*, *55*, 147–166.
- Bishop, S.R., Lau, M., Shapiro, S., Carlson, L., Anderson, N.D., & Carmody, J. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science and Practice*, *11*, 230–241.
- Carich, M.S. (1990). Symbolic imagery: The Dial Box Shrinking Technique. In D.C. Hammond (Ed.), *Handbook of hypnotic suggestions and metaphors* (p. 400). New York: W.W. Norton.
- Critchley, H.D. (2005). Neural mechanisms of autonomic, affective and cognitive integration. *Journal of Comparative Neurology*, *493*, 154–166.
- Dillworth, T., & Jensen, M.P. (2010). The role of suggestions in hypnosis for chronic pain: A review of the literature. *Open Pain Journal*, *3*(1), 39–51
- Dumont, L., Martin, C., & Broer, I. (2012). Functional neuroimaging studies of hypnosis and meditation: A comparative perspective. *Journal of Mind Body Regulation*, *2*(1), 58–70.

- Edelson, J., & Fitzpatrick, J.L. (1989). A comparison of cognitive-behavioral and hypnotic treatments of chronic pain. *Journal of Clinical Psychology, 45*, 316–323.
- Elkins, G., Jensen, M.P., & Patterson, D.R. (2007). Hypnotherapy for the management of chronic pain. *International Journal of Clinical and Experimental Hypnosis, 55*, 275–287.
- Grant, J.A., Courtemanche, J., Duerden, E.G., Duncan, G.H., & Rainville, P. (2010). Cortical thickness and pain sensitivity in Zen meditators. *Emotion, 10*(1), 43–53.
- Grant, J.A., Courtemanche, J., & Rainville, P. (2011). A non-elaborative mental stance and decoupling of executive and pain-related cortices predicts low pain sensitivity in Zen meditators. *Pain, 152*, 150–156.
- Grant, J.A., & Rainville, P. (2005). Hypnosis and meditation: Similar experiential changes and shared brain mechanisms. *Medical Hypotheses, 65*, 625–626.
- Halsband, U., Mueller, S., Hinterberger, T., & Strickner, S. (2009). Plasticity changes in the brain in hypnosis and meditation. *Contemporary Hypnosis, 26*, 194–215.
- Hammond, D.C. (Ed.). (1990). *Handbook of hypnotic suggestions and metaphors*. New York: W.W. Norton.
- Holmes, A., Christelis, N., & Arnold, C. (2012). Depression and chronic pain. *Medical Journal of Australia, 1*(Suppl 4), 17–20.
- Holton, C. (2000). The 5-4-3-2-1 Technique, practiced by Betty Alice Erickson, daughter of Milton Erickson, MD, www.chuckholton.com/stepfa21technique.doc (see Appendix).
- Jha, A.P., Krompinger, J., & Baime, M. (2007). Mindfulness training modifies subsystems of attention. *Cognitive, Affective, and Behavioral Neuroscience, 7*, 109–19.
- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*, 144–156.
- Kirsch, I., Montgomery, G., & Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 63*(2), 214–220.
- Kozasa, E.H., Sato, J.R., Lacerda, S.S., Barreiros, M.A.M., Radvany, J., & Russell, T.A. (2012). Meditation training increases brain efficiency in an attention task. *NeuroImage, 59*, 745–749.
- Lazar, S.W., Kerr, C.E., Wasserman, R.H., Gray, J.R., Greve, D.N., Treadway, M.T., & Fischl, B. (2005). Meditation experience is associated with increased cortical thickness. *Neuroreport, 16*, 1893–1897.
- Linden, D.E.J. (2006). How psychotherapy changes the brain – the contribution of functional neuroimaging. *Molecular Psychiatry, 11*, 528–538.
- Lovibond, S.H., & Lovibond, P.F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney: Psychology Foundation.
- Lynn, S.J., Malktaris, A., Maxwell, R., Mellinger, D.I., & van der Kloet, D. (2015). Do hypnosis and mindfulness practices inhabit a common domain? Implications for research, clinical practice and forensic science. *Journal of Mind-Body Regulation, 2*(1), 12–26
- McCracken, L.M., Zayfert, C., & Gross, R.T. (1992). The Pain Anxiety Symptoms Scale: Development and validation of a scale to measure fear of pain. *Pain, 50*(1), 67–73.
- Melzack, R. (1987). The short-form McGill Pain Questionnaire. *Pain, 30*(2), 191–197.

- Miller, L.R., & Cano, A. (2009). Comorbid chronic pain and depression: Who is at risk? *Journal of Pain, 10*, 619–27.
- Mrazek, M.D., Smallwood, J., & Schooler, J.W. (2012). Mindfulness and mind-wandering: Finding convergence through opposing constructs. *Emotion, 12*(3), 442–448.
- Nicholas, M.K. (2007). The pain self-efficacy questionnaire: Taking pain into account. *European Journal of Pain, 11*, 153–63.
- Penedo, F.J., & Dahn, J.R. (2005). Exercise and well-being: A review of mental and physical health benefits associated with physical activity. *Current Opinions in Psychiatry, 18*(2), 189–193.
- Rainville, P., Duncan, G.H., Price, D.D., Carrier, B. & Bushnell, M.C. (1997). Pain affect encoded in human anterior cingulate but not somatosensory cortex. *Science, 277*, 968–971.
- Rainville, P., & Price, D.D. (2003). Hypnosis phenomenology and the neurobiology of consciousness. *International Journal of Clinical and Experimental Hypnosis, 51*, 105–129.
- Raz, A., Fan, J., & Posner, M.I. (2005). Hypnotic suggestion reduces conflict in the human brain. *Proceedings of the National Academy of Sciences of the United States of America, 102*(28), 9978–9983.
- Saltis, J., Tan, S.G.M., & Cyna, A.M. (in press). Hypnosis for pain relief. In J. Yong, R. Urman, & M. Nguyen (Eds.), *Pain medicine: An essential review*. New York: Springer.
- Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. (1998, 2006) The Mini-International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry, 59*(Suppl. 20), 20–33, quiz 34–57.
- Segal, Z.V., Williams, J.M.G., & Teasdale, J.D. (2002). *Mindfulness-based cognitive therapy for depression*. New York: Guilford Press.
- Song, Y., Lu, H., Chen, H., Geng, G., & Wang, J. (2014). Mindfulness intervention in the management of chronic pain and psychological comorbidity: A meta-analysis. *International Journal of Nursing Sciences, 1*, 215–223.
- Veehof, M.M., Oskam, M.-J., Schreure, K.M.G., & Bohlmeijer, E.T. (2011). Acceptance-based interventions for the treatment of chronic pain: A systematic review and meta-analysis. *Pain, 152*, 533–542.
- Wilson, S.C., & Barber, T.X. (1978). The Creative Imagination Scale as a measure of hypnotic responsiveness: Application to experimental and clinical hypnosis. *American Journal of Clinical Hypnosis, 20*, 235–249.
- Yapko, M.D. (2001). *Treating depression with hypnosis: Integrating cognitive-behavioral and strategic approaches*. Philadelphia: Brunner/Routledge.
- Yapko, M.D. (2010). Hypnosis and depression. In S.J. Lynn, J.W. Rhue, & I. Kirsch (Eds.), *Handbook of clinical hypnosis*. Washington DC: American Psychological Association.
- Yapko, M.D. (2011). *Mindfulness and hypnosis: The power of suggestion to transform experience*. New York: W.W. Norton.
- Yapko, M.D. (2012). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York: Routledge.

APPENDIX

The 5-4-3-2-1 Technique: Sourced from Charles Holton, LCSW, 22 April 2000, www.chuckholton.com/stepfa21technique.doc

This is a description of an anti-anxiety technique taught to me by Yvonne Dolan, MA, author of *A Path With a Heart* and *Resolving Sexual Abuse*. It is also taught by Betty Alice Erickson, daughter of Milton Erickson, MD. The technique is very simple and direct. It does not involve complicated visual imagery or hypnotic inductions, it does not ask the client to close their eyes, imagine themselves somewhere else, or even to trust the therapist very much. It is a way to relax and release anxiety while orienting yourself comfortably to the physical reality around you.

1. Establish a position that you can maintain comfortably for a few minutes. Pick a spot on the wall or nearby and let your eyes remain on that spot, and let your head remain in a comfortable, stable position. Moving your eyes, moving your head, moving around and re-orienting will tend to interrupt the experience, so let yourself settle into a comfortable position and stay there for a few minutes.
2. Say out loud in a slow, gentle rhythm five things you see, then five things you hear, then five things you feel in your body. Then say out loud four things you see, four things you hear, four things you feel. Next, say out loud three things you see, three things you hear, three things you feel. Then, two of each, and finally one of each. You'll find yourself repeating a lot, and that's fine.
3. For most people, somewhere before they get to the one-of-each category they find themselves relaxing into the pleasant sensations of just noticing what's around them in all its detail and richness. They slow down a little, they kind of enjoy the process and get distracted by that, and actually lose their place in keeping track of which step they're on. That's the point of the exercise. When you lose your place, just ask yourself, would you like to continue to get absorbed by the pleasant sensations around you, just kind of drift into daydreaming and relaxing, or would you like to go back to the exercise?
4. Let me demonstrate for you. (Adjust your posture, take a deep breath, fix your gaze, and begin.) "I see the print on the wall, I see the trees out the window, I see the chairs in the room, I see the lamp in the corner, I see the print on the wall. I hear the sound of my own voice, I hear the traffic

outside, I hear the hum of the building's air-conditioner, I hear the sound of your breathing, I hear the sound of the traffic outside. I feel the chair supporting me, I feel my feet on the floor, I feel my watchband on my wrist, I feel my glasses on my nose – is that four or five? I lost my place already. So, at this point I can choose to return to the exercise or just go along into noticing what I'm noticing, and continuing to relax and breathe deeply and evenly without the exercise."

5. Would you like to try it?

I once worked with a client who had been traumatized with countdowns, so she preferred to reverse the order of the exercise and make it the "1-2-3-4-5 technique." Another client found it unpleasant to notice body sensations so used "I smell . . ." as the third sequence. Remember to be flexible and follow your client's lead, and may this exercise be useful and valuable to you and your clients!

HYPNOSIS TO ENHANCE ACADEMIC PERFORMANCE IN YEAR 12

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This case study presents the use of hypnosis with an adolescent who was completing her Year 12 exams and matriculation. Ill health throughout her high school years caused reduced confidence in her ability to study and sit for exams. The effectiveness of hypnosis to increase confidence and school performance is demonstrated. The adolescent attended five hypnotherapy sessions beginning late Term 2 focusing upon her ability to sit her exams late in Term 3. A collaborative, solution focused Ericksonian style of hypnosis was employed and special effort was made to individualize treatment involving a discussed and agreed upon purpose for each hypnosis session.

Keywords: adolescent, hypnosis, confidence, exams.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

A young woman, for whom the pseudonym Sally will be used, was concerned about her performance ability for Year 12 exams and study. She self-referred and sought hypnotherapy to improve her capacity to study. She was unconfident about her ability to learn, to recall information, and to write quickly enough in exams to complete questions on time. Problems with exams had occurred in Years 10 and 11 and she was concerned that problems would happen again in her final year of exams.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Sally, a single 17-year-old girl attending a local private high school, is the focus of this case study. She spoke clearly, had a small, fine build with long, fine brown hair. She displayed a friendly disposition and a good sense of humour. Her affect was normal. She lived with both her parents. The oldest child in

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her family, she has a 16-year-old sister. She described her parents as supportive and herself as artistic and a dreamer. She enjoyed music, art, and socializing with friends.

Sally described a relatively normal upbringing and participated successfully in art, singing, and choir in her primary and secondary school years. However, since Grade 8 she suffered ill health and fatigue. At the time a gastroenterologist had queried Crohn's disease. Her condition settled but she remained fatigued. During this time, she recalled losing motivation for study. In Year 10 she was diagnosed with moderate to severe ulcerative colitis which required hospitalization and being placed on a steroid drip for three days. This was then followed by six months of high dose steroid therapy in Year 10 and for six months again in Year 11. In Year 10 she missed school and was not able to partake in exams due to ill health. She reported that in Year 11 she struggled to complete exam questions on time. She takes Mesalazine 2000 mg per day to manage her condition. She recognized experiencing bouts of depression each time she ceased her steroid treatment in Years 10 and 11.

In Year 12 her medical condition had stabilized but she still suffered fatigue. Sally currently viewed herself as happy and well-adjusted: enjoying school, her hobbies, and friends as well as receiving the support of the choir, school, and church community.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

In this case, hypnotherapy was the primary technique applied as the client had come to therapy for this purpose to address specific goals. Hypnotherapy was, however, integrated with supportive psychotherapy and cognitive-behaviour therapy, namely psychoeducation on skills necessary for learning and the introduction of positive cognitions related to learning. A careful assessment was undertaken to explore depression, anxiety, and grief issues. Sally did not display anxiety, depression, or any other mental health problem requiring other forms of therapy at this time. She rated as experiencing very low anxiety on the Beck's Anxiety Inventory and she rated 12 on the K10, indicating that she was well. She had adjusted well to her chronic condition of ulcerative colitis with the support of her family, friends, medical practitioners, and community. She had friends with other chronic conditions and informed that she had accepted this as part of her life.

Sally reported her mental and physical health condition as now stable. She noted being motivated to participate in hypnotherapy. This lends her to

being a suitable candidate for hypnosis. As quoted in the Australian Society of Hypnosis *Student Handbook*, “patients who are attracted by the notion of hypnosis tend to be more hypnotizable than the general population” (Walker, 2014, p. 17).

Good rapport was established with the client and this is fundamental to the therapeutic relationship and hypnosis (Hammond, Hepworth, & Smith, 1977). She showed positive signs of hypnotizability in the second session using the Stanford Hypnotic Clinical Scale. Specifically, Sally achieved a score of 3, placing her in the medium susceptibility level. She readily responded to moving hands together, the dream, and age regression. The client did not experience total amnesia but did experience some amnesia, being able to record only three events prior to the instruction regarding remembering. She was able to remember eight events after said instruction.

Sally, a creative individual, had a capacity for absorption in her art and music and loved to daydream. According to the Australian Society of Hypnosis *Student Handbook*, these qualities (absorption and spontaneously moving in and out of altered states of consciousness in everyday life) are characteristics which relate to hypnotic responsiveness (Walker, 2014). Likewise, Bowers and Bowers (1979) as cited in Hammond (1990, p. 434) also concluded: “The personality characteristics that allow one person to be more susceptible to hypnosis than another coincide to some extent with those characteristics that make him more creative.”

Walters and Havens outline Erickson’s therapeutic approach to enhance performance through hypnosis in the chapter “Enhancing Performance in Sports, Intellectual Activities, and Everyday Life” (Geary and Zeig, 2001). Hammond (1990) devotes a chapter to “Concentration, Academic Performance, and Athletic Performance.” In both the above sources, research over the years is cited where hypnosis has been used successfully to enhance academic performance and reduce test anxiety. Specific scripts for some of the issues my client expressed are presented in Hammond (e.g., being slow, difficulty with memory recall, concentration, and exam anxiety). Sally’s difficulties thus appeared well suited to hypnotic intervention.

TREATMENT PROGRESSION

Gaining informed consent in the first session focused not only on establishing rapport with Sally but also on rectifying any misconceptions she had about hypnotherapy. We had a discussion on her experience, fears, beliefs, and expectations regarding hypnosis. Sally had no prior experience of hypnosis but

had misconceptions about what to expect while in hypnosis. Issues involving loss of control and depth of trance were rectified and hypnosis was explained as a natural and generally positive experience where she would experience focused attention, relaxation, and increased openness to suggestion as she focused inward. Consent was gained for hypnotherapy for her involvement in same to be formatted for publication.

The overall therapeutic goals were to enhance both Sally's capacity to study and her exam performance. During therapy, related concerns emerged as she identified a lack of confidence in studying for exams, concern regarding recalling information in exams, and not completing exam questions in a timely fashion. We therefore targeted these concerns in the different individual hypnosis sessions as appropriate.

The focus for each subsequent hypnotherapy session was negotiated with Sally at the end of the preceding session. This collaborative approach was particularly important given the developmental challenges of identity formation (Erikson, 1994) and separation in late adolescence/early adulthood and information gained about her independent personality.

ENGAGING IN HYPNOSIS

The first session comprised an assessment, a discussion of the client's understanding of hypnosis, education on hypnosis, and a clarification of her therapeutic goals. Psychoeducation on skills required for learning, study, and recall was provided. During this session the Ericksonian principle of utilization was applied and an understanding of the client's interests, strengths, and personal qualities was gained. We discussed having fun with hypnosis and seeing how she responded to the Stanford Hypnotic Clinical Scale in the following session. Sally, who was studying psychology, was interested in this approach.

After administering the SHCS, we agreed to focus the next hypnosis session on enhancing Sally's confidence in studying for her Year 12 exams and assessments. Therefore, the focus for the third session was on ego strengthening. Clinically a focus was on making her first hypnotic experience positive and pleasant.

In Session 3, before commencing formal hypnosis Sally was given permission to experience whatever level of trance was comfortable for her. Sally had raised concerns about level of trance in the first interview so she was instructed that whether it was a light or a deep trance, she would still benefit from hypnosis and find it a pleasant experience. A "yes set" was used to encourage receptivity to suggestion and to aid the induction process.

The Spiegel Eye Roll Induction was used (Spiegel, 1978). I incorporated this with Sally raising her arm as she rolled her eyes up to her eyebrows and lowering her arm on the out breath as she closed her eyes, with a suggestion that, as she lowered her arm, her body would begin to relax. For Sally's first experience and to aid initial success, the Spiegel induction gives an uncomplicated and quick focusing technique. This was then followed by the application of prolonged deep muscle relaxation. During this relaxation, the client appeared visibly relaxed. Specifically, Sally's body and facial muscles softened.

Sally was subsequently introduced to ideometer signalling (Yapko, 2003). For deepening, the client was guided down a flight of 10 stairs. She was asked to signal when she was ready to take the first step down the stairs. At the end of the stairs she was guided to sit in a comfortable chair to further relax. The client was guided through a basket of worries exercise where she could put her study worries and concerns in the basket and watch her concerns float away to the horizon. Ideometer signalling was requested to indicate when this had taken place. The client took her time and her finger slightly flickered when she signalled.

To illustrate hypnotic phenomena, Sally was guided through a body dissociation activity where her body remained in hypnosis while she came out of hypnosis from the neck up. During this time a brief discussion with the client occurred in which her voice quality had changed and her rate of speech was slower than in her waking state. I asked her to explain what was happening. She responded that the lower part of her body remained very relaxed and heavy. This activity was repeated twice to provide fractionation and an opportunity to deepen the trance experience.

For ego strengthening, a visualization of Sally's art room where she could paint a picture was employed. We discussed the skills Sally uses including the skills of concentration, focus, and recall to paint a picture. It was noted that Sally already had these skills which are necessary for study and as the year progresses it was noted that she may be surprised at how she increasingly uses these skills. Specifically, how the more she studies and learns, the more confident she will become, and that she could take from today into the study semester whatever was most helpful to her to achieve her goal. This was the applied post-hypnotic suggestion.

Sally was re-alerted, re-oriented, by counting back from 5 to 1. A brief discussion after the session showed that while the client thought she had only

achieved a light trance, she also thought the session was a mere 10 minutes where in reality the session duration was 40 minutes.

Sally noted at the end of Session 3 that she had an exam the following month and was concerned that she would not be able to “finish in time” and upon further enquiry she said that she writes and thinks slowly. We agreed that her speed of thinking and writing would then become the focus of the next hypnosis session.

At the fourth session, Sally noted that she had increased the time she was devoting to concentrating on her studies and she was pleased with this achievement. Her study skills were thus improving and this progress was reinforced. For continuity in hypnosis, the same Spiegel induction was used. A naturalistic hypnotic induction was prepared and used for deepening to cater to the needs and talents of Sally who tends towards the creative. Specifically, the naturalistic hypnotic induction from *Hypnotic Induction and Suggestion* (Hammond, 1998) was altered to refer to notions of speed (not slowness) wherever possible. These ideas were gained from Erickson’s suggestions for facilitating speed of learning (Hammond, 1990). Notably, Erickson refers to different degrees of speed in learning, suggesting rapidity, rather than referring to slowness. Therefore, words such as “speed,” “rate,” “fast,” “pace,” and “tempo” were incorporated into the script which complemented Sally’s goals and background as she was also familiar with musical terms. The following statements are some examples of altered wording or phrases inserted into the script used with Sally: “I don’t know if you are aware of all these changes, changes in speed, tempo, pace, whether you want to go fast, think fast, whether you thought fast in the past, whether you’ll think fast in the future, only your unconscious mind knows”; “And I don’t even know what kinds of thoughts are racing through your mind”; “It is almost as if the quieter you get, the more energy and speed is available to your unconscious mind”; “Because you have the ability to automatically create the speed that you need just in time”; “And so I hope you’ll be listening to your inner voice, to that part of you that knows what you need to write just in time.”

A story about a friend who had a child whose speed of thinking, talking, and learning had changed throughout her young life was presented. Under five, the child had been fast at learning, talking and thinking, but as she grew older she had to learn so many things at school and in life; she became slow as her energies went to developing many talents and learning many life lessons. But this changed again as she became a young adult; how after her long period in life learning, she became fast again and remembered these talents “just in

time.” A post-hypnotic suggestion was given that her unconscious mind will have the ability to create the speed she needs just in time and that she might be surprised to discover that she can think more quickly.

In Session 5 Sally reported that she had finished her exam questions on time during her recent testing and with surprising ease. She also noted feeling more independent in her family unit as she took on more responsibility for her study. Some time was devoted to savouring and reinforcing this success.

Sally had to sit another end of year exam soon and stated that she felt anxious about being able to recall material in the exam. Creating a calm place for her and to take her back to a time of success in the past and to rehearse successfully sitting for the exam in the future was therefore discussed. What is calming for her was explored and she stated “an imagined fairyland” as being soothing.

After clarifying the purpose of the day’s session, hypnosis began with a fixed eye induction and later using arm levitation for deepening. The client visibly relaxed with the induction and she responded well to the arm levitation. Her fingers flickered as her arm rose up high. She was then taken down stairs in her mind, for further deepening, to a fairyland where dreams come true. She was instructed via ideometer signalling to signal when in the fairyland.

A combination of the scripts *Taking Examinations* and *Achievement Motivation* (Hammond, 1990, pp. 436–437) was used in session. Achievement motivation guides the client to think back to a time in the past where they experienced a success (no matter how small) and to recapture that feeling. Ideometer signalling was used when she had recaptured this feeling. She was then instructed to take this feeling into her future exam, to see herself entering the exam room, calm, confident, and relaxed; to see herself sitting down with her pen and the ideas flowing, leaving the exam delighted, and being thrilled at its completion. A post-hypnotic suggestion was provided that when she picked up her pen in her exam she would be surprised at how freely her ideas would flow.

During the post-hypnosis discussion, the client stated that the arm levitation took her deeper into hypnosis this time and that she could experience a feeling of “happiness connected to moving forward in her life.”

COMMENTS ON THERAPY APPLICATION AND OUTCOME

At the conclusion of therapy, the client reported increased motivation for study and confidence in taking exams. The exams were in psychology and she achieved a high standard. She studied steadily throughout the term

and successfully completed all her assessment tasks for other subjects. Sally reported achieving more independence in her family as she took increasing responsibility for her study and her chronic health condition.

Sally's case report demonstrates how hypnotherapy can be effectively used to enhance academic performance and manage exam anxiety. Hypnotherapy was used in combination with psychoeducation, support, and the use of a strength-based approach to treatment. Having each session target a specific exam-related concern and goal Sally wanted to achieve enhanced the benefits of hypnosis. Sally's commitment to hypnotherapy, rapport in therapy, and her desire to increase her motivation and performance for Year 12 significantly enhanced the benefits of treatment.

Because Sally was very creative, one could assume that a naturalistic induction and script, which was less prescriptive, would best enable a trance state. Interestingly, Sally reported achieving a deeper level of trance with the eye fixation induction and arm levitation for deepening. Thus, perhaps these more directive induction methods could have been used earlier instead of the quick Spiegel induction. In retrospect, the introduction of self-hypnosis skills and, as homework, the provision of a recording to engage with after each hypnosis session to augment her learning in between sessions would have been beneficial.

REFERENCES

- Bowers, P.G., & Bowers, K.S. (1979). Hypnosis and creativity: A theoretical and empirical rapprochement. In E. Fromm & R.E. Shor (Eds.), *Hypnosis: Developments in research and new perspectives* (pp. 351–379). New York: Aldine.
- Erikson, E.H. (1994). *Identity and the life cycle*. New York: W.W. Norton.
- Hammond, D.C. (Ed.). (1990). *Handbook of hypnotic suggestions and metaphors*. New York: W.W. Norton.
- Hammond, D.C. (Ed.). (1998). *Hypnotic induction and suggestion*. Illinois: American Society of Clinical Hypnosis.
- Hammond, D.C., Hepworth, D., & Smith, V.G. (1977). *Improving therapeutic communication*. San Francisco: Jossey-Bass.
- Spiegel, H., & Spiegel, D. (1978). *Trance and treatment: Clinical uses of hypnosis*. New York: Basic Books.
- Walker, W.-L. (2014). *Student handbook*. Australian Society of Hypnosis Ltd.
- Walters, C., & Havens, R.A. (2001). Enhancing performance in sports, intellectual activities, and everyday life. In B.B. Geary & J.K. Zeig (Eds.), *The handbook of Ericksonian psychotherapy* (pp. 374–382). Phoenix: The Milton H. Erickson Foundation Press.
- Yapko, M.D. (2003). *Trancework: An introduction to the practice of clinical hypnosis* (3rd ed.). New York: Routledge.

HYPNOTIC TREATMENT OF REPEATED CHILDHOOD NIGHTMARES: A CASE HONOURING AND UTILIZING RELIGIOUS BELIEFS IN TREATMENT

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The following case demonstrates how hypnosis can be used to treat repeated childhood nightmares in a manner honouring and indeed utilizing the active religious faith of the child client and her mother. Specifically, repeated nightmares involving loss and danger were reported for the young female client age 9 by both her and her mother. Psychologically, these nightmares were presumptively triggered by the young girl's witnessing the alleged verbal and emotional domestic violence towards her mother by her stepfather prior to and following the couple's separation and subsequent divorce. Spiritually, the mother believed said nightmares to have a demonic as well as psychological basis. The young girl wished to not have nightmares and her mother wanted to protect her daughter both psychologically and spiritually from her nightmares. The treatment designed and applied to assist with the repeated childhood nightmares was specifically created to integrate and utilize the religious beliefs of the family. Specifically, the imagery from the Bible (Ephesians 6:10–18) that describes "the Armor of God" was used to empower the young girl to no longer be a victim in her nightmares. This provided a sense of control and mastery for the young girl who reported a decrease in nightmares. The young child subsequently reported experiencing only the occasional nightmare and no longer was plagued by a series, or pattern, of repeated nightmares. Moreover, in the wake of some inadvertent contact regarding the former husband and stepfather the nightmares returned months after last therapeutic contact but were handled by the young client in an empowering and proactive manner. Furthermore, the mother's actions in limiting contact with the former stepfather appear to have facilitated the therapeutic intervention.

Keywords: hypnosis, nightmares, Christian, domestic violence.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

A 9-year-old girl was presented by her mother for hypnotic intervention regarding repeated nightmares. The mother indicated that her daughter was having regular nightmares and upon waking she would be tearful, quite distressed, and come into her mother's bed for cuddles and comfort. The young girl had subsequently developed a strong waking focus on not having nightmares. The mother noted that the nightmares had themes of the young girl's mother and other loved connections being harmed and killed, the mother-daughter pair being separated, and then the young girl herself being harmed or imprisoned. The mother was interested in hypnosis to help strengthen her daughter's sense of safety and reduce her fear of nightmares.

History and details were taken without the young girl client present. Information was presented by the mother. The mother indicated she did not wish to discuss the difficulties in front of the daughter so as not to upset her.

The mother and daughter live together and report to be their own small family. The mother has no maternal or paternal contacts in the country, and the daughter's only family contact is her mother. The girl, for whom we use the pseudonym Joy, is an only child. The family describe themselves as being very involved in their church, active in their faith, and closely connected with each other. The young girl is of average intellect and at grade level. Her mother is a professional working single mother who is highly educated and experienced in her area having worked in her professional field for over two decades.

When asked about the nightmares, the mother indicated that she thought the nightmares were both psychological and spiritual in nature. She reported that she was doing her utmost to protect her daughter from being influenced by stress and had sought psychological support for her daughter which was generally helpful for the daughter's anxiety. She also advised that she was praying for her daughter, as were select members of their church. Nevertheless, nightmares remained a concern.

Regarding psychological causes of the nightmares, the mother noted both she and her daughter had experienced high levels of anxiety and stress over the last couple of years. Namely, the mother indicated that she had married a few years back and although positive at first the relationship with her then husband quickly soured. The mother further pointed out that, in parallel, the connection between her daughter and the then stepfather started positively

but quickly lessened, became distant, and ended altogether shortly after the mother separated from the now former husband. She also observed the former husband had never asked to see Joy, nor had Joy asked to see her former stepfather since contact ended almost two years ago.

Explicitly, the mother noted verbal and emotional abuse of her by her now former husband. She reported having profanity yelled at her, being told she could basically do nothing right, and that no one liked her. Apologies would then follow with explanations of the former husband being under pressure regarding his work. A subsequent negative angry outburst would occur over time followed by another reconciliation. Consequently, a typical verbal and emotional domestic violence pattern was described (Lifeline, n.d.; see also Olson, 2002).

The mother reported also that her then husband's profanity towards the mother was overheard by Joy and the mother's upset in the relationship was witnessed by the former couple's Christian couple counsellor, some close church friends, as well as her daughter. Whereas all couples have disagreements, when someone is abusive they try to dominate the other through criticisms, threats, and demands which they may rationalize via situational justifications for non-normatively aggressive or abusive behaviour (Olson, 2002). For the victim, and witnessing children, this behaviour can be very frightening (Kolbo, Blakley, & Engleman, 1996). Moreover, the harm witnessing such violence for children tends to be cumulative (Powell & Morrison, 2015). Intimate partner violence is commonly reciprocal (Whitaker, Haileyesus, Swahn, & Saltzman, 2007) but is not reported to be such in the present case. In this instance there were apparently some police reports made by the mother following the end of the relationship. Thus, the upset experienced by Joy would seem to fit the new DSM-5 category "child affected by parental relationship distress" (V69.29 or ICD10 Z62.898: Bernet, Wamboldt, & Narrow, 2016). All mandatory reporting obligations have been honoured by those involved with the current case report.

The mother added as background that her daughter had clearly been affected by the stress present in her former marriage. This had been in the form of various somatic signs and symptoms that seemed clearly coincident with stressful incidents. In the history, though, it appeared that the stepfather relationship had evolved, such that it was, after Joy's main psychological and social attachments had already been developed. The marital and step-parent relationships quickly soured as well and thus were short in duration. Thus, Joy's already well developed attachments and general emotional regulation had

been minimally impacted by her witnessing the verbal and emotional violence present in the home (Holt, Buckley, & Whelan, 2008; Powell & Morrison, 2015).

Nevertheless, after the relationship ended fear remained present. Consequently, the daughter wanted to sleep with the mother regularly and continued to show physical signs of stress including headaches. She additionally experienced nightmares. However, many symptoms lessened greatly after contact was increasingly limited and then ended altogether with the former husband and stepfather.

The mother reported significant feelings of guilt for not having left the relationship and taking her daughter to emotional safety sooner. She noted, however, that she felt she had made marital vows that she wished to honour, if possible, due to her religious beliefs. There are a number of reasons women do not leave an abusive relationship: Attempting to maintain a commitment to a relationship is often noted; isolation from others can make it difficult to leave; and a lack of nearby family contacts can make moving quickly impractical (Freiburger & Marcum, 2015; Southern Domestic Violence Action Group & Onkaparinga Crime Prevention Program, 2002).

The mother left when it became clear that the marriage was obviously not salvageable. She left with her daughter and they became their own small family unit once again. The mother reports that the daughter's somatic and behavioural difficulties (notably headaches) improved dramatically upon the physical marital separation. However, there was continued contact and legalities that needed attention with the ending of the marriage, which continued to be stressful for both the daughter and mother. The mother reported that her daughter was continuing to have nightmares and focusing, as a result, on not having nightmares during her waking day. For instance, Joy would often pray desperately to not have nightmares. She clearly continued to be in distress regarding nightmare activity and at the thought of having a nightmare.

The mother had attempted shielding her daughter from the stress involved with making legal the ending of the marriage and from the verbal and emotional abuse in the marriage itself. However, she was unable to protect her daughter entirely. The mother also tried to reassure the daughter that they both were safe and the mother could care for them both. On some level the daughter was aware of the mother's own anxiety and had memories of witnessing yelling and her mother's emotional distress and physical symptoms resulting from same in the former marriage. Thus, the daughter did not feel that she and her mother were completely safe and associated fear and anxiety

were coming out in Joy's repeated nightmares. Joy's mother agreed and believed this assessment to be correct. However, Joy's mother also reported that she thought there existed a "spiritual" dimension to her daughter's nightmares.

Regarding the family's spiritual beliefs, the family can be described as actively Christian. They attend church weekly, the daughter attends various Christian camps, they are involved with regular Bible study, and they have an active prayer life. The mother believed her daughter's nightmares to have a demonic as well as psychological basis. The mother noted the young girl to have regular nightmares followed shortly thereafter by a negative interaction or event involving the former husband. For instance, within a couple of days of the young girl having a nightmare the mother would receive a negative email communicate or other contact from or regarding the former husband.

The mother viewed these "foreshadowing" nightmares not as "premonitions" but as "spiritual attacks" on her daughter that coincided with negativity involving the former marriage. The mother's rationale for this explanation was the "torturing" nature of the nightmares involved. The mother subsequently noted that in the family's religion they did not believe God would "torture" believers with nightmares and thus the nightmares were not "premonitions" but simply negativity without purpose other than to torture. This by definition fit with the mother's belief system regarding what is considered demonic in the spiritual realm. She did not believe her daughter to be "possessed" but reacting to negative spiritual "attacks" and believed this to be the case due to her sensitivity to the "spiritual realm" and closeness to the mother.

Psychologically speaking, the pattern seemed to mirror a continuing domestic violence cycle of "calm" before "negativity" as described by the *Duluth Wheel*, in the contacts and connections with the former husband of which both the mother and Joy could be aware of on some level and thus impacted by same (Dodd, 2009; Lifeline, n.d.). This possibility was reflected to the mother who acknowledged this in a friendly manner and noted that she also believed a "spiritual" dimension to be at work. She clearly noted that she thought both psychological and spiritual influences were at play in the creation of her daughter's nightmares. The mother noted she was aware their belief system was not necessarily going to be accepted by others not of their faith but that she would maintain her belief system nonetheless. Following Rajaei (2010), these beliefs became a foundation for therapy rather than just a contextual consideration.

Although unusual, the mother's religious beliefs and presentation did not indicate the existence of any paranoid ideations, delusions, or hallucinations. The mother's reality testing was intact. The mother simply believed her daughter to be experiencing repeated nightmares as a result of combined psychological stress and spiritual influence. The mother referred to Ephesians 6:12 from the Bible, which notes that human struggles involve the spiritual realm. She wished her daughter to be aided psychologically and spiritually. She wanted her daughter to both be and feel emotionally safe.

Psychology has a long tradition of promoting rational thought as a cure for the many irrationalities that plague those afflicted with mental illnesses of various types. A scientific mindset may lead to looking askance at some phenomena based on pseudoscientific or unscientific beliefs (e.g., Shermer, 1979) but there is growing recognition that elements of personal narratives are useful in therapy, irrespective of the rational basis they may have (White & Epston, 1990). Specifically, religious elements could be expected to bring across a dimension of meaning, through linkages to life narratives, such as that emphasized by Little (1996; see also McAdams, 2015) as part of personality development overall. Rajaei (2010) raises this potential in evolving Religious Cognitive-Emotional Therapy with no reference to hypnosis. In this article we extend that line of thinking to the hypnotherapy context.

In summary, the young girl wished to be free of nightmares and her mother wanted to protect her daughter both psychologically and spiritually without undermining religious beliefs. The mother was attending to general anxiety with the daughter via a clinical psychologist and to spiritual areas via prayer. She was shielding her daughter from the anxieties involved with life and the ending of her marriage to the best of her ability. She presented as wishing to reinforce her daughter's sense of safety via hypnosis.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Nightmares are dreams that occur during rapid eye movement (REM) sleep that result in fear, distress, or extreme anxiety. They generally occur in the latter part of the night and can awaken the sleeper. Most nightmares are a normal reaction to stress but a frequent occurrence of nightmares can become a disorder referred to as nightmare disorder or repeated nightmares (DSM-V 307.47). Specifically, repeated nightmares as a term refers to a series of nightmares with a recurring theme usually beginning in childhood before the

age of 10 and are considered normal unless they interfere with functioning. Such repeated nightmares tend to occur more in girls than boys and can be associated with anxiety and trauma (*Psychology Today*, 2015; Sadeh, 1996).

Joy's symptoms were a classic presentation of repeated nightmares. Additionally, as her waking time was disturbed by the nightmares, her nightmares were lengthy, elaborate and narrative, seemed real, and triggered fear and anxiety she was easily diagnosed as having nightmare disorder or what is sometimes called dream anxiety disorder (*Psychology Today*, 2015; American Psychiatric Association, 2013).

There were no medical issues under investigation and no legal processes involving the daughter under way or planned and thus there were few, if any, contradictions to the use of hypnosis in this case (Yapko, 2003). Additionally, despite some controversy in some religious circles regarding altered states of consciousness (Court, 2010; Durbin, 2001), the mother was positively oriented to the use of hypnosis to reinforce the psychological, social, and spiritual actions she had put in place for her daughter's benefit. This case is an exemplar as to how hypnosis does not need to be 'demonised' but can use an altered state of consciousness in a spiritually-honouring manner (Court, 2010; Durbin, 2001). Indeed, there is some indication that religiousness can be a correlate of absorption (Levin, Wickramasekera, & Hirshberg, 1998) and thus facilitate the use of hypnosis.

Nightmares as well as anxiety have been treated successfully with hypnosis (Ng & Lee, 2008) and this success has included the treatment of school-age children (Anbar & Slothower, 2006). Indeed, Krakow et al. (2001) note that imagery rehearsal therapy was effective for treating chronic nightmares in adjudicated adolescent girls. In such treatment the nightmare content is adjusted through suggestions and repetition of modified imagery in a non-hypnotic context.

Clinically this tactic has worked well for the second author with clients suffering repetitive nightmares, who are asked to "play it backwards" upon waking, or "play it back in black and white," and then changing a character "to a cartoon one, like Homer Simpson." Clients using these techniques report that the cognitive processing displaces affective reactions, and re-associates dream content with new emotional reactions (e.g., laughter), diminishing the fearfulness and often the content of the original dream. This is all consistent with the well-established reconstructive model of memory (Bartlett, 1932; Loftus & Palmer, 1996) which treats every instance where material is recalled as an opportunity for extraneous factors to modify the memory permanently.

Similarly, Kennedy (2002) noted in a review of hypnosis as a treatment for parasomnias that a key element in effectiveness was the specific hypnotic suggestion to alter nightmare content. Kingsbury (1993) noted that even those who awaken in the middle of a nightmare can have this waking event re-framed as an interrupted middle rather than an end point to allow a more benign dream completion, or, as was focused upon in this case, an empowering completion. Research by Hauri, Silber, and Boeve (2007) indicates that the hypnotic treatment of parasomnias was effective and positive effects lasted at the one month, 18 month, and 5 year follow-up period; although with reduced effectiveness over time.

TREATMENT PROGRESSION

Treatment to assist Joy's coping with her repeated childhood nightmares was specifically designed to integrate and utilize the religious beliefs of the family. Namely, the imagery from Ephesians 6:10–18 from the Bible using "the *Armor of God*" was used to empower her. Imagery from Ephesians was purposefully chosen to provide a sense of control and mastery for the young girl in the face of her nightmares versus reliance on her mother to protect her from harm, or a simple lessening/shrinking of the fear imagery encountered in her nightmares. The mother was already doing her best to help her daughter (a) cope with anxiety including gaining her psychological support as well as (b) shield her daughter from harm and reduce the anxiety provoking contact/communication related to the former stepfather. The addition of mastery in (c) dealing with the nightmares in an empowering manner could be said to have enabled the application of a three-pronged approach to the repeated nightmares being experienced. Halliday (1987) has reviewed various direct psychological therapies for nightmares and this "face and conquer" approach (that we are referring to as empowerment) has been helpful for some.

The senior author had previously used religious imagery, specifically Jewish religious imagery involving Moses (from The Torah or Numbers 20 in the Christian Bible), in a description of work with a Jewish adult child of Holocaust survivors (Pelling, 2015). Thus, she was comfortable with investigating and then integrating religious imagery into a hypnotic session, and so printed out the relevant passage from the Bible describing the Armour of God. This was used subsequently to construct a hypnosis session utilizing the most pertinent aspects. Specifically, the shield of faith, helmet of salvation, and sword of the spirit were to be incorporated into the hypnosis with one variation.

Instead of discussing/visualizing a helmet of salvation the salvation headgear was envisioned as a crown. Thus, the young girl could connect with herself being a beloved *Child of God* and in essence a princess of the *King of Kings* in her own young religious understanding. It was hoped that the image of a crown would also be inviting to Joy as many young girls like to see themselves figuratively as a princess in dreams. Despite the princess imagery connected with the religious imagery in the hypnosis intervention developed, Joy was to be empowered and not rescued (as often is the case in traditional princess stories) through the imagery employed.

After apprising Joy's mother of the intended focus for the hypnosis and explaining its rationale (summarized in the previous three-pronged approach discussion), the senior author discussed with her the general approach and the process taken when conducting hypnosis. We decided to meet specifically half a dozen times to conduct generally the same hypnosis session at the family's home in Joy's room. This location was determined appropriate given the aim of the intervention was to empower Joy to cope with the nightmares she was experiencing as part of her general sleep routine. The sessions were not, however, planned at bedtime and were not to involve Joy falling asleep during the sessions.

As all the information gained in creating the hypnotic intervention and plans for implementation to this point came from and involved the mother (to shield the daughter from negative talk and thus anxiety), time was spent specifically discussing the nightmare issue with Joy immediately before the first hypnosis session. Joy did indeed indicate repeated nightmares and that she prayed ardently to not have them. She also pointed out a "dream catcher" (again an imagined passive "protection" from nightmares versus empowering mastery in nightmares originating from Native North American culture) in her room which she thought often caught bad dreams but she noted a lot still came through.

We did not discuss anxiety in detail nor her experience of the former stepfather as such issues were previously addressed in her regular psychological support sessions. She described a number of nightmares to me. She indicated waking after the nightmares, gaining cuddles and comfort from her mother after waking, recalling her nightmares, describing her nightmares to her mother, and being very frightened and distressed by her nightmares. She is aware that the nightmares are not real although she finds them distressing. For instance, she does not check to see if what has occurred in her nightmares has occurred in her actual environment after waking. What follows are three representative condensed nightmare descriptions illustrative of Joy's nightmare experiences.

Nightmare 1 – Someone is hurting and yelling at my mum and she is crying. They have put her in the garbage bin and she has been thrown away. I don't have her anymore and I am alone and put into a cage and locked up. I am all alone without my mum and I am going to be hurt.

Nightmare 2 – Someone stabbed my pet budgie Peter, hanged my pet budgie Paul, and is pulling out the feathers of my pet budgie Mary. I love my pets and they are hurting and I am scared my pet hamster Moses is going to be hurt next. I am scared I can't help them.

Nightmare 3 – Someone is pulling the stuffing out of Puppy [a well-loved stuffed dog toy who has a matching larger “mother” stuffed dog toy]. He is hurting and I can't stop it. Poor little Puppy is hurt and I love him.

Joy seemed genuinely unaware that there was a connection between anxiety and her nightmares – for herself, her mother, and the previous marital relationship. Joy was aware of her own feelings and noted a few school stressors. Similarly, she was aware that her mother worked very hard and was sometimes very sad regarding her former stepfather whom she referred to by his first name. However, she did not overtly connect these events with her nightmares as others involved with Joy's care have done.

After briefly talking to Joy about her nightmares, the first actual clinical session was spent orienting Joy to hypnosis in terms focusing on relaxing and having good dreams as well as dealing with the bad dreams in a new way if/when they occur. Joy overtly noted that she was interested in any ideas the therapist had for her that could help her deal with nightmares.

ENGAGING IN HYPNOSIS

As planned, hypnosis was used as a means of introducing a manner in which Joy could “interact” with mastery in her dreams. Specifically, the induction used with Joy introduced her to a magical peaceful landscape with castles that she could explore with all her senses of sight, smell, touch, and hearing. She was told that her dreams similarly are a landscape that she can explore when she is asleep. While deepening the hypnotic session, Joy was encouraged to propel herself across bridges and make choices to move left or right or straight ahead when pathways presented themselves to reinforce the idea that she herself has choice when imagining and dreaming.

While conducting the bulk of the hypnosis session, the hypnotist wondered aloud if Joy was aware that she was wearing a crown and was indeed a princess

in this magical land. The idea that Joy could protect herself from nightmares with her shield and sword was then introduced. She was told that her crown, shield, and sword matched and were part of a set made just for her by God and that they would be available to her whenever needed. She was provided with an anticipatory warning that she was about to be asked about her experience if she wished. She offered that she could see the crown, shield, and sword.

In Hypnosis Description – I have a crown on my head and it has flowers and diamonds on it. It sparkles and it is beautiful. My shield and sword also have diamonds and flowers on them [Joy was smiling widely while giving this description].

Joy was told that her crown made her special, a *Child of God*, and then asked her if she knew what to do with her shield and sword.

In Hypnosis Answer – Yes, I can make them stop with my sword. Anyone trying to hurt me or my mum [Joy pushed her arm out forward as if fending off a foe].

The senior author followed up on this response by noting that she could choose to use her shield as well. It was pointed out that shields protect people from things thrown at them. Joy was told that her shield was special as bad dreams could “bounce” off them and then away from her.

The post-hypnotic suggestion involved Joy remembering upon seeing her “dream catcher” before going to sleep that although her “dream catcher” can catch dreams, she can actively shield herself from them, make them go away, and actively protect herself from harm with her sword as well because she is a true princess. Consequently, the form and substance of the hypnosis session centred upon Joy’s own mastery and choice to deal with her nightmares and incorporated her religious beliefs.

Upon reorienting from the hypnosis, the idea that Joy had a shield and sword at her disposal was strengthened by finding the Ephesians section noting same in her youth Bible complete with illustrative pictures. This had a reinforcing effect as the information was not simply discussed but was also in print in her own Bible.

Although we had planned on meeting with Joy half a dozen times to engage in hypnosis, we met formally regarding same on three occasions. After the formal meetings, Joy’s mother agreed to simply reinforce the empowerment themes, versus engage in formal hypnosis, with her young daughter.

Final formal contact with Joy’s mother concerning Joy’s nightmares prior to this case’s publication was made approximately three months after our last formal session regarding the nightmares. Joy’s mother indicated Joy was again

upset and having nightmares, after a period of relative calm, in response to exposure to inadvertent contact details regarding the former husband and stepfather. Specifically, the former husband and stepfather had begun making contact with Joy's school principal and had physically attended the school office during school hours after over a year and a half of having no contact with Joy and having neither parental nor contact rights with the young girl. Specifically, as a result of the school contact, Joy overheard the former husband and stepfather's name and some negativities mentioned by the school principal to her mother and became anxious. As a result, her nightmares started to occur again and again Joy was reminded of her special shield, sword, and crown. The mother made the appropriate police reports regarding the contact by the former husband and stepfather and changed Joy's schools for her emotional wellbeing. The new school has been warned to allow no contact and to safeguard Joy's privacy and information. About a month after the school move Joy reported another nightmare. While the nature of the nightmare remained consistent with Joy's history her response had changed dramatically and now indicated a sense of mastery.

After Hypnosis Treatment Nightmare – Someone has kidnapped my mum and has taken her out of the house. She is being taken away but I have super powers and have used them to get the bad person away and bring my mum back into the house and have locked the doors. We are safe now [Joy relayed this nightmare and her empowered resolution of same with a smile and a hug to her mum].

The mother, seeing the effect of even minimal dealings on Joy, has since worked even harder to shield the daughter from the anxiety and angst associated with the former husband and stepfather. At last contact the mother was working on legal avenues to minimize the likelihood of contact with the former husband and stepfather and subsequent related harm.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

Joy reported a decrease in nightmares and a subsequent decrease in her waking focus on avoiding nightmares. Her mother reported Joy discussing her shield, crown, and sword on occasion. Additionally, the mother noted she reminded Joy that she had these tools to help with her nightmares when necessary, say when a nightmare was the result of Joy overhearing talk of the ex-husband and related relational angst. Formal hypnotic intervention for the repeated

nightmares thus became more informal and family-based yet still involved the hypnotic elements discussed.

In conclusion, hypnosis was used in this case to actively empower a young girl experiencing repeated nightmares. The imagery used harnessed the active religious faith of the young girl and mother involved. Readers who have found this case study interesting may also wish to review a forthcoming case study created by the same authors (Pelling & Gee, in press). This case study involving Joy's mother, for whom we use the pseudonym Hope, is currently under review for publication. In this following case study, the use of religious and cultural imagery, as well as archetypes, are explored in relation to Hope's coping with post-traumatic symptoms and challenges to her basic underlying assumptions of the world as a safe and fair place.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Anbar, R.D., & Slothower, M.P. (2006). Hypnosis for treatment of insomnia in school-age children: A retrospective chart review. *BioMed Central Pediatrics Series*, 6(23). DOI 10.1186/1471-2431-6-23
- Bartlett, F.C., (1932). *Remembering*. Cambridge: Cambridge University Press. Format: Abstract.
- Bernet, W., Wamboldt, M.Z., & Narrow, W.E. (2016). Child affected by parental relationship distress. *Journal of the American Academy of Child Adolescent Psychiatry*, 5, 571–579.
- Court, J.H. (2010). Altered states in the Church and clinic. *Pastoral Psychology*, 59(4), 411–422.
- Dodd, L.W. (2009). Therapeutic groupwork with young children and mothers who have experienced domestic abuse. *Educational Psychology in Practice: Theory, Research and Practice in Educational Psychology*, 25(1), 21–36.
- Durbin, P.G. (2001). Hypnosis and religious faith. *Australian Journal of Clinical Hypnotherapy and Hypnosis*. Australian Society of Clinical Hypnotherapists, 2001. Retrieved June 20, 2016 from HighBeam Research: <https://www.highbeam.com/doc/1P3-109556119.html>
- Freiburger, T.L., & Marcum, C.D. (2015). *Women in the criminal justice system: Tracking the journey of females and crime*. Boca Raton, FL: CRC Press
- Halliday, G. (1987). Direct psychological therapies for nightmares: A review. *Clinical Psychology Review*, 7, 501–523.
- Hauri, P.J., Silber, M.H., & Boeve, B.F. (2007). The treatment of parasomnias with hypnosis: A 5-year follow-up study. *Journal of Clinical Sleep Medicine*, 3, 369–373.
- Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse and Neglect*, 32, 797–810.

- Kennedy, G.A. (2002). A review of hypnosis in the treatment of parasomnias: Nightmare, sleepwalking, and sleep terror disorders. *Australian Journal of Clinical and Experimental Hypnosis*, 30, 99–155.
- Kingsbury, S.J. (1993). Brief hypnotic treatment of repetitive nightmares. *American Journal of Clinical Hypnosis*, 35, 161–169.
- Kolbo, J.R., Blakley, E.H., & Engleman, D. (1996). Children who witness domestic violence: A review of empirical literature. *Journal of Interpersonal Violence*, 11, 281–293.
- Krakov, B., Sandoval, D., Schrader, R., Keuhne, B., McBride, L., Yau, C.I., & Tandberg, D. (2001). Treatment of chronic nightmares in adjudicated adolescent girls in a residential facility. *Journal of Adolescent Health*, 29, 94–100.
- Levin, J.S., Wickramasekera, I.E., & Hirshberg, C. (1998). Is religiousness a correlate of absorption? Implications for psychophysiology, coping, and morbidity. *Alternative Therapies*, 4(6), 72–76.
- Lifeline. (n.d.). *DV-Alert: Domestic Violence Response Training*. Workbook: Author.
- Little, B.R. (1996). Free traits, personal projects and idio-tapes: Three tiers for personality psychology. *Psychological Inquiry*, 7, 340–344.
- Loftus, E., & Palmer, J.C., (1996). Eyewitness testimony. P. Banyard and A. Grayson (Eds.), *Introducing psychological research*. Sydney: Palgrave-Macmillan.
- McAdams, D.P., & Guo, J. (2015). Narrating the generative life. *Psychological Science*, 26, 475–483.
- Ng, B.Y., & Lee T.S. (2008). Hypnotherapy for sleep disorders. *Annals Academy of Medicine*, 37, 683–688.
- Olson, L.N. (2002). “As ugly and painful as it was, it was effective”: Individuals’ unique assessment of communication competence during aggressive conflict episodes. *Communication Studies*, 53, 171–188.
- Pelling, N. (2015). Counseling and psychotherapy in Australia: Cynthia’s story. In R. Moodley, M. Lengyell, R. Wu, & U.P. Gielen (Eds.), *International Counseling: Case Studies Handbook*. Published online: 25 September 2015. Doi: 10.1002/9781119222781.ch8
- Pelling, N., & Gee, T. (in press). The use of metaphor in the treatment of domestic violence related post-traumatic stress disorder. *Australian Counselling Research Journal*.
- Powell, O., & Morrison, K. (2015). Psychological intervention for children and young people who have experienced family violence. *InPsych*, 37(5), 16–17.
- Psychology Today*. (2015). *Nightmares*. Available online: <https://www.psychologytoday.com/conditions/nightmares>
- Rajaei, A.R. (2010). Religious cognitive–emotional therapy: A new form of psychotherapy. *Iranian Journal of Psychiatry*, 5(3), 81–87.
- Sadeh, A. (1996). Stress, trauma, and sleep in children. *Child and Adolescent Psychiatric Clinics of North America*, 5, 685–700.
- Shermer, M., (1997). *Why people believe weird things: Pseudoscience, superstition, and other confusions of our time*. New York: Henry Holt & Co.

- Southern Domestic Violence Action Group & Onkaparinga Crime Prevention Program. (2002). *Is someone you know being abused a relationship? A guide for families, friends & neighbours*. Pamphlet: Author.
- Whitaker, D.J., Haileyesus, T., Swahn, M., & Saltzman, L.S. (2007). Differences in frequency of violence and reported injury between relationships with reciprocal and non-reciprocal intimate partner violence. *American Journal of Public Health, 97*, 941–947.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton.
- Yapko, M.D. (2003). *Trancework: An introduction to the practice of clinical hypnosis* (3rd ed.). New York: Routledge.

HYPNOSIS FOR ADJUNCTIVE PAIN RELIEF IN A PATIENT WITH MULTIPLE SCLEROSIS RELATED TRIGEMINAL NEURALGIA

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In this case study the use of hypnosis as a strategy in the treatment of pain associated with trigeminal neuralgia as a result of multiple sclerosis is described. The effectiveness of hypnosis and self-hypnosis as an adjunct to regular medication in supporting and providing a foundation for pain reduction and relief is demonstrated. Therapy further aimed to reduce anxiety and improve stress management. Two sessions spaced three weeks apart with follow-up contact one month post hypnosis comprised the treatment provided.

Keywords: hypnosis, multiple sclerosis, trigeminal neuralgia, tic douloureux, pain relief.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

A 55-year-old female, to whom we will refer by the pseudonym Susan, requested hypnosis to assist with her trigeminal neuralgia. Trigeminal neuralgia, also called tic douloureux, is a disorder of the fifth, trigeminal, cranial nerve that causes episodes of intense stabbing pain that can feel like an electric shock (Trigeminal Neuralgia Association Australia, 2016, para. 1). Susan's request for hypnotic intervention followed her six-month struggle with severe trigeminal neuralgia while experiencing minimal relief from various treatments, including drug therapy. Susan had become increasingly anxious and stressed as the constant pain experienced was keeping her awake at night, making her unable to enjoy eating or chewing, and even creating difficulty talking. Thus, Susan's day-to-day workload and the relationships with family and friends were being significantly impacted by this difficulty.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Susan was diagnosed with multiple sclerosis (MS) in 1989 following the birth of her first child. MS is a condition of the central nervous system that interferes with nerve impulses within the brain, spinal cord, and optic nerves (Multiple Sclerosis Society Australia, 2016, para. 1). She has had numerous mild relapses/remitting episodes since being diagnosed and recently endured several severe long-lasting bouts of trigeminal neuralgia, a difficulty often associated with MS. Susan has found this debilitating, severely painful, and therefore highly distressing. Moreover, ongoing sleep disturbance due to chronic pain has left Susan feeling emotionally and physically drained. As a result, Susan is no longer interested in the social and physical activities she once enjoyed.

Susan is the mother of two adult children ages 20 and 24. She is married to a farmer and is a qualified wool classer by trade. Her first experience with MS was in 1989 when she woke in the morning and noticed while washing herself in the shower that she had a “numb” abdominal area. At this time she was also unable to walk correctly without having to consciously lift her leg. Susan initially incorrectly attributed these symptoms to excessive exercising following the delivery of her first child. Said symptoms lasted for one to two weeks and they continued to recur over the following months along with other symptoms including facial tingling and numbing over other parts of her body. In the last 25 years Susan has had mild relapses (i.e., leg weakness, some muscle spasms) and several episodes of trigeminal neuralgia. Susan's health, despite these difficulties, has been generally good and she maintained a constant workload on the family farm as well as raised two children. During the time involving hypnotic contact, Susan was on minimal medication (Baclofen for muscle spasms and Tegretol for nerve pain).

In January 2014 the pain in Susan's face from the trigeminal neuralgia began to increase and her ability to function normally was becoming an issue. After consultation with her neurologist she commenced the medication Pregabalin to help control the shooting pains and, while the initial results were fair, within six weeks the Pregabalin was having minimal effect.

Following a discussion between Susan and this clinician involving hypnotherapy, an arrangement was made to meet with Susan for an initial session. Informed consent was obtained at the beginning of the first session by discussing the process of hypnosis and answering questions regarding it. Susan's initial concerns included the urban hypnosis myths involving Susan

possibly being made to “cluck like a chicken” and experiencing “post-hypnotic suggestions that would make her do something out of character.” It was explained to Susan the goal of hypnosis was to empower her and help her relieve pain caused by the trigeminal neuralgia. Susan was reassured that she would maintain autonomy during her sessions due to the nature of hypnosis and ethics surrounding the use of hypnosis (Australian Society of Hypnosis, 2013).

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Hypnosis has been described as “attentive receptive focal concentration” with the trance state being a “normal activity of a normal mind” which occurs regularly, as when reading an absorbing book, watching an engrossing movie, daydreaming, or performing monotonous activity. A common assumption is that, during hypnosis, the subconscious mind is in a suggestible state while the conscious mind is distracted or guided to become dormant (Stewart, 2005). Drawing from these descriptions, the concept and experience of hypnosis were explained. Although Susan has had no previous experience with hypnosis she has tried meditation as a form of relaxation. Her hypnotizability was assessed using the Church Steeple induction technique (Cyna, 2013).

On visual direction, Susan was able to convincingly extend her arms so her hands were about eye level. I asked her to fold her fingers under at the second knuckle, all except her index fingers which she extended up, parallel to each other. I then suggested Susan let her eyes focus on her fingers and as she did this she would notice something very interesting beginning to happen (as previously described); her fingers began to come together, almost as though they were being pulled together by magnets. As Susan’s fingers began to pull together verbal affirmative comments were offered. Once the fingers had pulled together Susan placed her hands on her lap and allowed her eyes to close. In discussions following this induction Susan reported not being able to stop her fingers coming together and that she experienced a heightened state of relaxation. The outcome of these preliminary hypnotic exercises indicated that Susan was suitable for hypnotically based therapy.

Pain relief was to be the focus of our hypnotic work. The primary objective throughout these hypnotherapy sessions was to teach Susan the tools that would allow her to use self-hypnosis to significantly reduce the amount of pain she was experiencing. This would develop her mastery and help

her regain control of her life and thus function better with her day-to-day activities as well as enjoy relationships with her family and friends again.

Pain is a common and significant problem in many people with MS (Multiple Sclerosis Society Australia, 2016, para. 1). Preliminary evidence suggests that self-hypnosis training could potentially benefit people with MS and chronic pain, supporting the need for controlled trials to examine this approach. A number of literature reviews have concluded that hypnosis can be effective for a variety of acute and chronic pain conditions (Montgomery, DuHamel, & Redd, 2000; Patterson & Jensen, 2003, 2014), although there are yet to be any published controlled trials studying pain in subjects with MS specifically.

The evidence for hypnosis in chronic pain management has improved significantly over the past 20 years. Studies have shown that hypnosis therapy is highly effective in the reduction of pain, although outcomes may vary between individuals. Hypnosis treatment can lead to long-term changes in how the brain processes sensory information in a small group of patients' studies. These results have important implications for how clinicians can help their clients experience maximum benefits from hypnosis and the treatments that include hypnotic components (Patterson, 2014; Patterson & Jensen, 2014).

TREATMENT PROGRESSION

Relaxation hypnotherapy was the first technique used for Susan as her stress levels due to the pain from trigeminal neuralgia were causing an inability to concentrate. A pain reduction "dial down" therapy using Patterson's technique (Patterson, 2014) was chosen during the second hypnotherapy session. Additionally, self-hypnosis techniques (Cyna, 2013) were demonstrated to Susan. It was hoped that same would provide ongoing self-support to enable her to relax and minimize her pain when required. Self-hypnosis was also chosen as a between-sessions activity as well as a maintenance activity following the completion of our visits.

ENGAGING IN HYPNOSIS

Susan's first hypnosis session focused on building a rapport and gaining an understanding of her circumstances (living with MS and trigeminal neuralgia for over 20 years). Additionally, time was spent establishing her goals and facilitating her understanding of what strategies and methods would be used to help achieve a positive experience.

The induction of hypnosis by eye fixation and distraction (Wicks, 1982) was used. Possibly aided by her experience with meditation, Susan relaxed and her eyes closed quickly. Ideomotor finger signalling was established with three fingers to communicate a “yes,” “no,” or “not sure” response prior to induction (Hammond, 1998). This allows a participant to respond while remaining in a hypnotic state. It also allows a participant to communicate their comfort during the process. Once a comfortable place for Susan to be safe and happy was established, suggestions were given for her to take time out for herself to enjoy the calm, peaceful surrounds she had created and to experience them while being in control of her sensory inputs.

Ideomotor signalling (counting from 5 to 1) was used as an indication for Susan to return to her normal alert and wide awake state feeling safe, comfortable and refreshed, back in the here and now. After the hypnosis, Susan was given a moment to orientate and to bring her focus back to the room. An opportunity was then given for us to discuss her experience. Susan stated that she found her first session soothing. She was able to visualize herself relaxing on the front veranda of the cabin they own in the Flinders Rangers – her “safe place.” She stated she did not notice any effects from the trigeminal neuralgia during the hypnotic session. Our first session concluded as a positive and hopeful experience. Susan was subsequently happy to use the Church Steeple technique (Cyna, 2013) used in our initial pre-hypnosis visit and discussion as a means of self-hypnosis until our second session.

Susan’s second session took place three weeks after Session 1. During this time Susan used the Church Steeple technique (Cyna, 2013) as a form of self-hypnosis and visualized herself in her “safe place,” relaxing and enjoying her surroundings, and feeling happy as well as calm. At Susan’s second session we discussed “dialling down” Pain and Reinterpretation of Pain techniques (Patterson, 2014; Patterson & Jensen, 2014) and Susan was keen to explore these. Consequently, the following script was used in Session 2 and was prepared based on the Elevator Deepener technique (Bastarache, 2005).

I'd like you to use your imagination for a few moments. Just imagine that right in front of you within a few feet is an elevator door, visualize the door clearly in your mind ... the colour ... the texture ... how tall it is ... how wide it is ... what it is made of ... in just a moment you're going to enter the elevator and it will take you on a wonderful relaxing journey. It will be a very comfortable, spacious elevator. You will only have wonderful, relaxed feelings ... now the elevator doors open as you imagine yourself walking in and turning around so you're facing the doors and you see them close in front of you. You notice how comfortable you feel and how much

larger the elevator seems on the inside than you thought it would be. As you are looking at the doors of the elevator you notice just to the right of the doors a large panel. On this panel there are 25 buttons arranged from 25 on the top going all the way down to the number 1, which represents the bottom floor. Visualize this panel as clearly as you can, if you can't see it clearly, just imagine it and the same purpose is being served. What are the shapes of the buttons? Are they square, or rectangular or round? What colour are the buttons? What colour are the numbers on the buttons? Are they large or small? See as many details as you can ... you are on the 25th floor, and in just a moment you are going to press the number 1 button and you'll feel yourself descending downward. With each floor that you descend, you'll feel yourself descending downward. With each floor that you descend, you'll feel your body relax more and more until you get all the way down to the bottom floor ... and when the doors open you'll find yourself more relaxed than you have ever been before.

So let's go ahead and begin.

Imagine yourself reaching down and pressing the number 1 button ... as you feel the elevator descend downward to the 24th floor ... and you allow yourself to relax 23, 22 ... deeper and deeper ... 21, 20, 19 ... with each floor you descend, you go deeper and deeper ... 18, 17, 16 ... more and more relaxed ... 15, 14, 13 ... all the way down ... 12, 11, 10 ... peaceful and serene, all outside sounds just fading away into the distance ... 9, 8, 7 ... deeper and deeper ... 6, 5, 4 ... total relaxation, feeling wonderful in every way ... 3, 2 ... and finally ... 1 ... Deep ... Deep ... relaxation and you can remain in this deep relaxed state, and even deeper if you decide to, for the remainder of the session.

The suggestion was then made to Susan that we use guided imagery and again use the elevator control panel to dial down any discomfort she was experiencing from trigeminal neuralgia. This pain-decreasing action was reinforced by asking Susan if she was curious or even surprised to notice how comfortable she felt and the amount of control she had over her body. Following this exchange, Susan was asked to focus on the positive things that help her feel in control. Ego strengthening techniques were also implemented and a post-hypnotic suggestion was given encouraging her to return to her "safe place" at any time she felt the need and it was appropriate. This post-hypnotic suggestion was based on the Re-alerting technique (Cyna, 2013).

In our second session Susan reported similar feelings of calmness and control to those of the first session. She noted she felt she was able to minimize the pain from her trigeminal neuralgia and she also stated the stress of her workload was reduced dramatically. Susan noted feeling more "empowered"

and that she had found the visualization experiences in which she participated including colour and smell wonderful.

A month after our last meeting a follow-up phone conversation occurred. When asked if she was still using the above techniques Susan reported feeling significantly calmer and surprised at her ability to use both the Church Steeple and Elevator techniques to relieve some of the facial discomfort resulting from trigeminal neuralgia. She felt a greater level of control over her pain experiences. She reported sleeping more soundly and therefore has become less anxious and stressed. As a result, she has been able to function better and enjoy life more.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

Susan gained a great amount from using hypnosis as an adjunct for pain management. Her willingness and openness to experience something new was paramount in helping her learn new coping techniques. Unfortunately, living in the country limited and limits her access to various professionals, including those practised in hypnosis. Nevertheless, Susan has verbalized and encouraged this clinician to continue hypnosis with her any time I am visiting the area.

If Susan lived closer to Adelaide the hypnosis sessions might have taken place in a closer space of time and a couple more sessions could have been added. A larger repertoire of hypnotic suggestions and metaphors might have been helpful in her pain control.

In summary, hypnosis and self-hypnosis as an adjunct to medication for pain relief in a patient with MS and related trigeminal neuralgia was beneficial for Susan. Additional sessions and work would likely consolidate and further the gains made in pain management.

REFERENCES

- Australian Society of Hypnosis. (2013). *Code of Ethics*. Retrieved from Hypnosis Australia website: <http://www.hypnosisaustralia.org.au/wp-content/uploads/Code-of-Ethics.pdf>
- Bastarache, R. (2005). *Clinical hypnosis: Training manual from A–Z*. Retrieved from the American School of Hypnosis website: <http://www.choosehypnosis.com/free/book-hypnosis-certification-free-9-27-10-1.pdf>
- Cyna, A. (2013). *Student handbook – “Church Steeple” induction technique*. South Australia: Australian Society of Hypnosis Ltd.
- Hammond, D.C. (1998). Unconscious exploration with ideomotor signaling. In D.C. Hammond (Ed.), *Hypnotic induction and suggestion*. Chicago: American Society of Clinical Hypnosis.

- Montgomery, G.H., DuHamel, K.N., & Redd W.H. (2000). A meta-analysis of hypnotically induced analgesia: How effective is hypnosis? *International Journal of Clinical and Experimental Hypnosis*, *48*, 138–153.
- Multiple Sclerosis Society Australia. (2016). *What is MS?* Retrieved 16 October 2016 from <https://www.msaustralia.org.au/what-ms>
- Patterson, D.R. (2014). *Student handbook - dialling down pain-hypnosis for the management of pain*. Conference Hypnosis for Pain Control workshop. Adelaide, Australia.
- Patterson, D.R., & Jensen, M.P. (2003). Hypnosis and clinical pain. *Psychological Bulletin*, *129*, 495–521.
- Patterson, D.R., & Jensen M.P. (2014). Hypnotic approaches for chronic pain management: Clinical implications of recent research findings. *American Psychologist*, *69*, 167–177.
- Stewart, J. (2005). Hypnosis in contemporary medicine. *Mayo Clinic Proceedings*, *80*, 511–524.
- Trigeminal Neuralgia Association Australia. (2016). *What is trigeminal neuralgia?* Retrieved 16 October 2016 from <http://tnaaustralia.org.au/>
- Wicks, G.R. (1982). A rapid induction technique, mechanics and rationale. *Australian Journal of Clinical and Experimental Hypnosis*, *10*, 117–119.

HYPNOSIS AS AN ADJUNCTIVE TREATMENT FOR INTRAPSYCHIC RESTRUCTURING AND HEALING IN AN ADULT CHILD SEXUAL ABUSE SURVIVOR

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This case report outlines the use of hypnosis as an adjunctive treatment to a multi-modal psychotherapeutic intervention to achieve intrapsychic restructuring. The aim of treatment was to create a more compassionate “inner parent” to support the client’s tolerance of emotional vulnerability, her own and that of others. Hypnosis was offered to assist in the development of posited underutilized right brain functioning to enable intra- and inter-relational connection to be experienced at a depth of satisfaction not previously possible. The case report outcomes support the proposition that hypnosis can assist such development.

Keywords: childhood sexual abuse, age regression, hypnosis, corrective attachment experience, right-brain enhancement.

PATIENT’S PRESENTING PROBLEM AND REFERRAL DETAIL

This client, to whom we will refer as Sarah, was referred for psychological services by her general practitioner two years previously. Sarah noted her current problem and consequent area for therapeutic work as regarding an unresolved relationship issue between herself and her past perpetrator of sexual, physical, and emotional abuse. Sarah’s verbalized goal was to “get free from the pre-occupying bitterness that continued to surround thoughts of the person and items connected to him.” Sarah was clear that she was not seeking a “forgiving and forgetting” outcome nor was she interested in responding to his demands, both covert and overt, to have regular “normal” contact. After a discussion about the potential helpfulness of using hypnosis to address outstanding issues from past painful experiences, it was agreed to concentrate our work together on the use of a hypnotic induction and age

regression as an adjunct to the use of other psychotherapeutic modalities to aid in her verbalized goal.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

While engaging in hypnosis, Sarah was a new mother to a healthy infant. Although enjoying motherhood and reporting to be “surprised at how well” she was coping with a newborn, Sarah continued to seek psychological services to address interpersonal problems. These difficulties included a chronic and pervasive critical and dismissive reaction to the emotional and relational demands of significant others.

Sarah, a 31-year-old married client with tertiary qualifications, was on maternity leave from full-time professional employment while engaging in hypnosis. Sarah had been receiving psychological therapy from this clinician regularly for two years prior to any use of hypnosis. Her presenting issue as detailed on her original referral for services was unresolved grief resultant from the neo-natal death of her first-born several years previously. At the time of referral, she remained childless after two miscarriages. At that time, she was also having weekly sessions with a psychiatrist for psychoanalysis. The focus of our work had evolved to recognize unresolved and outstanding issues connected to her experiences of childhood sexual abuse (CSA). Sarah reported significant family of origin (FOO) issues including paternal alcoholism and emotional neglect and abuse from both parents.

Sarah's responses to and descriptions of interpersonal situations indicated a chronic state of anger (often in a passive state) which was usually directed at, but not restricted to, members of her FOO and significant others including her in-laws. Her reported experiences of their insensitive and hurtful behaviours seemed to interfere with her ability to “let go” several years on from the loss of her newborn baby. One could surmise that this situation is consistent with Parkes and Weiss' (1983) “Social Environment” as a factor interfering with healthy expression of grief and a sense of support within that experience, which Sarah reported was significantly absent.

Shear et al., (2011) proposed complex grief disorder (CGD) criteria to be included in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, 2013). Sarah met the following proposed criteria:

1. At least one of the following symptoms of persistent, intense, acute grief has been present for a period longer than is expected by others in the person's social (or cultural) environment:

- i. Persistent intense yearning or longing for the person who died
 - ii. Frequent intense feelings of loneliness, or that life is empty or meaningless without the person who died
2. At least two of the following symptoms are present for at least one month:
- i. Frequent, troubling rumination about the circumstances (or consequences) of the death
 - ii. Recurrent feelings of anger or bitterness related to the death
 - iii. Persistent difficulty trusting or caring about other people, or envy of others who have not experienced a similar loss

The meeting of these criteria supported the preliminary diagnosis of CGD, now referred to in the DSM-5 as persistent complex bereavement disorder. However, as psycho-therapeutic work continued with this client it became apparent that her psychological distress which included symptoms of depression and anxiety was related to a personality and cognitive style referred to as “intra-psychic structure” (see Klein, 1989). A developmental theory based upon attachment theory and object relations theory would suggest that this defensive structure is the probable result of early experiences of a family environment characterized by fear and lack of emotional availability (Masterson, 1985, 2000). Specifically, the early experiences of sexual abuse perpetrated by an older family member would likely also have contributed to Sarah’s lack of trust and fear of intimacy (Siegel, 1999, 2001).

Sarah presented with a highly “dismissive attachment style” (see Masterson, 2004; Wallin, 2007) and a well-developed defence against experiencing emotional vulnerability, her own or that of others. Considering the above, psychological work focusing upon her unintegrated experiences of CSA was warranted. This change of therapeutic focus to her past CSA was also supported by the fact that Sarah had completed a significant amount of work with a previous counsellor who specialized in grief, particularly grief resulting from the loss of an infant. Sarah also demonstrated a resourcefulness in “tapping into” bereavement groups that offered support for parents of deceased infants along with practices that would appear healthy in acknowledging the loss of her infant. Sarah’s problem presented as a sustained “bitterness” and “resentment” toward others who have not lost as she had and did not appear to “understand” her loss. She acknowledged this held position and her perceived inability to relinquish it. Sarah was at that time seeking help to overcome this psychological position.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

The decision to employ the hypnotic technique of age regression in my work with this client was supported by Barnett's (1981) descriptions of the application of such a technique. See also Dolan (1991) for further details on the use of Eriksonian techniques with clients specifically presenting with issues related to experiences of sexual abuse in childhood. It is important to also note that there was no intention to access "forgotten memories" but more to revisit emotionally painful and frightening situations with the goal of creating an opportunity for reparative work with the desired outcome being emancipation from the preoccupying destructive emotions and their accompanying thoughts. Furthermore, it has been well documented that when an individual can make sense of childhood traumatic experiences and apply a new meaning to an often shame-filled memory, transformation can occur (Delaney, 1991; Hughes, 2007). Hypnosis offers an opportunity to initiate new meanings regarding traumatic memories, making sense of childhood experiences in a way that has not been previously possible.

Having worked consistently with Sarah for nearly two years, this clinician could confidently rule out any contraindications for the use of hypnosis. Her ego-strength and lack of any personality disorder diagnosis supported the suitability of hypnotic engagement. Additionally, the purpose of hypnosis was agreed upon and the "recovery of lost memories" was explicitly not to be part of the work. Indeed, we both heeded warnings provided by McConkey and Sheehan (1997) drawn from a number of publications which also alert professionals considering the use of any psychological technique to recover memories of CSA, that such an endeavour needs to be embarked upon with considerable caution as the therapeutic value of such is highly questionable and "the emotional, societal, legal, and financial stakes can be very high in such cases" (McConkey & Sheehan, p. 270).

The process and possible outcomes of augmenting therapy with hypnosis were discussed. The possibility that some helpful "inner work" may be conducted during the hypnotic state within an area of the psyche that may not be as accessible during a regular alert state of consciousness (see Walker, 2014, p. 13) was reviewed. Opportunity was provided for questions and further discussion concerning hypnosis and its associated techniques and phenomena. Consequently, consent was obtained from Sarah to provide hypnotically based treatment for her presenting issues.

The following goals for hypnosis with Sarah emerged:

- To experience freedom from preoccupying “bitterness” towards her perpetrator and others regarding her experiences of childhood sexual abuse (CSA).
- In her relationship with her new baby, she expressed her desire neither to “pass on any of this bitterness” nor to allow it to adversely influence her parenting capacity.

My work in assisting Sarah to reach her second goal was to support “the development of a more adaptive working model of relationships” (Roberts & Roberts, 2007, p. 68). The development of such would serve to create a more optimal parenting capacity, one that would support a healthy parent-child relationship (Wallin, 2007).

TREATMENT PROGRESSION

In previous work, Sarah and this clinician had focused on mentalization based therapy (Bateman & Fonagy, 2006), mindfulness based cognitive therapy (Segal, Williams, & Teasdale, 2002), and psychodrama theory and techniques (Clayton, 1993; Moreno, 1977). Hypnoanalytic techniques informed largely by Watkins (1992) were chosen for use within the hypnotic treatment intervention. Sarah’s “inner working model of attachment” (Bowlby, 1988) was one of a dismissive attachment style which is recognized to put the relationship between herself and her infant at risk of transgenerational transmission (Berlin, 2005) of such an attachment status (Olds, 2005; Slade & Cohen, 1998). Sarah’s expressed goals along with this assessment seemed to create a good argument for the use of a therapeutic modality that may assist with intra-psycho repair work. Such a modality would need to provide an opportunity for the right hemisphere of the brain to be activated and nurtured in a way that originally did not occur (Wallin, 2007). As this is the area that responds and develops in nurturing relationships it is likely to be underutilized and therefore underdeveloped resulting in, as stated by Wallin (2007, p. 222), an excessive “dwelling mainly in a left hemisphere world organized by linear logic and language.”

In Sarah’s case it was hypothesized that the creation of an enhanced or adaptive “inner working model of relationships” (Bowlby, 1988) may be supported by the use of age-regression within hypnosis as there is the need for an internalizing of a different experience within relationships (Roberts & Roberts, 2007). Age regression, as a vehicle to achieve the creation of a different relationship with herself, through the integration of unintegrated “parts” (Barnett, 1981) or “roles” (Clayton, 1993; Moreno, 1997), was employed. For Sarah to provide herself with a “sensitively attuned” “inner

parent” (Cassidy et al., 2005) within the age-regressed state may provide a corrective attachment experience. The transgenerational benefits of such outcomes are well documented (Berlin, 2005; Lieberman & Zeanah, 1999). In summary, the intention was to use hypnosis to bypass Sarah’s well-developed “dismissive” defensive response (see Pratt, Wood, & Alman, 2009) and access a more compassionate way of responding to emotional experiences and needs, her own and those of others.

ENGAGING IN HYPNOSIS

The following hypnotic techniques, among others, were utilized and the rationale for each is provided in the context of the session in which they were elicited and provided: seeding, imagery, dissociation, anchoring, fractionation, utilization, post-hypnotic suggestion and ideomotor signalling, age regression, revivification, as well as partial regression and stage regression.

Our first session, as previously agreed, was dedicated to discussing the use of hypnosis to provide an introduction to the hypnotic experience and provide Sarah with a positive experience of being taken into a deep state of relaxation, visualization and trance. Additionally, the goal was to facilitate her experience of a visualized empowered state with positive affect and to build her capacity to use this “state” as a resource when required.

The induction utilized was a modified version of Graham Wicks’ “The Induction of Hypnosis by Eye Fixation and Distraction” (2014). Ideomotor finger signalling was established with three digits identified for communicating an affirmative, negative, and a not knowing/choose not to answer response (see Hammond, 1998b). The deepening technique of descending a 20-step staircase including visualization of the covering of the steps was then provided (see Hammond, 1998a) emphasizing safety and control.

As Sarah started to produce a spontaneous coughing fit requiring her to sit up and reach for her bottle of water, with her eyes still closed, contingent suggestions utilizing this behaviour were made to “take her even deeper” (see Hammond, 1998a). Suggestions that served to facilitate the provision, by Sarah’s unconscious mind, of a safe place where positive affect could be experienced along with a broad range of sensory experiences. Ideomotor signalling was used to ascertain Sarah’s capacity to engage in this imagery. An “anchoring” technique was then taught to reinforce the connection between the image, the good feelings, and the pressing of the thumb and index finger to make a circular okay sign (see Levitan, 1998).

Leading on from having Sarah “anchor” feelings of empowerment and freedom that she had created and guided by Levitan’s article (1998), I provided instruction on how she might achieve a temporary and brief state of self-hypnosis to take herself into her safe place by stating the following before ideomotor signalling was used to indicate Sarah’s readiness to be re-alerted by ascending the aforementioned 20-step staircase:

It will be your little vacation from such difficult feelings and inner experiences ... you just press that finger and thumb together take a deep belly breath in and blow out all the feelings you don’t want at that time, blow them out into the atmosphere and you will find that you can be there, back there, in your special place where you can think in a clear and calm way, where you feel warm and relaxed, confident and comfortable and in control ...

After emerging from hypnosis, Sarah was provided time to reorient to her surroundings and discuss her experiences as she so desired. Sarah’s safe place, where she experienced a sense of empowerment and joy, was on her surfboard out in the waves as a teenager. She described herself as a “bold” and “gutsy” 18-year-old. Sarah reported that she enjoyed the experience and found it “powerful.” She expressed her keenness to have further hypnosis in an attempt to heal the emotional and psychological pain resultant from her history of CSA.

In our second session, Sarah reported using the anchoring technique when she experienced distressing emotions resultant from interpersonal situations. She reported that she found this helpful. We then discussed the use of age regression techniques and Sarah expressed her willingness to do this work. Given the ease with which Sarah went into trance in her previous session a briefer trance induction was provided (Shum, 2013). In trance, a communication system was established via setting up ideomotor signalling. Deepening was achieved by visualizing descending a 20-step staircase. A safe place was established with the suggestion that this place could be returned to if and when required both within trance and post hypnosis. The following suggestions and script was then provided:

[T]his is a good time for your unconscious mind to let you know about one of the memories that needs to be revisited for healing ... a time in your life when you had some very strong feelings and were unable to manage them because you were too little and there was no one there or available to help you with strong painful feelings so they just went inside and you carried on with your life however you could to get by, to survive, to stay safe, to develop and succeed in so many areas of your functioning ... so let me know with your finger signalling when you have been presented by your

unconscious mind of a moment, a time when this was your experience ... If there is a need to talk ... you can allow your tongue and mouth to speak while staying a deep state of trance and the speaking will actually take you deeper ...

Subsequently, a dialogue was had with Sarah regarding the situation she was experiencing and the associated feelings. She presented in a child-like state. Reassurance was provided to her in this state, that she was too young to be responsible for what she experienced and that she was only doing what any little girl would do to elicit love and affection from her parents that was unavailable to her at that time and who were in fact the ones who should have been providing that nurturance and protection. Focus then was turned to her grown-up self by stating:

Okay so now it's time to take your grown-up self [transitioning her to a partial regression], your wise, mature, and intelligent self to this scene, to little Sarah and be with her to give her exactly what she needs in that moment ...

From this point forward, the use of ideomotor signalling rather than any dialogue between clinician and client was implemented.

[T]hat's right you are a great resource to that little girl because you and only you know exactly what it is that she needs and would help her to feel that something can be done about those strong uncomfortable feelings as an adult and you can revisit little Sarah ... and let her know how much you care about her sadness and pain and anger and aloneness whenever the need arises ... in fact you can take this little girl into your safe place and be with her to help her heal, to help her know that something can be done and that she is not alone, not abandoned in her distress ... Just be with her for as long as you need and when you're finished for now let her know that you can revisit her at any time she needs you but for now you'll say farewell ... just let me know with your yes finger when you have finished being with her for now ... and we will start our ascent back to your normal fully alert state ...

As the next therapeutic session was conducted with Sarah's baby present we agreed that a hypnotic induction was not appropriate but we would use the session to discuss what had been happening since our previous session and any feedback from the hypnosis Sarah wished to provide. Sarah reported applying her "adult self" (the one we used in hypnosis to respond to the needs of the "little one") to distressing thoughts, memories, and current challenging interpersonal situations. She stated that she had developed a sense of empowerment and competence to manage psychological distress by using this position of compassion and wisdom to the frightened or angry "little girl." In discussing future sessions, Sarah expressed an enthusiasm and a willingness to attend to childhood memories that may require further healing and psychic integration.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

In retrospect, it would be interesting to consider the use of the Affect Bridge technique to possibly provide a more powerful experience with the inclusion of abreaction and a resultant greater intra-psychic healing. Nevertheless, Sarah developed a different relationship with herself and the use of hypnosis, in particular the hypnotic techniques of age regression, revivification, and partial regression appeared to play a significant role in this intra-psychic enhancement. Roberts and Roberts (2007) refer to this intra-psychic development as “reproceduring” which can also be attained through an adequate and diagnostically informed relationship between psychotherapist and client (see also Broom, 2010). The well-established therapeutic alliance that existed between this client and myself must be considered to have played a significant role in therapeutic outcomes. It is clearly beyond the scope of this paper to go into greater detail of the neurobiological development that may have resulted from the hypnotic interventions provided for this client. But suffice to say that, according to Masterson (2005) and other neuropsychological scientists and therapists (see also Schore, 1994; Siegel, 1999), within the right orbitofrontal cortex can be found “a neurobiologic center of the self” (p. 10) which is dependent upon an early attuned relationship for its very development. I posit that by Sarah providing her own “little one” with an attuned response to her distress that she was assisting such neurobiological development. In summary, hypnosis was used as an adjunct to the established therapeutic work ongoing with Sarah. Hypnosis was observed to add a helpful dimension of support for the intra-psychic and resultantly inter-psychic development goals identified. Our work together continues.

REFERENCES

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- Bateman, A., & Fonagy, P. (2006). *Mentalization based treatment: A practical guide*. Oxford: Oxford University Press.
- Barnett, E.A. (1981). *Analytical hypnotherapy: Principles and practice*. Kingston, Ontario: Juniper.
- Berlin, L.J. (2005). Interventions to enhance early attachments. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson, & M.T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 3–33). New York: Guilford Press.
- Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.
- Broom, J. (2010). Towards, away, against: Coping role strategies as attachment styles. *Australian and Aotearoa New Zealand Psychodrama Association Journal*, 19, 10–20.
- Cassidy, J., Woodhouse, S., Cooper, G., Hoffman, K., Powell, B., & Rodenberg, M. (2005).

- Examination of the precursors of infant attachment security. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson, & M.T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 34–60). New York: Guilford Press.
- Clayton, G.M. (1993). *Living pictures of the self: Applications of role theory in professional practice and daily living*. Caulfield, Victoria: ICA Press.
- Delaney, R.J. (1991). *Fostering changes: Treating attachment-disordered foster children*. Fort Collins, CO: Corbett Publishing.
- Dolan, Y. (1991) *Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors*. New York: Norton.
- Hammond, D.C. (1998a). Methods of deepening involvement in a hypnotic state. In D.C. Hammond (Ed.), *Hypnotic Induction and suggestion* (pp. 71–79). Chicago: American Society of Clinical Hypnosis.
- Hammond, D.C. (1998b). Ideomotor signaling: A method for rapid unconscious exploration. In D.C. Hammond (Ed.), *Hypnotic induction and suggestion* (pp. 113–121). Chicago: American Society of Clinical Hypnosis.
- Hughes, D. (2007). *Attachment: Family focused therapy*. New York: W.W. Norton.
- Klein, R. (1989). Application to differential diagnosis. In J.F. Masterson & R. Klein (Eds.), *Psychotherapy of the disorders of the self* (pp. 9–29). New York: Brunner/Mazel.
- Levitant, A.A. (1998) Training patients in self-hypnosis. In D.C. Hammond (Ed.), *Hypnotic induction and suggestion* (pp. 80–82). Chicago: American Society of Clinical Hypnosis.
- Lieberman, A.F., & Zeanah, C.H. (1999). Contributions of attachment theory to infant–parent psychotherapy and other interventions with infants and young children. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 555–574). New York: Guilford Press.
- Masterson, J.F. (1985). *The real self: A developmental, self and object relations approach*. New York: Brunner/Mazel.
- Masterson, J.F. (2000). *The personality disorders*. Phoenix, AZ: Zeig, Tucker & Thiesen.
- Masterson, J.F. (2004). The self in the personality disorders: An integration of attachment theory, neurobiologic brain research, and developmental object relations theory. In J.F. Masterson & A.R. Lieberman (Eds.), *A therapist's guide to the personality disorders* (pp. 13–21). Phoenix, AZ: Zeig, Tucker & Thiesen.
- Masterson, J.F. (Ed.). (2005). *The personality disorders through the lens of attachment theory and the neurobiologic development of the self*. Phoenix, AZ: Zeig, Tucker & Thiesen.
- McConkey, K.M., & Sheehan, P. (1997). Recovered memory, hypnosis and professional issues. *Australian Journal of Clinical and Experimental Hypnosis*, 25, 263–280.
- Moreno, J.L. (1977). *Psychodrama: First volume* (4th ed.). Beacon, NY: Beacon House.
- Olds, D. L. (2005). The nurse–family partnership: Foundations in attachment theory and epidemiology. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson, & M.T. Greenberg (Eds.), *Enhancing early attachments: Theory, research, intervention, and policy* (pp. 217–249). New York: Guilford Press.
- Parkes, C.M., & Weiss, R.S. (1983). *Recovery from bereavement*. New York: Basic Books.

- Pratt, G.J., Wood, D.P., & Alman, B.M. (2009). *A clinical hypnosis primer* (3rd ed.). La Jolla, CA: Psychology and Consulting Associates Publishers.
- Roberts, D.D., & Roberts, D.S. (2007). *Another chance to be real: Attachment and object relationship treatment of borderline personality disorder*. New York: Jason Aronson.
- Schore, A.N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.
- Segal, Z., Williams, M., & Teasdale, J. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
- Shear, M.K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., Reynolds, C., et al. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, 28(2), 103–117.
- Shum, N. (2013). Deep trance. *Australian Journal of Clinical and Experimental Hypnosis*, 40, 160–161.
- Siegel, D.J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford Press.
- Siegel, D.J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships, “mindsight” and neural integration. *Infant Mental Health Journal*, 22, 67–94.
- Slade, A., & Cohen, L. (1998). The process of parenting and the remembrance of things past. *Infant Mental Health Journal*, 17, 217–238.
- Walker, W.-L. (2014). *Student handbook*. Australian Society of Hypnosis Ltd.
- Wallin, D.J. (2007). The dismissing patient: From isolation to intimacy. In D.J. Wallin (Ed.), *Attachment patterns in psychotherapy* (pp. 211–223). New York: Guilford Press.
- Watkins, J.G. (1992). *Hypnoanalytic techniques: The practice of clinical hypnosis: Vol. 11*. New York: Irvington.
- Wicks, G. (2014). The induction of hypnosis by eye fixation and distraction. Hand-out provided to students enrolled in the 2014 ASH (South Australian Branch) Diploma of Clinical Hypnosis program.

METASTATIC CANCER AND HYPNOSIS

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Hypnotherapy was aimed at providing relief from the side effects of chemotherapy in a woman undergoing cancer treatment. Medical hypnosis has profound implications regarding the treatment of chemotherapy side effects. In particular, the power of the subconscious and the remarkable changes that can occur when a patient is open to suggestion of change are of special relevance to those suffering chemotherapy side effects. With the use of hypnotherapy a client was able to overcome the side effects of her chemotherapy. Despite her grim cancer prognosis, she was able to remain focused and regain a sense of control over her life. With the utilization of relaxation therapy, self-hypnosis, and autogenic training the client was equipped with tools enabling her to become adequately self-sufficient in the practice of hypnosis, thus maintaining a relatively normal lifestyle. The hypnotherapy sessions outlined openly illustrate and explain how hypnosis can be effectively used in conjunction with medical treatment and practice.

Keywords: anxiety, cancer, chemotherapy, hypnosis, relaxation, self-hypnosis.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

Shaz, a pseudonym, was referred for hypnosis by a friend who thought hypnotherapy would be a helpful and a cost-effective way to assist Shaz with her cancer treatment. Specifically, Shaz was fearful of the unknown despite the fact that she had previously experienced three or four rounds of chemotherapy and knew what to expect from the side effects. Shaz's main goal was that she wanted to be able to remain as active and stress free as possible throughout treatment. However, she found it difficult to relax. Understandably so, as Shaz had found that her breast cancer had metastasized to her lungs.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Shaz was born in England in 1958, married, and had two children. She presented as a well-dressed modern young woman with steady eye contact. At our first meeting she appeared apprehensive and as though she was attempting to control her emotions. Shaz noted she had just come from her oncologist who had confirmed that her breast cancer had now metastasized, invading her lungs. Shaz was determined to try hypnotherapy. She noted she had survived cancer before and was eager to start treatment and hypnotherapy as soon as possible as she believed she had everything to live for and wanted to focus positively on living.

Shaz has had no other medical problems prior to breast cancer. She was first diagnosed with it in 2007 and a left mastectomy was performed along with the removal of her axillary lymph nodes. This surgical procedure was followed by three to four rounds of chemotherapy. In September 2012 Shaz was re-diagnosed with breast cancer, which had now metastasized to her left lung and was scheduled for a further chemotherapy.

Shaz was sent to boarding school at the age of seven and she is now aware that this had a negative effect on her life. She has a very supportive husband and daughter. Shaz, who feels that her mother is too self-involved to care for her appropriately, has also had no contact with her father since she was a child. She is a successful businesswoman and enjoys riding her horse whenever possible. Shaz knows what is ahead of her concerning her cancer treatment, as she had cancer five years previously, and she believed she would handle the side effects of chemotherapy one day at a time. She declined psychological and social related intervention support initially when it had been offered to her.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Shaz was a good subject for hypnotherapy as she had the determination, courage, and resilience to focus on her health problem and challenge the nature of same. The oncologist had truthfully portrayed a grim road ahead and she had everything to gain from overcoming cancer and nothing to lose by persevering. She expressed her desire to use her voiced ability to visualize and change sensations, perceptions, thoughts, and behaviour. She noted that

she could make the “not so nice factors” recede into the background and the “pleasurable experiences” appear closer. Shaz was indeed very visual and went into a trance readily, which was likely aided by the fact that she had been doing meditation for six weeks since her most recent cancer diagnosis and found it helpful (Yapko, 2003, 2012). Having experienced benefits from meditation most likely helped her trust in the hypnotic process.

The hypnotherapy goals were to enable Shaz to maintain adequate rest using relaxation and breathing techniques to calm her sympathetic nervous system and activate her parasympathetic nervous system (Yapko, 2003, 2012). Another goal was to assist Shaz in relaxing so that she was able to be relatively stress free and courageously face her fears, to use laughter as medicine, and to utilize music for relaxation and hypnotherapy sessions (Temes, 2004; Yapko, 2003, 2012). Shaz expressed her wish to use hypnotherapy for support and assistance throughout her medical interventions and resulting side effects. Another goal was to teach her self-hypnosis and autogenic training to provide a sense of control over her treatments, her life, and to assist her coming to terms with what was happening to her health (Schultz & Luthe, 1959). To summarize, the hypnosis sessions were designed to maintain hope above all else.

TREATMENT PROGRESSION

The techniques chosen were to maintain hope and positivity by providing Shaz the ability to overtly cause changes in her sensations, perceptions, thoughts, and behaviour. Therapeutic rapport was built quickly within the first session by purposefully mirror matching, and pacing. Initially we worked with Shaz's eyes closed and used the metaphor and visualization of her favourite place to allow the unpleasant side effects of her chemotherapy to recede into the background and pleasurable experiences to come forward. Autogenic training as well as general relaxation and breathing techniques for her own use were discussed, employed, and practised (Schultz & Luthe, 1959; Temes, 2004; Yapko 2003, 2012). This helped Shaz gain a sense of control over her treatments and her resulting shortness of breath. Recordings for sleep and relaxation as well as autogenic training were made (Schultz & Luthe, 1959). These proved paramount in her sense of healing and regeneration of cells through calming her parasympathetic nervous system and enabling digestion and regeneration to occur. She felt this allowed her brain to rest and recuperate. Shaz's ability to take herself into a deep trance was to assist her with the side effects

of chemotherapy when severe (i.e., nausea, vomiting, fatigue, weight loss, depression) (Temes, 2004).

Information from her dietician was incorporated into her hypnotherapy sessions and other suggestions were given for the milder side effects of chemotherapy to be regarded as therapeutic and integrated as positive (an expulsion of toxins) to show that the chemotherapy was doing what was intended (Temes, 2004). A goal was for her to weigh herself daily, giving back some control which she felt she had lost. When she was fatigued the goal was to pace herself using relaxation and autogenic techniques (Schultz & Luthe, 1959). On the days she felt herself becoming less positive a goal was to maintain reasonable endorphin levels by using either self-hypnosis or the relaxation recording previously created for her with suggestions to go to her favourite place (Barber, 1996). Music was included during her sessions and on her recordings to increase her endorphin levels. Specifically, when Shaz felt anxious or the side effects of the chemotherapy were overwhelming the music could enable her to return to a time in her life when happy and healthy memories prevailed and the goal reframing from the negative to a positive was reinforced via the music (Temes, 2004).

ENGAGING IN HYPNOSIS

Prior to starting the first hypnotherapy session, Shaz was informed that hypnotherapy could be helpful for her life situation, even though it was not medication, meditation, psychotherapy, relaxation, or sleep. Basic information was provided and this included how she would maintain control and safety. Shaz had noted she was participating in both acupuncture and Chinese medicine techniques with her general medical practitioner who was also a naturopath. She expressed that she was stressed and fearful of the unknown as her cancer had returned and this time metastasized to her lung (Yapko, 2003, 2012).

In our first session the induction began with autogenic training to assist her with relaxation and by using a few metaphoric suggestions she went to her favourite place to relax and destress (Schultz & Luthe, 1959; Yapko, 2003, 2012). Metaphors to cleanse her chakras (envisioned key centres of energy in the body) were applied as this was synergistic with chemotherapy treatment. Ideomotor responses, contextualization, and post-hypnotic suggestions were used to assist with any side effects of chemotherapy suggesting she could extend this to future behaviour (Temes, 2004).

After the session, Shaz appeared and stated that she felt much more relaxed than she had for ages. She noted having gone to her favourite place which was described as the beach at sunrise and the metaphoric use of a dawn which often occurs after the darkest part of night was not misplaced. Shaz noted she “loved” the chakra cleanse and imagined it cleaning up all her “nasties” and requested a recording of same be made as it was an enjoyable experience for her. Such a recording was provided, as was one on autogenic training and relaxation (Schultz & Luthe, 1959; Yapko, 2003, 2012).

Prior to our second session, a phone follow-up contact occurred. Shaz noted that she was using the recordings and was sleeping and feeling much better.

Session 2 began with Shaz feeling more relaxed than during the first session. However, she was fatigued and asked if visualization and relaxation could be an initial focus. After the induction, Shaz was encouraged to visit her favourite place and once ideomotor responses noted she has arrived at same, suggestions were applied as requested. During this session rapid eye movement and altered breathing patterns were readily observable. The post-hypnotic suggestions applied were chosen specifically to target the chemotherapy side effects that were likely to become more apparent in the weeks to come. Closure and disengagement then completed the session.

After this session, Shaz was notably excited and voiced she could visualize “Pac Men” (i.e., cartoon computer entities that consume cartoon computer symbols) working in with the chemotherapy (Temes, 2004). To state the event succinctly, Shaz could see her “cancer” being consumed and taken away visually. Upon reorientation she noted she wished the session had not come to an end.

As previously, a follow-up contact was made by phone. During this contact Shaz indicated she was sleeping better, having naps as needed, and learning to pace herself as well as listen to her body. However, she continued to note she was fatigued.

Session 3 found Shaz stressed as she was waiting for her most recent blood results. Thus, she wanted to concentrate on relaxing as she was concerned about her shortness of breath which had occurred while riding her horse. Consequently, the session began with an ultimate body relaxation concentrating on breathing techniques in conjunction with music in the background while going to her favourite place (Yapko, 2003, 2012).

Shaz noted after reorientation that she felt refreshed and revitalized. Indeed, she appeared more relaxed and refreshed. Shaz stated that she had seen herself riding her horse along a beach and feeling his flesh against her skin. She indicated that she could have stayed there forever.

During our regular follow-up by phone, Shaz said she was sleeping better and was taking naps when necessary. She noted she was very happy with her progress in treatment for her cancer and hypnosis.

Session 4 started with Shaz relaying that she had received a good report on her blood results, which were improving with her chemotherapy. However, her emotions were fluctuating, she had been feeling nauseated, was still short of breath, and now she was rapidly losing her hair. Shaz stated she also felt very lonely despite gaining support from her husband, daughter, friends, and horse. She asked to target relaxation and breathing techniques and this request was accommodated (Yapko, 2003, 2012).

Shaz went quickly into a trance which was evidenced by her altered breathing, muscle relaxation, and lacrimation. She was directed to her favourite place to relax and enjoy the moment. A metaphor for cleansing emotional baggage was applied and then closure and reorientation proceeded.

At our regular follow-up phone call, Shaz was coping well and was eager to announce that she did recall one thing from the emotional baggage scenario. Specifically, Shaz noted seeing a book on the floor and the title of the book was "Mum." It Turns out that Shaz had phoned her mother but was disappointed with her mother's response. Shaz was left feeling that her mother was too preoccupied with herself, as was her usual experience, to be really bothered to do more than provide superficial comfort (lip service) to Shaz. This led to the realization that Shaz's feelings of loneliness and abandonment were issues which originated from within her early childhood. She has now decided to adjust her expectations of her mother as she feels she has enough to cope with.

Session 5 began with Shaz expressing happiness with how she has been coping with her chemotherapy. An update on her progress noted that Shaz's bloods were still down, nausea was in hand, but occasionally she needed medication to relieve her vomiting. She could manage digesting smoothies full of nutrients as suggested by her dietitian to combat weight loss. Nothing had changed regarding her relationship towards her mother, but she was willing to continue with hypnotherapy to see what ensued. In Session 5, a metaphor for growing herself back up was applied (Lee, 2001). The session progressed

smoothly and on reorienting back to the current time and place she felt exhausted but also as though a huge weight had been lifted from her. Shaz noted she could now see her parents in a different light and she expressed the insight that the things that had been triggering her were from her past experiences.

During our follow-up phone call Shaz noted she was feeling far more at peace and found the last session particularly helpful to her and has decided because it was school holidays she would have a two week break from all her therapies and just concentrate on her family.

A subsequent follow-up phone call found Shaz noting that she was now considered to be in remission from cancer.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

At last contact, Shaz was persisting with her self-hypnosis and expressing her wish to maintain the confidence and control she has felt in her life through our work together (Barber, 1996). She indicated she would make another appointment for hypnosis after the school holidays. Shaz was coping remarkably well with her ongoing side effects and was feeling more positive about her health. She indicated specifically “I am taking one day at a time.”

In retrospect, it appears medical hypnotherapy is not used often in the field despite it being relatively simple to learn, cost effective, and easy to teach to clients. The use of medical hypnosis was helpful for Shaz as she had a very good imagination. The use of suggestion and metaphor worked well with her as opposed to the use of direct instruction to avoid resistance. The trance state allowed Shaz the freedom to let her subconscious mind solve problems and gain fresh perspectives. This case report has described the successful use of hypnosis regarding the emotional and treatment of side effects of chemotherapy in a client with cancer. The fear, anxiety, and vulnerability with being a cancer patient were aptly addressed via hypnosis (Temes, 2004; Yapko, 2003, 2012).

REFERENCES

- Barber, J. (1996). *Hypnosis and suggestion in the treatment of pain*. New York: W.W. Norton.
- Lee, J. (2001). *Growing yourself back up: Understanding emotional regression*. New York: Three Rivers Press.
- Schultz, J.H., & Luthe, W. (1959). *Autogenic training: A psychophysiological approach in psychotherapy*. New York: Grune & Stratton.

- Temes, R. (2004). *Self-hypnosis: The complete idiot's guide to hypnosis* (2nd ed.). New York: Penguin Group.
- Yapko, M.D. (2003). *Trancework: An introduction to the practice of clinical hypnosis* (3rd ed.). New York: Routledge.
- Yapko, M.D. (2012). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York: Routledge.

HYPNOTIC ENHANCEMENT OF COGNITIVE-BEHAVIOURAL THERAPY FOR REDUCTION OF CHRONIC HEADACHE INDUCED BY ACADEMIC ANXIETY

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This case is illustrative of how hypnotic interventions can support cognitive-behavioural therapy (CBT). Specifically, academic stress triggered tension headaches in a university student are addressed via hypnotically supported CBT. The hypnotic interventions were of an ego-strengthening nature and ranged from a basic form of self-hypnosis using the classic “dial” imagery to a more complex and clinician-guided approach to “age progression” to facilitate the mental rehearsal of problem-solving skills. Despite measurable treatment gains, the limitations of this brief and skill-building approach are examined from a psychodynamic perspective.

Keywords: hypnosis, cognitive-behavioural therapy, headache, achievement anxiety, university student, psychodynamic perspective.

PATIENT’S PRESENTING PROBLEM AND REFERRAL DETAIL

The client, for whom the pseudonym Amy will be used, was 21 years old and a local (Singaporean) Chinese full-time undergraduate student. Amy was in the third year of her studies in information technology. She was the only child from an intact family and had never been married or in a romantic relationship. She was a self-referred client at the psychology clinic at her university and reported difficulty in managing her academic stress and related headaches.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Amy reported experiencing headache approximately weekly, with each episode lasting from half to a whole day. The intensity of each headache episode generally varied from 4/10 to 9/10 with higher numbers indicating greater levels of pain. The pain was often felt on the right side of her head, but from time to time it also changed its location. The pain would cause her to lose concentration, energy, and appetite, and Amy reported she also became irritable. When she experienced headache, Amy's tendency was to look for friends to talk to about the intense discomfort or her prevailing distress. Her friends had indicated that they found her frequent complaints tiresome and were becoming increasingly unwilling to listen to her descriptions of distress. Consequently, she felt troubled about seeking social support in dealing with her overall stress at university and recurrent headache.

During Amy's intake session at the psychology clinic, where this clinician met her, she sat in a conspicuously slouching posture. Her results on two psychometric self-rating questionnaires (Corcoran & Fischer, 2000) were as follows:

AAT (Achievement Anxiety Test) ratings

Facilitating scale (for anxiety that strengthens academic motivation): 9 (Moderate)
 Debilitating scale (for anxiety that weakens academic performance): 20 (High)

PCS (Pain Catastrophizing Scale) ratings

Rumination: 10 (Moderate)
 Magnification: 11 (High)
 Helplessness: 14 (Moderate)

Amy stated that as a child she was "perfectionistic" and competitive with a tendency to get upset and teary if she did not get one of the highest marks in her class. She additionally noted being critical towards classmates who achieved better marks. Amy asserted that while her parents were constantly strict and emphasized that she should do her best in school, she had at no stage experienced in her family or otherwise any particularly traumatic incidents. In general, her academic performance had been above average and was mainly sustained by consistent self-discipline and stressful study habits. Amy had also adopted a habitually slouching posture, and her parents had pointed out that it could have contributed to her headache episodes.

Amy reported that her headaches had started at age 16 when she was feeling exceedingly distressed in preparing for her high school examinations, in which she achieved favourable results. Thereafter, her academic experience had continued to be a stressor but without any significant setbacks, indicating her overall resourcefulness and achievement orientation. Further, she demonstrated her psychological mindedness with her awareness of a pattern that the headache episodes had mostly been triggered by impending tests, examinations, or deadlines for major assignments.

Consultations with three medical specialists revealed no physical abnormality related to Amy's headaches. She had consistently been informed that she was experiencing tension headaches (i.e., not migraine or other forms of headache) and that her pain was predominantly the result of muscular and emotional tension.

Amy related that her methods of coping with headache (with varying degrees of success) included taking painkillers, sleeping, playing a musical instrument (a flute), and communicating with her friends thus gaining social support over the phone or through social media. She denied any otherwise significant stressors in her current life or psychiatric or medical history, including the consumption of alcohol or recreational substances. She did not fully meet the DSM-5 diagnostic criteria for any anxiety or depressive disorders (American Psychiatric Association, 2013).

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Amy initially said that she had not previously experienced formal hypnosis. Nevertheless, she was later able to relate hypnosis to the "calm and spacious" state of absorption she often experienced when she played her flute, and she became eager to learn the skills that could enable her to purposefully enter that soothing state.

Contraindications for hypnotic treatment (e.g., dissociative or psychotic conditions) were assessed to be not significant for Amy's condition. Further, she spontaneously reported relaxing and pleasant examples of the hypnotic phenomena of auditory hallucination (e.g., getting absorbed in hearing herself play her flute in her imagination) and time distortion (e.g., feeling that only five minutes had passed after almost 45 minutes of playing her flute), reflecting a suitable level of hypnotizability according to the Stanford Hypnotic Clinical Scale for Adults (Morgan & Hilgard, 1978). When physiological information

on how hypnosis could reduce school-related stress and therefore headache was provided to her this increased her confidence in her ability to manage the headache.

Arnett (2000) has coined the term *emerging adulthood* to characterize the psychological challenges and opportunities that are typically faced by persons from age 18 to age 29. Among the challenges and needs experienced by persons in this developmental stage is an attempt to consolidate a sense of personal identity and autonomy in relation to the pursuit of goals based on their own emerging value systems. A primarily cognitive-behavioural therapy (CBT) approach was selected for Amy because of its explicit focus on promoting self-efficacy through systematic self-discovery and the attainment of both rational and creative problem-solving capabilities.

The suitability of CBT for Amy's concerns was further supported by evidence that CBT was effective in reducing university student anxiety (Dickson & Gullo, 2015). Moreover, for both the presenting problems of tension headache and academic stress there is clear evidence of symptom relief following integrative applications of CBT and skills in self-hypnosis (Alladin, 2008; Patterson, 2010). Accordingly, the hypnotic interventions employed in treating Amy's achievement-related anxiety and headache were created to be of an ego-strengthening and skill-building (in contrast to regressive and uncovering) nature.

In sum, Amy's longstanding history of headache was conceptualized as mainly a result of a skill deficit, specifically, a lack of effective (academic) stress reduction skills and communication skills for gaining support from others. She was assessed as a suitable client for CBT based on (a) the CBT emphasis on resolving a skill deficit with skill-building methods, (b) her natural capacity in noticing her own thinking style, (c) her interest in the process of constructing a CBT formulation for her headache, and (d) an apparent absence of early traumas such that the treatment could focus more on shaping the present and future rather than reconstructing and resolving past issues. Additionally, specific neurophysiological pathways for pain have been shown to respond to both direct and indirect hypnotic suggestions (Dillworth, Mendoza, & Jensen, 2012). Her spontaneous experiences of hypnotic phenomena also indicated that she would be a responsive hypnotic client. Hypnotic interventions were then designed and incorporated to enhance the overall effectiveness of her CBT treatment plan (Eimer, 2008; Yapko, 2012).

TREATMENT PROGRESSION

Informed consent was obtained after Amy was briefed regarding typical experiences as well as seemingly strange thoughts and feelings that she might encounter while experiencing hypnosis. She was informed that, during any hypnotic activities in our sessions, she could gently raise one of her hands to indicate her wish to pause the process and communicate her needs anytime. Her consent to follow through a comprehensive, cognitive-behavioural treatment plan (presented below), which incorporated clinical hypnosis, was documented in her clinical notes.

Thus, treatment goals were collaboratively developed with the client and interventions were explicitly discussed. This CBT treatment plan integrated biopsychosocial considerations and kept a clear focus on symptom reduction through psychoeducational and skill-building interventions. The planned hypnotic interventions began with the foundational instruction on self-hypnosis for general relaxation training. Subsequently, hypnotic techniques were employed to target precise goals (i.e., using guided imagery to decrease the pain experiences and using age progression to decrease the academic anxiety, reinforce the social skills learned, and facilitate relapse prevention). These treatment goals and interventions are as follows:

Table 1: Cognitive-Behavioural Treatment Plan with Hypnotic Interventions

Goals	Interventions
(1) Increased knowledge about how stress heightens likelihood of headache	(a) Providing psychoeducation on stress physiology in general (b) Discussing with her CBT formulation of her unique pattern of cognitions, behaviours, emotions and bodily reactions that perpetuated her headache (c) Providing psychoeducation on relaxation response and simplified method of eliciting it
(2) Increased knowledge and willingness regarding adoption of postural habits that can reduce headache	(a) Providing recommendation for her to obtain from qualified physiotherapist assessment, advice or treatment toward maintenance of healthy posture for long-term relief from headache

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|---|---|
| <p>(3) Decreased stress level regarding academic tasks and achievement overall as measured by AAT ratings</p> | <ul style="list-style-type: none"> (a) Guiding her in identifying, challenging and modifying her perfectionistic pattern of cognitions (including core beliefs), behaviours and emotions that perpetuated her school-related stress (b) Guiding her in cultivating self-talk habits that were self-affirming and self-soothing (c) Guiding her in enhancing her existing methods for stress relief (including improving her social skills in gaining emotional support from others) (d) Instructing her on basic self-hypnosis (i.e., age progression) for managing school-related stress (e) Arranging for her to consult learning support team at her university on effective skills for managing assignments, tests, and examinations |
| <p>(4) Decreased headache (in its average frequency, intensity or duration) and related PCS ratings</p> | <ul style="list-style-type: none"> (a) Providing hypnotic treatment that incorporates dial imagery (b) Providing hypnotic treatment that incorporates age progression imagery |
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ENGAGING IN HYPNOSIS

After Amy's intake session, she was seen for four treatment sessions. During Session 1, Amy's AAT and PCS ratings and the significance of achievement were discussed in the context of her use of magnification as a cognitive coping style that had ironically perpetuated her stress level and experience of headache.

A self-perpetuating pattern of her thoughts, emotions, behaviours, and physiological reactions was formulated and presented to Amy as follows: "In

the face of an impending test or exam, her tendency was to think that she would do poorly at it which would be accompanied by feelings of anxiety and worries, leading her to ventilate her stress to others at length. She often then perceived others as withdrawing from her which then intensified her tension and fears. This amplified tension would lead to a severe headache, confirming her belief that she lacked the needed resources to deal with the test or exam.” She participated in the process of fine-tuning this formulation and agreed to monitor any traces of this cyclical pattern in her daily life.

The physiological basis of the headache in terms of the fight-or-flight response and, conversely, the relaxation response (Benson, 1975) was discussed. Amy selected the single focus of silently visualizing the word “loose,” while keeping a detached attitude toward any distractions from this single focus. She also creatively used the phrase “grassy green” to remind herself about a vast meadow that she had seen in a family trip to China. With this basic, two-step approach to self-hypnosis, she reported a reduction of SUD (subjective unit of distress) rating for discomfort around her head from 6/10 to 3/10 within two minutes of practising this method. She felt encouraged by the rapidity of even that partial relief and agreed to practise this method at least once each day.

In keeping with mind-body medicine, the usefulness of approaching the learning support services (e.g., for exam preparation) at the university as well as consulting a physiotherapist for possible postural causes for the recurrent headache was highlighted to Amy. Appropriate contact information was given to her to link her up with these additional resources. The next treatment session was scheduled to be two weeks later.

During Session 2 Amy reported that the headache episodes seemed to have become shorter (i.e., not exceeding half a day). She attributed this improvement to her reminding herself not to get caught in the cyclical pattern which used to precede episodes of headache, and also her practising the two-step self-hypnosis (for which the single focus of “loose” had been spontaneously replaced with a “quiet, moist, cool and green meadow with a grassy scent all around the head”) once or twice daily and up to 10 minutes each time.

In reviewing situations where this cyclical pattern was often triggered (e.g., feeling upset after Amy perceived her friends as withdrawing from her), she was guided to explore (a) more socially inviting and pleasant ways of eliciting emotional support (e.g., requesting others to teach her ways of solving various problems) and (b) alternative self-affirming ways of engaging in self-talk that could replace her perfectionistic and magnifying thinking habits (e.g., “this

headache won't last forever" and "this pain is 'annoying' but won't have to ruin my whole day").

To directly alleviate the intensity of an ongoing headache episode, Amy was instructed in the self-hypnosis method of using an imaginary dial. For induction, she was first guided to count backwards from 5 to 1 with the self-suggestion that, at the count of 1 she would reach a pleasant state of absorption like an enjoyable time when she was playing her flute. For deepening, she was guided to use the method of noticing (with her eyes closed throughout) three things she heard and kinaesthetically sensed, and then two things heard and sensed, and then one thing heard and sensed. Thereafter, she was guided to vividly imagine a round dial that looked like a clock, which had numbers from 1 to 10 around its circumference that indicated levels of intensity of any discomfort in her head. With her active imagination she was able to apply the paradoxical strategy of first slightly increasing the intensity of the discomfort by dialling up this device and subsequently decreasing it by dialling down this device to a larger degree than before. By the end of this session she managed to lower the discomfort from 7/10 to 1/10. She was guided to give herself the post-hypnotic suggestion that this dial method will become even easier and more successful every time she practised it. After she was reoriented, she agreed to practise this dial method at least once daily until our next session two weeks later.

Session 3 found Amy reporting that, overall, the headache had reduced its frequency, duration and intensity and that she was more aware of the negative cyclical pattern that she used to have. Her difficulties and general experiences in applying helpful interpersonal skills (to enhance her social support), positive self-talk (to counter the magnifying cognitions), and practising both the two-step self-hypnosis and the dial method were discussed. She observed that, while she was still getting used to them as new skills and habits, she felt confident that she was on the right track to reducing anxiety and headache in her life.

Amy was then guided to practise age progression. After she carried out mostly on her own the induction and deepening processes that she had previously learned, she was guided to separately, realistically, and vividly imagine two future scenarios: (a) preparing for an exam or a major assignment and (b) seeking social support while fearing rejection by others. For each of these scenarios she was systematically guided to imagine visual, auditory, behavioural, somatic, and affective details to the extent that they appeared compelling. She was further guided to imagine herself successfully carrying out positive self-talk, social skills, two-step self-hypnosis, and the dial method

that produced for her calmness, confidence, and comfort in her head and whole body. She noted that this age progression method was beneficial and agreed to practise it at least once a week until our next session, which was scheduled to be a month later.

In Session 4 Amy reported an overall improvement in her experience of headache and that she had learned useful strategies from the learning support services for managing assignments she would otherwise find overwhelming.

Amy was systematically guided through another round of age progression for relapse prevention purposes. While she was in a hypnotic state, she vividly imagined a number of potentially stressful scenarios (e.g., dealing with a lecturer whom she perceived as unreasonable and overly critical), in which she might not remember to practise her anxiety reduction skills. She was then guided to experience herself in these scenarios effectively applying positive self-talk, helpful communication skills, the two-step self-hypnosis method, and the dial method. She then vivaciously asserted that the CBT and self-hypnosis skills that she had acquired were sufficient for the time being without the need for any further treatment sessions.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

Amy reported that her anxiety and headache had reduced considerably with the following improved ratings:

AAT ratings

Facilitating scale (for anxiety that strengthens academic motivation): 11 (Moderate)

Debilitating scale (for anxiety that weakens academic performance): 10 (Low)

PCS ratings

Rumination: 8 (Low)

Magnification: 8 (Moderate)

Helplessness: 12 (Low)

Compared to the start of this treatment, Amy's headache episodes had decreased in the following ways: (a) from the average frequency of once a week to only twice in the past month, (b) from a maximum duration of 24 hours to only five hours, and (c) from a maximum intensity of 9/10 to only 4/10 with decreasing numbers indicating decreasing amounts of pain. She had also experienced much reduced disturbances in her concentration, energy, appetite, and general mood with no use of painkillers for the past month. Feeling encouraged by these improvements, she agreed to continue to practise the CBT and self-hypnosis skills acquired.

After consulting a physiotherapist and gaining practical strategies for correcting her habitually slouching posture, Amy learned to minimize physical strain on her upper body and thus further decrease episodes of headache. Moreover, with her extended repertoire of social skills she had built closer friendships with two fellow students, with whom she was able to engage in mutually satisfying conversations and interactions.

As a motivated young adult, who actively sought support at a university-based psychology clinic, Amy was ready to benefit from a structured, methodical, and psychoeducational approach to identifying, understanding, and alleviating stress-related symptoms. The CBT treatment plan, which integrally involved hypnosis with research evidence for its effectiveness for headache relief, then seemed appropriate and was carried out with positive results.

In retrospect, however, there were three aspects of this treatment that were, psychodynamically speaking, not thoroughly addressed which could then compromise the sustainability of Amy's treatment gains into the future. Specifically, these considerations are as follows:

1. Although Amy denied any emotional traumas in her childhood, the "constantly strict" parenting that she had been subjected to could have left unresolved memories (which her conspicuously slouching habit might partly suggest) that had neurotically impacted on her sense of personal worth and the emotional significance of achievement. Without a fuller exploration of this historical aspect of her emotional struggles (through hypnotic age regression or otherwise), it was unclear whether there were unacknowledged traumas in her early developmental stages and injuries to her sense of personal identity that might later limit the full expression of the therapeutic effects of this course of predominantly ego-strengthening treatment.
2. Similarly, this treatment did not fully explore the meaning and functions of Amy's current defensive style. Her often excessive concern over her academic achievement might have signified the presence of certain defence mechanisms, for example, compensation (to counterbalance substantial, underlying feelings of inadequacy) or sublimation (to discharge in socially acceptable ways hidden feelings of inadequacy that were experienced as unacceptable) (Cramer, 2008). Given that this course of treatment was mainly psychoeducational and skill-building in nature, it might have succeeded in facilitating her development of more mature defences but have left unexplored possible anxiety or emotional conflicts in her current

life that could later interfere with her ability to optimally exercise the more recently developed mature defences.

3. If Amy had held a belief that she would be acceptable only if she complied with expectations from authority figures (e.g., her parents and the clinician in this treatment), then this treatment would have missed an opportunity to examine a possible (transferential) re-enactment of such interpersonal dynamics. Her symptom reduction might even have unconsciously confirmed a potentially maladaptive belief that she had again earned social approval because of her compliant behaviour. To minimize the likelihood of such a negative re-enactment, this treatment could also have more directly addressed her developmentally sensitive quest for authentic self-acceptance and individuation.

Opportunities to directly address these psychodynamic considerations would have become available if Amy had returned for another consultation for further support. However, since she had expressed her satisfaction with her demonstrable symptom relief and skill acquisition such that she did not feel a need for additional treatment, a planned process of termination was completed in the spirit of affirming and empowering her developmentally significant sense of self-determination.

REFERENCES

- Alladin, A. (2008). *Cognitive hypnotherapy: An integrated approach to the treatment of emotional disorders*. West Sussex: John Wiley & Sons Ltd.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Arnett, J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, *55*, 469–480. doi: 10.1037//0003-066X.55.5.469
- Benson, H. (1975). *The relaxation response*. New York: William Morrow & Company.
- Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook*. New York: Free Press.
- Cramer, P. (2008). Seven pillars of defence mechanism theory. *Social and Personality Psychology Compass*, *2*, 1963–1981. doi: 10.1111/j.1751-9004.2008.00135.x
- Dickson, J., & Gullo, M. (2015). The role of brief CBT in the treatment of anxiety and depression for young adults at a UK university: A pilot prospective audit study. *Cognitive Behaviour Therapist*, *8*(e14), 1–9. doi: 10.1017/S1754470X15000240
- Dillworth, T., Mendoza, M., & Jensen, M. (2012). Neurophysiology of pain and hypnosis for chronic pain. *Translational Behavioural Medicine*, *2*(1), 65–72. doi: 10.1007/s13142-0110084-5
- Eimer, B. (2008). *Hypnotize yourself out of pain now*. Bethel, CT: Crown House.

- Morgan, A., & Hilgard, J. (1978). The Stanford Hypnotic Clinical Scale for Adults. *American Journal of Clinical Hypnosis*, 21, 134–147. doi: 10.1080/00029157.1978.10403968
- Patterson, D. (2010). *Clinical hypnosis for pain control*. Washington, DC: American Psychological Association.
- Yapko, M. (2012). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York: Routledge.

CLINICAL HYPNOSIS IN THE MANAGEMENT OF PANIC DISORDER WITH COGNITIVE-BEHAVIOURAL AND SPIRITUAL STRATEGIES

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This case report illustrates the use of hypnotic interventions in support of a brief course of panic control therapy (PCT) within a cognitive-behavioural framework for an adult male with strong spiritual values. In particular, hypnotic interventions including cue-controlled self-hypnosis, simple guided imagery, and the “inner adviser” method were applied to maximize the effectiveness of PCT’s three main treatment components: cognitive restructuring, training in breathing skills, and exposure with response prevention. The client’s longstanding religiosity was therapeutically utilized in the delivery of hypnotic interventions. However, certain complicating systemic elements and potential resources in this case that could have been utilized further in this treatment, but were not, are explored.

Keywords: hypnosis, cognitive-behavioural therapy, panic control therapy, death anxiety, religiosity, spirituality, systemic perspective.

PATIENT’S PRESENTING PROBLEM AND REFERRAL DETAIL

The client, for whom the pseudonym Zack will be used, was a 30-year-old local (Singaporean) Chinese man. Zack was a part-time MBA student and also worked as a part-time manager at his father’s restaurant. He had been married for three years and had a two-year-old son. Zack was a self-referred client who reported that he had been experiencing symptoms of panic disorder.

PATIENT’S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Zack presented as experiencing symptoms of panic disorder including palpitations, sweating, choking sensations, dizziness, and an intense fear that he was going to die. These panic attacks occurred once or twice monthly

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and typically when he was alone. Each episode of panic typically lasted 20 minutes with a level of intensity that hovered around 8/10 with higher numbers indicating greater levels of distress. Zack's frequent concern about being struck by panic attacks and thoughts regarding dying in relation to them were consistent with the DSM-5 diagnosis of 300.01 (F41.0) panic disorder (American Psychiatric Association, 2013). At the intake session he reported the following psychometric test ratings (Corcoran & Fischer, 2000):

PACQ (Panic Attack Cognitions Questionnaire) ratings

During last attack: 69 (High)

After last attack: 40 (Moderate)

TDAS (Templer Death Anxiety Scale) rating

12 (High)

Zack recounted that the panic attacks started after he almost drowned while swimming in the sea during a family vacation 10 months previously. From the time of this near-drowning incident, he frequently had thoughts revolving around (a) the fact that he could have really died in the sea, (b) the possibility that he could die from various accidents and dangers present in his current life, and (c) the feared outcome that his wife, son, and parents would have no one in their lives to depend on if he died in another accident.

Apart from the near-drowning incident, Zack stated that he had not encountered any significant traumas in his life and that he did not experience any significant symptoms of post-traumatic stress disorder following this incident. He denied any medical history (including psychiatric history) and any consumption of alcohol or recreational substances relevant to the panic he was experiencing.

The panic attacks had periodically caused Zack to be unable to perform his managerial duties at his father's restaurant and to miss classes in his MBA course, which he described as demanding and distressing. He disclosed that he had refrained from having open conflicts with his father about how the restaurant should be managed and that his silent wish was to leave these managerial duties and devote his time to completing his MBA course as a full-time student. Zack expressed no other significant stressors in his personal (including marital) life.

In general, despite his stress and near-drowning experience, he asserted that he had adequately managed both his work and academic responsibilities. Zack attributed his ability to cope with the panic problem to his Buddhist faith and close-knit family.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Zack reported that, although he had not previously experienced formal hypnosis, he had attended Buddhist meditation classes which had enabled him to develop soothing states of physical and emotional comfort. He did not show any signs of psychopathology (e.g., dissociation and psychosis) that would suggest any contraindications for a hypnotic treatment. He demonstrated hand lowering, dream, and age regression as per the Stanford Hypnotic Clinical Scale for Adults (Morgan & Hilgard, 1978), indicating his suitability for hypnotic interventions.

There is strong empirical evidence for the effectiveness of panic control therapy (PCT) (Craske & Barlow, 2007), which is based on a cognitive-behavioural framework for panic attacks. PCT consists of three main components: cognitive restructuring, training in breathing skills, and graded exposure with response prevention. Meanwhile, hypnosis has been shown to be effective in alleviating panic symptoms (Alladin, 2008; Iglesias & Iglesias, 2005; Yapko, 2012). Hypnotic interventions for panic attacks that were methodically crafted according to cognitive or cognitive-behavioural frameworks have also indicated positive outcomes (Ajinkya, 2015; Nolan, 2008). Moreover, innovative integrations of spiritual principles and various frameworks of hypnotic techniques (e.g., assimilating regressive but also ego-strengthening approaches, opportunities for catharsis but also problem-solving, emphases on personal choice but also seeking guidance from a higher power, and interpretations that were consistent but also inconsistent with pre-existing beliefs) have produced creative and promising models of hypnotic treatment (Lesmana, Suryani, Tiliopoulos, & Jensen, 2010; Zahi, 2009). To maximize therapeutic gains for Zack, hypnotic interventions were flexibly and strategically employed to optimize each of PCT's major components.

For the cognitive restructuring component of PCT, the hypnotic *inner adviser* method was utilized to help Zack develop an appropriate degree of cognitive and emotional detachment from the panic experiences and, further, access his own resourcefulness in resolving them. This method facilitated his metacognitive processes and hence ability to objectively examine and dis-identify with the panic-related thoughts and feelings. Additionally, given Zack's Buddhist faith, this inner adviser method was helpful not only for direct symptom reduction but also for enriching the subjective meaning of this process of healing from the panic attacks. According to Benson (1984), incorporating a spiritual perspective (i.e., the faith factor) in relaxation training

can promote a sense of personal meaning and fulfilment in the person's experience of the relaxation skills which can in turn motivate the person to commit to practising these skills in a regular and sustainable manner.

Second, in training Zack to breathe diaphragmatically, the hypnotic imagery of a dark blue healing fluid was utilized in accordance with his deeply held personal beliefs, which added further meaning and conviction to his experience with this otherwise rather mechanical breathing exercise.

Third, in Zack's graded (imaginal) exposure treatment, the cue-controlled method of anxiety reduction essentially took the form of self-hypnosis with the post-hypnotic suggestion regarding the relaxation effect of the self-administered cue of "calm." The inner adviser method was again activated to regulate the intensity level of the exposure process that focused on the panic-related sensations.

TREATMENT PROGRESSION

Treatment goals were collaboratively developed with Zack and their interventions were explicitly discussed at the end of the intake session. His consent to follow through a comprehensive, cognitive-behavioural treatment plan (presented below), in which hypnosis played a complementary role, was documented. The goals and interventions were as follows:

Table 1: PCT Treatment Plan with Hypnotic Interventions

Goals	Interventions
(1) Enhanced knowledge about how anticipatory anxiety could trigger panic attacks	(a) Provided psychoeducation on how panic attack could be triggered by exaggerated perception of threat, hyperventilation, exaggerated attention to bodily sensations, and anticipation of panic episode (b) Discussed with him cognitive-behavioural therapy (CBT) formulation of his unique pattern of cognitions, behaviours, emotions, and bodily reactions that would trigger panic attacks (c) Provided psychoeducation on relaxation response and simple method of eliciting it through cue-controlled self-hypnosis

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| (2) Reduced panic attacks (in their average frequency, intensity or duration) and related PACQ ratings | (a) Guided him in cultivating positive self-talk habits that promoted de-catastrophizing cognitions |
| | (b) Guided him in enhancing the effectiveness of his current methods for anxiety reduction (e.g., Buddhist meditation and related breathing skills) |
| | (c) Guided him in using self-hypnosis skills to increase his ability to tolerate (without rigidly avoiding) anxious feelings in the context of graded exposure to panic-related stimuli |
| (3) Reduced fear of dying as measured by TDAS ratings | (a) Provided hypnotic treatment using post-hypnotic suggestion to desensitize thought that he was going to die in reaction to intense physical symptoms of anxiety |
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ENGAGING IN HYPNOSIS

Zack was briefed about typical experiences as well as seemingly strange thoughts and feelings that could arise in hypnosis. It was emphasized to him that he could at any time verbalize his needs or questions or gently raise one of his hands to indicate his wish to pause the process. After Zack's intake session, he was seen for five further treatment sessions.

In Session 1, Zack's PACQ and TDAS ratings were discussed and normalized in the way of reassuring him that it was not uncommon for people who had experienced panic attacks to have such elevated ratings.

We collaboratively formulated a cyclical pattern of Zack's thoughts, emotions, behaviours and physiological reactions that often led to a panic attack. When he experienced a slight sign of anxiety (e.g., some pressure on his chest or nasal congestion), he would think that he had to brace himself for a panic attack. This made him feel nervous and engage in either constricted breathing or hyperventilation which, in turn, amplified the emotional tension, physical signs of an impending panic attack, and expectation that a real panic attack was coming. This often ended up triggering a real panic attack, which in turn confirmed the belief that his anticipation of the panic attack was valid, indicating the presence of a negative self-fulfilling prophecy.

We discussed the physiological basis of stress (as a precursor of panic attacks) in terms of the fight-or-flight response and, conversely, the empirically validated “relaxation response” (Benson, 1975), which could be reliably elicited by focusing on a neutral target (e.g., a phrase or mental image) and keeping a detached attitude toward any distractions. He chose the single focus of silently saying the word “calm” while reminding himself not to mentally pursue any distracting thoughts that might appear. He expressed that this simple, cue-controlled, self-hypnosis method was practical and helpful for increasing his confidence in his ability to lower his anxiety at school and at work. He agreed to practise this simple self-hypnosis method for at least 10 minutes daily until our next session in the following week.

Session 2 saw Zack report that he had not experienced any panic attacks, while he had practised the cue-controlled self-hypnosis only three times with pleasant experiences.

We reviewed Zack’s CBT formulation for the panic attacks, and he was able to point out instances in the past week where he almost did get stuck at various parts of the negative cyclical pattern. For each of these potentially problematic junctures, we explored in detail more realistic and constructive thoughts (e.g., telling himself to focus away from bodily sensations) and actions (e.g., mindfully taking slower breaths to reduce hyperventilation) that he could develop to replace those anxiety-provoking ones.

We discussed practical ways of utilizing his current methods of invoking calmness and confidence throughout the day, especially those practices that were personally meaningful in the context of his Buddhist faith (e.g., reminding himself to experience gratitude at meal times and having compassion for his own perceived weaknesses).

Zack was then instructed on diaphragmatic breathing with a physiological explanation of its calming effect through vagus nerve activation. He was guided to visualize a dark blue (which was his chosen colour) healing fluid filling up his abdomen through his nostrils with each gentle inhalation. He felt particularly comfortable with this method of integrating diaphragmatic breathing and imagery because dark blue was a colour that was associated with the “Medicine Buddha.” This personalized technique consequently evoked feelings of being “steady and still” in his body and mind. He agreed to practise this imagery-enhanced breathing method for at least 10 minutes daily until our next session in the following week.

In Session 3 Zack reported that he had a moderately intense panic attack in Session 3 (i.e., 6/10) two days previously. He believed the panic was mainly

triggered by the usual thought, “What if I die in another accident (as it almost happened in the near-drowning incident)?” He again became preoccupied with the feared scenario that his wife, son and parents would be forever grief-stricken and have no one to take care of them. Recognizing that this recurrent death-related fear was unhelpful, he agreed to explore two methods of reducing its emotional threat: (a) graded imaginal exposure and (b) the inner adviser hypnotic intervention.

For graded exposure, Zack was guided to construct a (four-level) hierarchy of intensity of his fear of dying with respect to mental images that ranged from a peaceful family scene before the ill-fated family vacation (representing the lowest intensity) to an imagined frenzied scene of his family members wailing about his death at his funeral (representing the highest intensity). After constructing this fear-of-dying hierarchy, he applied either the cue-controlled self-hypnosis method or the imagery-enhanced breathing method to bring his SUD (subjective unit of distress) score to 0/10 and then progressively navigated this hierarchy from the scene with the lowest intensity to the scene with the next higher level of intensity whenever he was able to reach a SUD score of 0/10. When he reached the scene with the highest intensity, he managed to minimize his SUD score to 3/10 and felt that his fear of dying was considerably relieved.

After a brief discussion on this graded exposure experience, we proceeded to the inner adviser hypnotic intervention. Since Zack’s attention was already substantially focused on his internal experiences, he was directly guided (i.e., without a formal hypnotic induction) from this light trance into a deepening process with the suggested imagery of his *true self* (which he visualized to be an image similar to that of the Buddha) inside his body gently expanding outwards and ascending into cosmic heavens and progressively higher dimensions of consciousness. These higher dimensions of consciousness then revealed to him correspondingly higher levels of awareness, knowledge, and wisdom. When he reached the level of infinite wisdom, he was guided to gaze with compassion at the finite form of himself (i.e., the earthly Zack who had been struggling with the panic attacks) in the physical world and speak to the limited self, giving him the most nurturing and healing understanding, acceptance, reassurance, and advice that the limited self needed to transform and release away the panic attacks. This inner adviser then verbalized to the limited self that the panic attacks and terror of dying were only spiritual tests and that, as soon as those fearsome but passing experiences were realized as ephemeral and illusory they would indeed fade away, because the intended

spiritual lessons would have been learned. This inner adviser also reassured the limited self that, despite whatever troubling circumstances, he and his family could gain protection from the compassionate Medicine Buddha.

A post-hypnotic suggestion was given to him to gently squeeze his left hand into a fist with the knowledge that, every time he did this action in the future, he would re-experience these transcendent emotions and compelling realizations. After he was re-oriented from this deeply moving guided imagery, he felt profoundly peaceful, blissful, and liberated.

Zack agreed to practise graded exposure at his own comfortable pace and use his fist cue to consolidate the above spiritual insights several times each day until our next session, which was scheduled to be three weeks later.

Session 4 found Zack reporting that a week earlier he had a bout of moderately panicky sensations but that it did not become a full-blown panic attack. He, his wife, and his son went for a swim in a pool and, while he was swimming, he choked slightly on the water that went into his mouth. He recalled that in an uncanny way he noticed a “*wave* of [panicky] thoughts and feelings” arising in him but that he was detached from it. He was able to quite calmly observe (i.e., without escaping, resisting, or struggling) that *wave* as passing sensations that were separate from himself. He simply stood still in the swimming pool while the *wave* of sensations dissipated completely within 10 minutes. To his amusement he later realized that, throughout that whole *wave*, he forgot to fear or even think about death. He attributed this ability to rise above and transcend the passing thoughts and feelings to the inner adviser skill, which he had only occasionally practised since our last session.

Zack was then guided through a more physical (in contrast to imaginal) form of exposure treatment. He used hyperventilation in a measured way to repeatedly produce bodily sensations that mimicked panic attacks, for example, palpitations, choking sensations, and dizziness. After each round of such controlled hyperventilation, he dispassionately “watched” (from the vantage point of his inner adviser) whatever *waves* of thoughts, feelings and sensations would appear and then disappear. After five cycles of deliberately hyperventilating and then observing how any panicky reactions subsided within minutes, he smiled and said that he was getting bored with the predictable routine and confident that he would probably not be caught off guard by those reactions in the future. We scheduled our next session to monitor his progress six weeks later.

Zack reported in Session 5 that, after our last session, there were two brief occasions when he experienced mildly panicky sensations but that he could

notice them as they gradually started to appear. Further, he managed to stop them from becoming actual panic attacks by simply tolerating and not reacting to them. Meanwhile, he had not been bothered by thoughts about death. He again attributed these improvements to his inner adviser, who reminded him that all panicky sensations would sooner or later pass and that he only needed to patiently wait for that to happen.

Zack also related that he had informed his father about his intention to leave the restaurant to finish his studies as a full-time student and that his father had accepted with regret his decision to do so.

We reviewed Zack's previous CBT formulation as well as self-calming skills relating to cue-controlled self-hypnosis, constructive thinking, Buddhist self-cultivation practices, diaphragmatic breathing with the dark blue healing fluid, graded exposure (involving imaginal and physical stimuli) and inner adviser. While he regretted having to disappoint his father in relinquishing his manager position in their family restaurant, he affirmed his satisfaction with his demonstrable progress in this treatment and that he did not require any further consultations.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

At the conclusion of treatment Zack reported that the panic attacks and fear of death had become minimal, which was corroborated by the following improved ratings:

PACQ ratings

During last attack: 4 (Low)

After last attack: 3 (Low)

TDAS rating

2 (Low)

Compared to the time when Zack's treatment commenced, the panic-related disturbances had reduced in the following ways: (a) from the frequency of up to twice a month to no significant episodes for more than two months, (b) from an average duration of 20 minutes to less than 10 minutes, and (c) from a maximum SUD score of 8/10 to 2/10 with higher numbers indicating higher levels of distress. He was pleased with not only the measurable symptom relief but also the enriched appreciation that he had cultivated for the spiritual principles and practices of his chosen faith.

The healing capacity activated by Zack's spiritual outlook and values seemed to have added more personally compelling and sustainable effectiveness to the hypnotic interventions within the CBT framework. This underscored the clinical utility of integrating interventions with the client's belief system, which can provide strategic clues for the choice of various symbols (e.g., colours and images) in hypnotic treatment.

In retrospect, this primarily psychoeducational, skill-building, and spirituality-inspired course of individual treatment for Zack can be critiqued from a systemic perspective at two levels, one pertaining to the formulation of the case and the other the planning and execution of the treatment.

First, although Zack asserted that there were no significant stressors in his current life apart from the panic attacks, it was not altogether clear whether his symptoms had persisted for nearly a year because they had also served needed or desired functions in his life, suggesting the possible presence of secondary gains from those symptoms that might have maintained a certain homeostasis within his family system. For example, since his marital relationship was not fully explored, panic-related symptoms might have been (a) unwittingly reinforced by enabling behaviours (i.e., excessively solicitous behaviours that had partly perpetuated the symptoms) from his wife or (b) perpetuated in order to preserve a coalition that he had formed with her against some of their other family members or vice versa (Minuchin, Reiter, & Borda, 2013).

Apart from conceivable functions of the panic symptoms within his marriage, those symptoms could also have served dual functions in his relationship with his father: (a) discharging his underlying tension (due to likely rigid boundaries that had contributed to his suppressed conflicts with his father about whether he could relinquish his manager role at their family restaurant) symbolically and indirectly such that open confrontations with his father had been safely averted and (b) persuading his father to relent and consent to his wish to leave the manager role. Displaying his exceedingly disturbing distress in order to gain sympathy and support from his father and, hence, power to satisfy his own needs and wishes would have been consistent with the strategic family therapy's view of symptoms as tactics in human relationships (Haley, 2005). If these systemic conceptualizations of the panic attacks are valid, this treatment might have achieved mostly *first order changes* (i.e., merely quantitative reductions in the presenting symptoms) rather than *second order changes* (i.e., qualitative alterations of the rules regulating his family relationships that might have partly engendered the presenting symptoms) (Davey, Davey, Tubbs, Savla, & Anderson, 2012). A relapse of the panic attacks

or other stress-related symptoms could then occur in the face of significant family conflicts again, since implicit rules for managing his family conflicts to meet his own needs might continue to require displays of distressing symptoms. However, from his relatively rapid and seemingly unobstructed improvements in response to the treatment, it appeared that there were no secondary gains from the panic attacks and no intractably dysfunctional family rules in any immediately consequential ways.

Second, there could have been missed opportunities in enhancing Zack's treatment outcomes that might have benefited from direct or indirect assistance from his family members (Carr, 2014; Gore & Carter, 2004). His wife and other family members might have been able to play active roles in minimizing unintentional enabling behaviours, tracking the occurrence of the panic attacks, and giving him consistent encouragement and giving him feedback on his practice of the PCT and hypnotic skills acquired. The potential participation of his family members as a therapeutic resource was neither deliberately engaged nor optimally utilized. This probably limited the maximum benefits that he could have received from the treatment. While he asserted that Zack did not require further treatment, it might have been helpful to actively recommend a follow-up meeting to monitor his ability to maintain his improvements in the context of both the inherent and the evolving individual and systemic conditions over a substantial period.

REFERENCES

- Ajinkya, S. (2015). Cognitive hypnotherapy for panic disorder with aquaphobia. *Sleep and Hypnosis (Online)*, 17(1), 11–13.
- Alladin, A. (2008). *Cognitive hypnotherapy: An integrated approach to the treatment of emotional disorders*. West Sussex: John Wiley & Sons.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Benson, H. (1975). *The relaxation response*. New York: William Morrow & Company.
- Benson, H. (1984). *Beyond the relaxation response*. New York: Times Books.
- Carr, A. (2014). The evidence base for couple therapy, family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy*, 36, 158–194. Doi: 10.1111/1467-6427.12033
- Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice: A sourcebook*. New York: Free Press.
- Craske, M., & Barlow, D. (2007). *Mastery of your anxiety and panic: Therapist guide*. New York: Oxford University Press.

- Davey, M., Davey, A., Tubbs, C., Savla, J., & Anderson, S. (2012). Second order change and evidence-based practice. *Journal of Family Therapy, 34*, 72–90. doi: 10.1111/j.1467-6427.2010.00499.x
- Gore, K., & Carter, M. (2004). Incorporating the family in the cognitive-behavioral treatment of an African-American female suffering from panic disorder with agoraphobia. *Journal of Family Psychotherapy, 14*(4), 73–92. doi: 10.1300/J085v14n04_07
- Haley, J. (2005). *Strategies of psychotherapy* (2nd ed.). New York: Crown House.
- Iglesias, A. & Iglesias, A. (2005). Awake-alert hypnosis in the treatment of panic disorder: A case report. *American Journal of Clinical Hypnosis, 47*, 249–257.
- Lesmana, C., Suryani, L., Tiliopoulos, N., & Jensen, G. (2010). Spiritual hypnosis-assisted therapy: A new culturally sensitive approach to the treatment and prevention of mental disorders. *Journal of Spirituality in Mental Health, 12*, 195–208. doi: 10.1080/19349637.2010.498696
- Minuchin, S., Reiter, M., & Borda, C. (2014). *The craft of family therapy: Challenging certainties*. New York: Routledge.
- Morgan, A., & Hilgard, J. (1978). The Stanford Hypnotic Clinical Scale for Adults. *American Journal of Clinical Hypnosis, 21*, 134–147. doi: 10.1080/00029157.1978.10403968
- Nolan, M. (2008). Hypnosis to enhance time limited cognitive-behavioural therapy for anxiety. *Australian Journal of Clinical and Experimental Hypnosis, 36*, 30–40.
- Yapko, M. (2012). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York: Routledge.
- Zahi, A. (2009). Spiritual-transpersonal hypnosis. *Contemporary Hypnosis, 26*, 263–268. doi: 10.1002/ch.392

HYPNOSIS SUPPORT FOR A CLIENT EXPERIENCING CLOZAPINE WITHDRAWAL SYMPTOMS

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The current case demonstrates the usefulness of hypnotic intervention in supporting a client to self-manage the physiological withdrawal symptoms resulting from her ceasing her 16 year use of the anti-psychotic medication Clozapine. The change in her management plan resulting in the cessation of said medication was collaboratively undertaken with her treating consultant psychiatrist. The client's anti-psychotic medication was gradually titrated down over the course of 6 months under the direction of her consultant psychiatrist who believed the client's presentation was reflective of a borderline personality disorder with co-morbid generalized anxiety disorder versus a psychotic disorder requiring Clozapine. Indeed, there was no evidence of psychotic symptom re-emergence post Clozapine cessation. Hypnotic interventions were used as an adjuvant to cognitive-behavioural interventions while Clozapine was titrated downward towards cessation and aided the client's self-management of the physiological withdrawal symptoms that can result from the cessation of Clozapine.

Keywords: hypnosis, withdrawal, Clozapine, anti-psychotic.

PATIENT'S PRESENTING PROBLEM AND REFERRAL DETAIL

The client, whom we will call Beth, was experiencing acute physical withdrawal symptoms after cessation of the anti-psychotic medication, Clozapine, which she had taken for the past 16 years. The physical withdrawal symptoms were a source of considerable distress for her as they emerged with sudden onset right after the last 50 mg of Clozapine she had been prescribed. She described experiencing insomnia, paraesthesia, would feel her feet were "on fire," diarrhoea, and skin itchiness. Her distress was compounded by emerging unhelpful cognitions centred on the physical withdrawal symptoms which further heightened her longstanding anxiety symptoms.

Beth had been referred for case management in August 2009 after geographical relocation. She was attending monthly medical reviews under her Clozapine protocol. She was offered and engaged in cognitive-behavioural interventions with the author for the management of her high anxiety which Beth described as being keyed up and on edge.

Beth's treating consultant psychiatrist from the local community mental health team, who had seen her regularly at monthly Clozapine reviews for nearly two and a half years, believed she had been misdiagnosed with schizophrenia at a time when she might have been experiencing emotional and behavioural dysregulation more in keeping with a presentation of borderline personality disorder with co-morbid generalized anxiety disorder. As a result, the consultant psychiatrist decided to trial Beth off Clozapine, which would be reduced gradually and eventually ceased over a six-month period.

PATIENT'S PRESENTING FEATURES AND RELEVANT PERSONAL INFORMATION

Beth presents as a pleasant lady who engages proactively in cognitive-behavioural interventions addressing her longstanding anxiety. She reported her anxiety as commencing from the young age of 5. From this early age, she recognized experiencing excessive anxiety and worry which she found difficult to control, causing her significant distress and interfering with her ability to concentrate. There was no evidence of any psychotic symptoms or signs in her presentation.

Beth was born and raised in Murwillumbah, New South Wales. She is the fourth of six siblings. She reported a long history of sexual and emotional abuse perpetrated by her eldest brother from the age of 5 to 20. When aged 10 she attempted to advise her mother about this; however, her mother failed to understand what Beth meant until several years later when as an adult Beth could describe her experiences more articulately. Beth left school at the age of 15 after completing Grade 10 with good marks. She procured the opportunity for traineeship at a branch of a local supermarket moving up to the position of office manager. She later engaged in youth work at a Catholic church for which she travelled to the United States of America where she stayed for six months. While overseas and supporting children with a history of sexual abuse, her traumatic memories re-emerged strongly. Upon her return to Australia she decompensated for the first time at the age of 23.

When Beth was 27, she returned to school via a Technical and Further Education (TAFE) institution and completed her Higher School Certificate (HSC). Beth later completed a course in aged care and subsequently another as a chaplain. Given her difficulties Beth had been on a disability support pension for nearly 15 years. She met her partner, whom we will call Ian, when she was 38 and married him in 2007. The couple now have a 5-year-old son. Beth worked full time at a hospital in Brisbane as a chaplain for a year while also doing part-time work as a kitchen hand at the same hospital. She stopped this work when the family relocated to their current house in 2008. She focused on looking after her son until he was three years old and had started attending a day care centre. At this time Beth found a part time job as a domestic cleaner and she has continued this work to the present time.

Beth believes that her employment as a youth worker overseas led her to consciously acknowledge her history of sexual and emotional abuse for the first time. Upon her return to Australia, she subsequently decompensated. Specifically, Beth started engaging in frequent deliberate self-harm behaviours and was being treated by the local mental health service in Sydney for paranoid schizophrenia. At the age of 30, Beth was commenced on Clozapine, which she identified as effective at stabilizing her mental state. She also underwent several years of trauma counselling which she found to be very beneficial. She ceased cigarette smoking in her thirties and had completely ceased self-harming by the time she met her husband. Her last hospital admission was at the time she was commenced on Clozapine. She has remained a patient of public mental health ever since under a Clozapine protocol. Beth had no history of alcohol or illicit drug abuse. Over the past four years she had experienced three miscarriages.

SUITABILITY OF PATIENT FOR HYPNOTIC PROCEDURES

Beth was well engaged in psychological interventions with the author and it was clear we shared a strong therapeutic alliance. From the time we met and throughout our work together, there was no evidence of any features of psychosis or personality disorder. She was receptive to the suggestion of exploring the use of guided imagery with relaxation as a potential strategy to cope with the discomfort of the physical withdrawal symptoms and the associated agitation relating to the discontinuation of Clozapine.

Beth was already well educated about the cognitive model of interactions between the various responses in any given situational trigger, that is, the

interactions between emotions, cognitions, the body's physiology and behaviour. She was offered the opportunity to explore hypnotic interventions as a strategy she could trial and opt to continue with if she found some helpful in dealing with the range of physiological disturbances she was experiencing as withdrawal symptoms. Beth had previously been introduced to mindfulness by the author and she reported finding it very useful in dealing with daily stressors. Beth was open to engaging in hypnosis work for her withdrawal symptoms.

Hypnotic interventions were therefore included as an adjunctive treatment modality within a cognitive-behavioural treatment approach. This included overall goals such as improving the client's self-awareness and understanding of the links between cognitions, emotions, behaviour, and physiological sensations/responses in the context of the relevant environmental/situational problems and withdrawal from Clozapine.

Although Beth reported being through several years of trauma counselling which had resolved her painful memories, the author was aware of the potential for abreactions occurring during the course of treatment. Therapy goals were therefore to help Beth integrate the various skills she had built so far with inner conflict resolution; ego strengthening; relaxation skill; and self-management of anxiety and stress. The goal was to ultimately enhance her overall functioning and quality of life. Beth was experiencing physical withdrawal symptoms during sessions. Therefore, the more immediate first goal of therapy was to help her find some relief from these discomforts and to be able to independently self-soothe when experiencing these physiological disturbances.

TREATMENT PROGRESSION

Beth was encouraged to continue seeing her general medical practitioner regularly to address any medical needs that might arise and to obtain a referral to an obstetrician from her doctor to address any gynaecological issues in need of attention. Beth was encouraged to continue with her antidepressant medication. She continued to see her treating psychiatric registrar and was also booked in to be seen by the consultant psychiatrist about three months after cessation of the Clozapine to complete a thorough assessment of her mental state and determine her follow-up needs and plan. The author liaised with all the above service providers including the nursing staff who provided her with regular monitoring of her weight and blood pressure. The rationale for this

approach was to ensure holistic medical and psychiatric care provision was well integrated with the psychological interventions and therapeutic support.

Beth was well educated about the potential for dependence if she were to use benzodiazepines in the long term for her emerging sleep difficulties because of her withdrawal symptoms. Although she had initially procured a script of Temazepam from her doctor for this purpose, she later opted to discard those tablets and instead make use of self-hypnosis. Beth was provided with general psychoeducation on consistently reported withdrawal symptoms upon ceasing Clozapine and relapse prevention strategies. Positive suggestions and imagery used during hypnotic interventions built on strategies from traditional cognitive-behaviour therapy, dialectical behaviour therapy and acceptance and commitment therapy.

ENGAGING IN HYPNOSIS

Beth's therapy regarding her cessation of Clozapine commenced in September 2009. This summary focuses more specifically on our last 8 sessions, after Beth's complete cessation of Clozapine, when she began experiencing a sudden onset of acute physical withdrawal.

First Session: In our first session Beth presented in a significantly distressed, tearful and agitated state with unhelpful cognitions centred on the withdrawal symptoms experienced such as “what if this goes on forever,” “is my life getting ruined,” and “how will I ever cope?” She described having a mere two hours sleep over the past couple of days, having severe itchiness all over her body, severe diarrhoea, and temperature dysregulation such that her feet felt like they were on fire. As she seemed most distressed by the insomnia, this first session following the cessation of her medication was focused on assisting her with sleep.

Specifically, an analogy was made comparing Clozapine withdrawal to withdrawal from any illicit substances such as heroin. Beth was encouraged to think about the many successful stories she had heard about people with several years of serious addictions and how these people reported turning their lives around after an initial period of intense difficulties when going through detoxification and rehabilitation. In other words, our interaction focused on a metaphorical forward projection of successful outcome. She was also encouraged to view the diarrhoea as a natural detoxification process – she reported finding this idea a positive reframing of the distasteful experience as very helpful. The induction of hypnosis in this session was completed

conversationally. Her breathing slowed, her facial muscles visibly relaxed, she sat very still, and toward the end of our time had developed a soft smile. Suggestions were content based and focused largely on generating a multi-modal experience which was juxtaposed with suggestions to begin noticing the tiredness in her body which was ready to go limp and how easy it seemed to sink into the comfortable oblivion of sleep. She was given a post-hypnotic suggestion that she could now easily regenerate a similar experience lending it the qualities she found comfortable and simply discover ways to sink into refreshing slumber.

Second Session: At the start of her second session Beth reported good success at sleep initiation using the strategy we had engaged in previously. She was now able to have about four hours of sleep every night instead of two. She was provided with psychoeducation on sleep hygiene principles and encouraged to use the strategy twice in a night upon waking if there was a break in her sleep. She described that a big reason for her tossing and turning in bed was that she kept feeling like her feet were on fire. As a result, in this session she was invited to explore the use of imagery to generate some relief from this sensation.

A more formal induction included suggestions for Beth to imagine reaching out into the freezer for some ice, to see the ice cubes in her hands, and notice how her hands were beginning to get cooler and cooler. She was then invited to reach over and touch her feet and marvel at how her feet were getting comfortably cooler and cooler. A post-hypnotic suggestion was given that Beth could easily now regenerate a similar experience to get comfortable and find relief for herself whenever needed. After reorientation in this session, Beth commented that her legs had become so much cooler that she was feeling very relaxed now.

Third Session: Upon returning to her next session Beth reported now handling the temperature dysregulation she was experiencing well. Although still achieving about four hours every night she reported her general energy and motivation through the day to be good. She reported that ever since she began thinking of the diarrhoea as part of a natural detoxification, it no longer bothered her. She was now noticing a drop in the frequency, duration, and intensity of the withdrawal symptoms. Suggestions for ego strengthening were offered in this session for her to now begin integrating the experience as enriching and as building her resilience. No overt hypnosis was engaged in during this session.

Fourth Session: By our fourth session Beth reported various general improvements. She noted her skin had become clearer, she lost about 10 kg without trying to lose weight, she was no longer struggling through her day-to-day activities which she could now identify she had done for years, and her relationships with her husband as well as her son were improving in many ways. She could now understand that she had grown emotionally warmer towards both of them and they were responding to this shift in her attitude such that the family time had become much more meaningful and fulfilling for each of them. At the time of the fourth session Beth was advised that the author would be leaving public practice and moving on to private practice in four weeks. She was emotionally upset by this news, but commented to the author that it was a positive move for the author and for future private clients. No overt hypnosis was engaged in during this session.

Fifth Session: For the first time in three years of therapy, Beth spoke about her childhood trauma in our fifth session. She spontaneously made a reference to this, to which the author responded with empathic listening and validation of her distress. Beth also commented that she had come a long way to the point when she no longer avoided conversational references by her parents to her eldest brother who was the perpetrator of the abuse. In fact she said she was ready to see him at an upcoming family gathering at Christmas. She had even spoken with him recently over the phone and had sent him a picture of her son. She now recognized that she had been able to accept her past and move on. No hypnosis was specifically engaged in during this session.

Sixth Session: Beth had completed a post-medication cessation blood test and the results were normal. She got tearful when recounting how she felt when the blood was being drawn. She described the feeling as very “liberating” to now be free of the medication. She had never imagined she would ever get to the point she would be free from the routine monthly blood monitoring associated with her previous medication use. She was still experiencing withdrawal symptoms and was somewhat surprised that over the last week the symptoms had not lessened noticeably. We reviewed the links between cognitions, emotions (anxiety more specifically), behaviours and physiological responses. No overt hypnosis was engaged in during this session.

Seventh Session: Beth was advised that her care was now to be transferred to a different case manager. She understood that the author would no longer have an involvement in the further management of her case and commented she would miss our sessions. She asked for the author’s clinical opinion on whether she would be able to manage independently. She was advised of her option to

seek a general medical practitioner referral to a private psychologist if she felt the need for further support although Beth was assured that the author would provide a thorough handover to the following case manager. Beth readily engaged in a review of her progress over the past several weeks, including our hypnosis sessions. Several positive hypnotic-like suggestions were offered to Beth conversationally during this session although no overt hypnosis was engaged in during this session.

Termination of Therapy/Session 8: Beth was provided with feedback on the handover given to her new case manager. She described being now emotionally prepared to continue the follow-up with the mental health service until the care was returned to her doctor. Therapy was brought to a comfortable close with suggestions and imagery ratifying her positive relearning, self-empowerment, and her ability to access positive inner resources with future projections to now expect a fulfilling and successful life although hypnosis was not overtly engaged in during the final session. The client was provided with education on the potential for spontaneous abreaction long after termination of therapy and ways she could handle this by using the imagery of her safe place.

COMMENTS ON THERAPY APPLICATION AND OUTCOME

The outcomes following the hypnotic interventions included decreased anxiety evidenced by a significant drop in her self-rating of subjective units of distress on the visual analogue scale from 95–99 out of 100 to 15–20 out of 100. Improved sleep was another benefit as she was now getting up to five hours of sleep every night with the use of auto hypnosis. Insight into how emotional distress and catastrophic thinking had contributed to her difficulty in dealing with the withdrawal symptoms was now evident and assisted in her coping with same. Beth also noted more effective self-management of physical discomfort with the use of specific self-determined open screen imagery. Beth noted subjective improvement in self-confidence as evidenced on the visual analogue scale: increasing from 40 out of 100 to 95 out of 100. She recognized this gain also in terms of resilience. Further, Beth noted improved family relationships with various members.

The work previously described is not an attempt to underplay the importance of psychiatric diagnoses. In fact the client's mental state was well monitored at every stage of pharmacological treatment change with diagnostic criteria for relapse of psychosis in mind. Previous trauma counselling, previous

treatment gains from cognitive behaviour therapy, the client's personality strengths, and family support were all factors which contributed not only to Beth's positive outcomes, but also served to prepare the groundwork for the subsequent trance work.

This case study demonstrates the usefulness of hypnotic interventions as an adjuvant treatment modality in helping cement functional gains made by the client involved. Additionally, hypnosis proved clinically versatile as a tool to assist with the client's withdrawal symptoms. The long-term functional gains made by the client could be better demonstrated by follow-up after a period of 6–12 months but, alas, the author's change in jobs has not allowed for this to occur.

REFERENCES

- Hammond, D.C. (1990). *Handbook of hypnotic suggestions and metaphors*. New York: W.W. Norton.
- Hunter, C.R. (2011). *Mastering the power of self-hypnosis: A comprehensive guide to self-empowerment* (2nd ed.). Carmarthen, UK: Crown House.
- Rosen, S. (1982). *My voice will go with you: The teaching tales of Milton H. Erickson*. New York: W.W. Norton.
- Yapko, M.D. (2003). *Trancework: An introduction to the practice of clinical hypnosis* (3rd ed.). New York: Brunner-Routledge.

MI'KMAQ TRADITIONAL MEDICINE: INTEGRAL METHODS, ERICKSONIAN METAPHOR, AND RECOVERY FROM TRANSGENERATIONAL TRAUMA

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This case study follows work with Aboriginal Australian men in recovery from transgenerational trauma leading to identity recovery. The work included individual and group methods that combined use of Indigenous story-as-medicine, Ericksonian therapeutic metaphor, integral human ecology, and altered states of consciousness. Memory retrieval, personal and group-based deep-memory exploration, associations with place and environment, along with rediscovery of family history and cultural values, nurtured recovery of personal meaning. As identity restructuring emerged new insights were formed around spiritual and metaphysical relationships that combined with a conscious use of mystical states of awareness. The symbolic use of a Sacred Wedge-Tailed Eagle Feather and the cultural teachings of the Mi'kmaq First Nation Elders, along with Western therapeutic methods, provided for a culturally appropriate dialogue leading toward a reclaiming of the Dreaming among Aboriginal Australian men.

Keywords: culture, trauma, metaphor, counselling.

THE IMPORTANCE OF CULTURE

For many years authors have suggested that Western “mainstream” approaches to health and wellness are inappropriate in application within Indigenous therapeutic interventions. For example, while claiming to bridge these divides, Eckermann, et al. (2006) in fact failed to provide adequate models due to an historic lack of Aboriginal and Torres Strait Islander Australian practitioners leading the discussion. Rather, an unintentional but nonetheless damaging presumptive colonialism continues to dominate discourse and health education.

Taking a wider historical view Dr Daniel Paul, Mi'kmaq Elder and author of *We Were Not the Savages* (2006), expressed in his work and career the pivotal moment when Indigenous practitioners take the stand to examine fields of practice from their unique perspectives. Recasting the historical record by taking a non-Eurocentric analysis, Dr Paul positions himself within the historical narrative with great force of logic and empathy. Significant for anyone regardless of background is the notion that Indigenous perspectives must come forward before models of health and recovery can generate appropriate interventions and methods of psychotherapy among Indigenous populations.

During the same period, Eduardo Duran (2006), an American Indian psychologist, published a significant work around ways of integrating Indigenous methods in psychotherapy and counselling with American Indian and other native peoples. His book has received quiet yet powerful consent among practitioners working in these fields for the ways that he has represented and included traditional cultural and spiritual perspectives in dialogue with Western psychology.

In addition, Ruth Holmes Whitehead (1988) has emerged as a quite significant voice in the ethnocultural and spiritual life recovery movement within the Mi'kmaq First Nation. While technically outside the therapeutic industry, her work has nonetheless provided vital insights to the notions of cultural forms of healing, counselling, and health among Native North American peoples.

In respectful acknowledgement of the Dreaming of Australian Aboriginal contexts, Native Americans hold the Medicine tradition. Sacred Medicine provides to a certain degree parallel layers of meaning to the Dreaming in how the depth of ancient wisdom translates into everyday living and therapeutic moments. These may include the intentional use of story, symbolic references, ecological and familial associations, ethical models, morality tales, value-based systems of learning, growth and initiation rituals, relationship and family rites of passage, ways of coping with crisis and illness, and systems of recovery and healing.

Nothing exists as yet among Western psychology and therapeutic fields of practice that can come close to Indigenous meaning-making systems. In fact, many Indigenous authors clearly convey the notion that Western practitioners are extremely young and yet to come to into their wisdom. Ironically, Western nations along with their colonial psychologists and health practitioners insist that they are the people doing the healing and the helping. But many Indigenous people see this effort as well-meaning but often misguided.

As expressed in earlier books (Bowers 2013a and 2013b), there is a widely held consensus among Indigenous scholars and practitioners that Western people need to reclaim their own traditions of spirituality and meaning-making prior to becoming effective intercultural practitioners. Simply put, you cannot hope to build sustainable and strong bridges to a deeply insightful and spiritually in-tune person, family, or culture with current materialistic, secular, and atheist-based beliefs and values that are held by the majority of Western practitioners.

In this regard, we can certainly witness the existence of Western traditions that have similar layers of intention such as the Celtic, Druidic, Teutonic, and Christian mystical and spirituality traditions, to name a few. However, much of this Western corpus of meaning and therapeutic wealth appears overlooked, lost, or in various modes of being slowly reclaimed after significant historical shifts (Bowers 2013a). Not the least of these have been the Industrial Revolution and the Enlightenment. Both movements converge, along with the emergence of science and the already prevalent dissociations generated by Greek and Roman philosophies, made more significant by the Great Schism of Western Christianity about 1000 years ago. These factors have tended to sideline the more intuitive, emotive, integral, and holistic layers that spirituality nurtures as a form of meaning-making and problem solving. Significant from an Indigenous view is the fact that Western mainstream movements have historically insisted largely on devaluing women's wisdom, while at the same time engaging in overt colonial operations to manipulate and abuse the environment, decenter family life as a cultural value, and insist on mere economic and soulless ends that continue to lead to ecological genocide (Bowers 2013b).

INTEGRATIVE CLINICAL HYPNOTHERAPY

Be this as it may, you will be asking how is this incredibly complex neo-colonial environment within which we now swim possibly related to a useful social psychology of clinical hypnotherapy among Indigenous practitioners. Well, central to this mystery is the fact that therapy as a field tends to grapple with the hardest and deepest of problems within a hopeful and therapeutic value-frame.

As such, we might consider the more integrative methods of somatic psychotherapy that seek to reshape character, deepen awareness, and lead toward valuable personal and social outcomes (Perlmutter 2015). This hopeful

field of practice reaches beyond the works of Rogers, Perls, and Satir, with a contemporary edge that is provided by postmodern critique and critical social theory. Perhaps a generational shift appears to be happening among the therapeutic industry that takes a more humble perspective brought about post-baby-boomer culture.

In this emerging conversation, revisiting the works of Milton Erickson (Rosen, 1982) in clinical hypnotherapy provides significant insights, particularly around the use of story and metaphor within a precise use of language for therapeutic intention. We have a fascinating model for effective bridge-building as Indigenous practitioners and those who support our intentions when we draw together ecological and holistic frameworks within Indigenous methods that combine Western cultural and therapeutic teachings. By including Erickson's precise knowledge of language, metaphor, unconscious processing, and use of story as medicine we strengthen this model. However, and to press the point of culturally grounded methods, from an Indigenous view Erickson's work in many ways echoes and perhaps explicates to a certain degree many Indigenous traditions in holistic Sacred Medicine. For instance, Indigenous methods may include purposeful visualization, imagination, altered states, lucid dreaming, and other shamanic procedures. One can see the potential congruence between these methods. Once combined these methods charge the therapeutic environment with an ecologically based scientific (read: observational, verifiable, and meaningful Indigenous science) and a culturally appropriate (read: respectful, relational, dialogue-based, and culturally grounded) method. A first step for many practitioners is to actively deconstruct colonial Western values that regularly contaminate relations, dialogue, and cultural assumptions. However, one must identify these values before enabling deconstruction and rebuilding of culturally grounded methods in practice. We do this work in dialogue with both our Indigenous peers and Western mainstream practitioners.

INDIGENOUS CO-DESIGNED INTERVENTIONS

Not only for non-Indigenous practitioners, but for all of us, to find a culturally safe way to enter the negotiated space of cross-cultural mental health demands continual attention to consent and to mutual adult-to-adult conversations that co-design interventions. To make this effective we must first facilitate mutual understanding at basic levels – and this one step if overlooked will lead to failure and enduring frustration. Most Western mainstream methods deny the

importance of this time in getting to know. However, the logic that doing deeply important cultural, familial, and personal work necessitates an actual respectful relationship (quite a great deal beyond a fly-by 50-minute hour) is in fact a quite reasonable expectation outside of Western-material cultural views.

Upon establishing relationships of endurance, the next step relies on finding points of similarity and divergence in perspectives on mental health, across each culture or family group. Additional layers involve exploring urban versus rural and remote Aboriginal and Torres Strait Islanders' understandings of mental health. Much of the current effort appears based in what remains a Western take on social emotional wellbeing that is based in Western cognitive behavioural frameworks, health measures and outcomes, and quite frankly still colonial attitudes that go unchecked and largely unconscious among practitioners. So prevalent is the Western cultural landscape that no other existence is imagined or entertained.

Likewise, having read the therapeutic literature over the past 25 years, much of the research data emerging suggests standard Western measures that tend to relate overall to notions of wellbeing. These may involve observing coping skills, testing knowledge, evaluating social support and lifestyle measures, and often quantifying various soft notions like connectedness, empathy, and identity. Literature often suggests unique or important new insights that to Indigenous readers and practitioners appears old and relatively useless.

For example, the past decade has shown minor progress in understanding notions of connectedness that involve descriptive analysis. Sometimes based in qualitative data, but more often on statistical measures. Connectedness to country, family and kinship, cultural knowledge, and social networks are noted as having unique contributions to understanding Indigenous health and well-being (Kilcullen, Swinbourne, & Cadet-James, 2016). However, clearly the lack of actual cultural depth in relationship building leads to shallow data that reflects surface observations. Research and practice remain infantile until Indigenous practitioners, authors, and researchers come together to explore the deeper felt meanings and cultural traditions in dialogue with Western methods.

CASE STUDY

This case study is based on a fictional “montage” that combines elements of theory and practice to ensure maximum respect and confidentiality of this work among First Nations peoples and practitioners. For the sake of this

discussion we introduce “Standing Eagle,” a male, 34-year-old, Aboriginal Australian father of three children who finished Grade 8 of school and grew up in Western New South Wales. Standing Eagle reports that he did not learn traditional language and has searched for his cultural identity all his life. He has been in and out of prison, involved in various personal and social conflicts, struggled with alcohol and drug addiction, and gained a reputation for playing up. After his partner passed away from breast cancer, Standing Eagle had a “turn around” and began seeking a more “spiritual path in life.”

When getting to know this person in greater depth, his spiritual life was self-reported as involving bushwalking, camping out, visiting what were known to be sacred sites on the land of his clan, and having certain types of conversations with peers while often seeking out the Elders in his community for advice. We met Standing Eagle during invited talks about Mi'kmaq First Nation Medicine traditions. Elders of our relations saw this kind of culturally based approach combined with our therapeutic expertise as significant and useful. We therefore receive many invitations to speak and talk in groups that lead to further invitations to engage in more intentional projects and methods, sometimes including the combination of psychotherapeutic methods with Indigenous First Nation and regional Aboriginal Australian methods.

Significant in this approach is the fact that therapy is not directly engaged. Even during therapeutic work in an office or clinic environment, rarely is this work simply about providing a direct service and writing up case notes. Instead of working on a 6–12 session model followed by termination, Indigenous methods tend to look at a long-term communal relational system that involves periodic therapeutic work that is appropriate for the individual in each moment. This being said, an intensity of quite deep therapeutic outcomes is possible with the right combination of factors – not the least of which is the readiness and openness of the practitioner to go with the flow of what is requested, needed, and possible in each encounter.

Having been introduced during talks among an Elder circle, Standing Eagle approached me afterwards and invited me to speak with a small group of men who had travelled into the area during the same timeframe. The invitation was to discuss the First Nation approach to Medicine among a circle of men from his clan who happened to be involved in a football match that weekend. As often happens also among my Indigenous connections in North America, one thing leads to another. At each step discussions and consent are mutually exchanged. From the Western clinical perspective we are already well outside of the nine-to-five workday, and quite beyond the notional systems

of workplace health and safety. However, when examining the frameworks of pastoral work, clinical social work, and community-based psychology we are still in familiar territory.

During the meeting with the men's group we note that most of them are in their twenties and thirties, with a few in their forties and fifties. We meet 12 individuals including Standing Eagle. They are all fairly quiet and show an eagerness to listen, receive the invitation to hear me speak, and to offer their own perspectives. We begin with an introduction of each member of the group and we agree that we will stay put for the two hours or so, then break for food. Instead of a camp fire, we simply meet around a couple of Rugby balls that are occasionally kicked lightly or thrown between members of the circle.

The introductions show me that the men carry a great deal of weight in feeling responsible for the health and status of their families and community. They share brief but very poignant stories of their lives, who they are, and what issues of grief they carry. A lot of this discussion is everyday "men's talk." But nonetheless, when correctly understood and with respect this form of "banter" holds a great deal of depth and power for therapeutic outcomes.

For example, you may be aware of Erickson's capacity for "reading" a person's physical and sensory systems for signs of evaluating dominant sensory modalities. He would listen carefully to speech and language, and how words are combined with physiological cues that demonstrated connections to auditory, visual, kinaesthetic, gustatory, and olfactory systems. He would combine this observation with knowledge of unconscious associations to childhood environments and patterns in relationships and experiential histories. In the intercultural setting of a men's group, these skills combine with a respectful curiosity around the ways that you might offer a therapeutic moment that is meaningful to the men around you. You therefore seek to put aside your own assumptions and enter their cultural and familial world. Hearing their stories and experiencing their manner of speaking, quite literally and figuratively, enables associations with the energies and issues they carry and that will likely remain entirely unspoken or just under the surface.

As such, at the time for my introduction the process was to offer a brief package. This included my family and tribal connections, how I came to be in Australia, and my work as an educator and therapist. The main points of the latter simply allowed the men to know that my work combined Indigenous North American and Western mainstream methods of therapy and healing, within a respect for and appreciation of Aboriginal Australian teachings.

In this way, the approach was to ask for consent to engage in a moment of ceremonial story sharing combined with psychotherapeutic use of language with the intention of healing our hearts and our families and clans. Each man was asked to offer consent as such, which they did, and shared a bit more during this process. Questions were raised and discussed. The next part was to offer the story of my Elders.

This story involved the use of the Sacred Eagle Feather dressed in the colours of my Nation, and the burning of White Buffalo Sage, a sweet smelling aromatic herb that provides a calming emotional and social space for listening and sharing. The traditional appearances of elemental sage, fire by way of a simple lighter, and the Eagle Feather with the Indigenous colours which are similar to Australian Indigenous colours, offered immediate conscious and unconscious associations that set the men at ease and gave them a window into a new world of perception.

Immediately from the therapy perspective, the men's expressions softened and the lines in their faces became muted. They found a moment of peace and inner reflection that aided their listening. They entered what Milton Erickson would describe as a trance state, but even more so because this was associated with cultural ceremonial associations and deep memory. Afterwards, many of the men debriefed saying they had never experienced this kind of ceremony. But they felt like they had come home to a part of themselves they always knew, and missed, and sought most of their lives but they did not know how to find. This suggested that cultural and familial unconscious memories or associations may have been activated, or at minimum that the experience offered the men something to consider that felt visibly and physically significant for them.

During the sharing of the Eagle Feather Medicine tradition, the stories of my Elders came forward and the teachings around the Seven Ways of Respect and Healing were discussed. This talk lasted the better part of 40 minutes. The men listened intently the whole time. The whole time I held up the Eagle Feather, at times signalling to the Four Sacred Directions and giving voice and honour to our Elders Past and Present. The men were at times visibly moved, several wiped tears from their eyes, others held their mouth open as if transfixed. At other times a joke broke the silence and intensity and allowed belly laughs and a great deal of fun.

Within this talk was an intentional weaving of Indigenous story as Medicine, therapeutic metaphors of learning and healing, and psychotherapeutic post-

hypnotic suggestions, all aimed at effecting an experiential knowing for the men in the circle. Already I had a sense of which men held the weight of the world on their shoulders and thus was able to weave in suggestions to help them, without any direct intervention that would make them feel uncomfortable. These suggestions were around the ways in which our body-mind comes to terms with issues and problems, how we grow over time, how our body heals from scrapes and bruises and major illness, and the ways in which we gain inner knowledge and wisdom. The suggestions encouraged cultural awareness and growth in understanding how to bring forward the wisdom of our Aboriginal histories.

These men were from a community that had largely lost its language. They were already tentatively seeking out and visiting other clans across the country to learn sacred ways and bring them home and share among their families. They had begun a process of intentional healing. My work was therefore quite timely and they were eager to understand and appreciate First Nations teachings and to bring this home to help their families.

After this sharing, each man got to hold the Eagle Feather and share his heart – whatever he wanted to say, or a period of silence, as he chose. Some of the older men shared a great deal, and the men got to hear stories they had never heard before. I was told afterwards that the kind of heartfelt openness was a breakthrough for certain individuals. They were hopeful this might be a turning point in their lives. After the burning of Sage again and the Thanks Giving and Closure of the Circle, the time was ended and the group dispersed.

This post-circle time was also pivotal. One might think things were done by then, but in Indigenous culture things have their own ebb and flow we learn to respect. One cannot simply turn on and off, or keep strict professional boundaries and then be at ease and unprofessional. Practitioners learn to carry themselves with integrity across all these moments and relationships. This is a rare gift that certain Elders convey with great ease and grace.

Certain men approached me for more in-depth talks. Each was related to aspects shared and to their way of bringing that awareness into their life and family. Standing Eagle approached me later and asked whether he could carry the Eagle Feather back to his people and share the Eagle Feather tradition among their clans. This request led to further discussions among the Elders present, and the men came to an agreement. Once they appeared at peace it was no issue for me to extend this teaching and therapeutic method to their own keeping.

The work with Standing Eagle led to more in-depth therapeutic efforts on his part. These included further meetings where he explored family histories

of violence and abuse. He had the insights that the Eagle Ceremony was related for him to this necessary healing. His personal courage and insights were quite remarkable.

Over two years Standing Eagle met with me, and several times with his children as well, to explore pathways of healing in their relationships. This work carried over into his role in his community. He later became a counsellor and healer in his own right, and began working in social welfare and assisting others in his clan and wider community.

DISCUSSION AND CONCLUSION

When working inside of Indigenous cultural methods, “expect the unexpected” appears to be one of the themes that becomes familiar. While this might appear trite, in fact this is quite the opposite and becomes central to the manner of working. Duran (2006) describes the nature of psychotherapy with First Nations individuals and families as a transformative encounter for therapist and clients. Both are influenced and changed in fundamental ways, and when either is not open to change the sharing of therapeutic intention appears to lessen and disappear.

We have a saying among Powwow Season back in Canada. If you are ready to go with the flow, you are ready to Powwow. This does not mean to party, but to open your heart and soul to being touched and moved and changed. This flow involves staying open to invitations, listening to inner impulses and intuitions, watching one’s dreams and hearing the music that comes to you each day. Even the smallest most insignificant event can have wisdom teachings for you, and influence your next move.

For example, during a research project while reconnecting with our Elders we met certain people at a gathering. One person invited us to visit their home. This felt alright so we went and at that place we met an Elder who invited us to an Elders’ gathering. This led to other invitations that opened up key discussions that led to the success of the research project but also provided enormous therapeutic value. A decade later these relationships of respect and trust are still significant and enduring. From these further therapeutic opportunities have emerged that enable sharing and caring between people during long-term recovery from transgenerational trauma, abuse and colonization, residential school and stolen generation experiences, and disrupted familial attachments that involve ongoing re-parenting and healing.

When re-reading the teaching tales of Milton Erickson there is much utility in an intercultural therapeutic project. We do not seek the details of

his method per se. Rather we can witness his cultural sensitivity to American mainstream cultures and the ways he appeared to work effortlessly to effect therapeutic outcomes based in part on his intimate observations of everyday life from his wheelchair. Over time this keen sense of observation and sensory acuity enabled him to effect major change in cases that were otherwise impassable at the time by any other methods.

In our estimating, Indigenous approaches to therapy carry a great deal of wealth for many nations. They combine a depth of cultural and spiritual values that circle around a naturalized scientific method of observation and testing of assumptions. Integrative ecological psychosomatic therapy combined with Ericksonian hypnotherapy has great utility across a range of environments and is dearly needed in today's world regardless of the cultural contexts.

REFERENCES

- Bowers, R. (2013a). *On the threshold: Personal transformation and spiritual awakening – a primer on the spiritual life with activities*. Armidale, NSW: Earth Rattle Publishing.
- Bowers, R. (2013b). *Sacred teachings from the medicine lodge*. Armidale, NSW: Earth Rattle Publishing.
- Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other native peoples*. Multicultural Foundations of Psychology and Counseling Series. New York: Teachers College Press.
- Eckermann, A., Dowd, T., Chong, E., Hixon, L., Fray, R., & Johnson, S. (2006). *Binan goonj: Bridging cultures in Aboriginal health*. Sydney: Elsevier.
- Homes Whitehead, R. (1988). *Stories from the six worlds: Micmac legends*. Halifax: Nimbus Press.
- Kilcullen, M., Swinbourne, A., & Cadet-James, Y. (2016). Aboriginal and Torres Strait Islander health and well-being: Implications for a cognitive-behavioural therapy framework. *Australian Psychologist*. doi:10.1111/ap.12159
- Paul, D. (2006). *We were not the savages: Collision between European and Native American civilizations*. Halifax: Fernwood Press.
- Perlmutter, J. (2015). *Healing body, self and soul: Integrative somatic psychotherapy*. New York: Balboa Press.
- Rosen, S. (Ed.). (1982). *My voice will go with you: The teaching tales of Milton H. Erickson*. New York: W.W. Norton Press.

REVIEW

PERSONAL CHANGE THROUGH SELF-HYPNOSIS (2ND EDITION)

Pamela Young

Fremantle, WA: Vivid Publishing. 2016. 272 pp. \$29.95

PAMELA YOUNG

I first met Pam Young at the joint International Society of Hypnosis (ISH) / Australian Society for Clinical and Experimental Hypnosis (ASCEH) conference in Melbourne in 1979 and I recall her telling me about her experiences as a student counsellor at the New South Wales Institute of Technology. I was impressed with the results she was obtaining and fascinated by the concept of naive subjects producing their own hypnosis recordings. The belief expressed then was that, as the subjects were themselves creating the recording to be used for self-hypnosis, their potential “resistance” to the suggestions being offered was very much reduced thus allowing the treatment to be so effective.

Ten years later, I was very pleased to find Pam had written a book of her experiences and so created a manual for those wanting to understand self-hypnosis. The original version of *Personal Change Through Self-Hypnosis* I acquired at another conference and found it enjoyable reading. It has been a great pleasure to re-read this book and recall the many things I had consciously forgotten presented so concisely and in such an eminently readable style.

THE BOOK

The first 11 chapters are aimed at those who are completely naive regarding hypnosis and covers a brief history of hypnosis, theories, expectations, misuse and dangers, and a discussion of stress. Behaviourism and psychodynamic

theories are reviewed, and the arguments for and against briefly presented. While necessarily brief, some 35 pages, it is a perfectly adequate review for someone who is looking to use self-hypnosis with very little understanding of it or experience of psychology.

In the first chapter Pam voices the often-expressed opinion that “all hypnosis is self-hypnosis.” This is a wonderful statement which de-fuses the power and control issues that many people fear and is a position taken by the great majority of users of hypnosis, including me.

Part Two contains suggestions for making the recording and several basic script formats while Part Three is of specific scripts for a range of different problems and applications: appetitive disorders (smoking, anorexia, drinking), functional problems insomnia, obsessive compulsive disorder, fears and phobias, breathing skin and heart problems, emotional problems, sexual dysfunctions, pain, performance, and academic and sport foci.

Part Four contains more advanced techniques from the works of Milton Erickson and Bandler and Grinder. Each of the above chapters is prefaced by a succinct description of the problem, psychological explanation of the possible causes, a rationale for treatment, and case examples where appropriate. A suitable script or scripts completes each segment.

Pam’s orientation throughout the book is the empowerment of the of the reader, not only to start their journey, but letting them be free to change their mode of transport at any point if they find there is a faster way to get their destination.

This is a thoroughly delightful book to read, with a wealth of information, suggestions, and scripts. It is not only a comprehensive text for those commencing to use self-hypnosis but an excellent review of hypnotic techniques and suggestions which any experienced practitioner will benefit from reading.

Those interested in Pamela Young’s work can visit her webpage: <http://selfhypnosis.net.au/>

JAMES AULD

Chair, Australian Society of Hypnosis – Board of Education

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The *Australian Journal of Clinical and Experimental Hypnosis* is pleased to announce the creation of two Special Journal Issues to be published in 2017 and 2018. We encourage all interested parties to submit manuscripts for review and possible inclusion in the special issues. Please send manuscript submissions to Dr Nadine Pelling, the guest editor for these issues, at nadine.pelling@unisa.edu.au and place AJCEH Special Issue in the heading.

The two special journal issues are as follows:

1. Special Edition of the *Australian Journal of Clinical and Experimental Hypnosis*: Hypnosis in Australia: Original Metaphor Descriptions and Scripts for use in Hypnosis due for publication in November 2017
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Regular submissions to AJCEH can continue to be submitted to the editor, Graham Jamieson, at gjamieso@une.edu.au.