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## EDITORIAL

The content of the current issue highlights the international nature of scholarship in the study and practice of hypnosis. Dr Carlos Alvarado writing at the University of Virginia provides us with a historical perspective on the development of the ideas of Charcot and the Salpêtrière School through the influence of a unique individual the hypnotic virtuoso Blanche Wittmann.

Dr Tom Kraft and Dr David Kraft writing from their practice in Harley Street, London, provide the final instalment of a series of papers on the place of hypnosis in behavioural medicine with a thoughtful and wide-ranging examination of the treatment of eating disorders. Sadly, Dr Tom Kraft passed away on 10 December 2008. In addition to a distinguished clinical career he contributed extensively to the practice of clinical hypnosis through many scholarly publications and his role in the further training of professionals through the Hypnosis Unit of University College London. He is especially remembered as a loving father by his son David, with whom he wrote this his final paper.

From Australia we have a case study of the use of hypnosis in the treatment of premenstrual dysphoric disorder by Sydney-based therapist Marianne Gabriel. Lynda Dolan, also writing from Sydney, presents a detailed rationale for the careful integration of hypnosuggestion and hypnoanalysis with wider therapy issues in her account of the treatment of a case of vaginismus. Priscilla Kwan from Honk Kong contributes a report on the use phase-oriented hypnotherapy for complex PTSD in battered women.

With contributions from Australia, North America, the U.K. and Hong Kong in a routine edition, it is apparent that *AJCEH* has the potential to serve not only the local community of hypnosis practitioners but also to draw upon and reach out to a much wider and genuinely global network. The development of such networks is a challenge and an opportunity for ASH and the immediate hypnosis community of practitioners and researchers. In order to do so we must identify and implement the steps necessary to ensure wide electronic availability of the journal and the listing of its contents in recognised international academic databases.

There is very much a chicken and egg problem. For clinical and academic hypnosis research to flourish there must be quality recognised publishing outlets for emerging researchers, but unless journals can consistently publish copy that quickly reaches and impacts a global readership they will not attract high quality contributions.

With this in mind it was very refreshing to meet with the strong group of young PhD students and postdoctoral researchers choosing to work with hypnosis who attended the most recent ASH conference, held on Norfolk Island. It is essential that *AJCEH* succeeds in tapping the interest and enthusiasm of such groups both at home and abroad. In this context the contribution of Priscilla Kwan writing and working in Honk Kong reminds us that Australia is neighbour and partner to a dynamic, prosperous, and intellectually vibrant East Asian region with which we are forming new partnerships in order to serve our mutual professional, community, and academic interests.

*Graham A. Jamieson*

## THE PLACE OF HYPNOSIS IN PSYCHIATRY, PART 3: THE APPLICATION TO THE TREATMENT OF EATING DISORDERS

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*This paper, the third in the present series, is based on a world-wide search of the literature focusing on the application of hypnotherapy in the treatment of eating disorders. According to DSM-IV (American Psychiatric Association, 1994), eating disorders are broadly divided into two main groups – anorexia nervosa (AN) and bulimia nervosa (BN). There is also an intermediate group where there are components of both anorexia and bulimia present and some authors refer to this as “bulimexia” (Thiessen, 1983). The authors review a range of treatment procedures which have been shown to be highly effective for the treatment of both anorexia nervosa and bulimia nervosa. Some of these treatments are based on behavioural lines, others are psychodynamically oriented, while a third group involves a combination of these approaches. Detailed accounts of the treatment procedures are given so that hypnotherapy practitioners may incorporate these techniques in clinical practice.*

According to the DSM-IV classification (American Psychiatric Association, 1994), eating disorders can be divided into two main categories: anorexia nervosa (AN) and bulimia nervosa (BN). In order to establish a diagnosis for anorexia nervosa, there must be a refusal to maintain a minimal body weight and this is associated with a distortion of body image. Before making the diagnosis, it is important to exclude organic illness which may simulate some of the features of anorexia nervosa. Female patients with anorexia nervosa frequently suffer from amenorrhoea and their reluctance to develop into

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## 2 *Kraft and Kraft*

a fully grown woman is reflected in their appearance. Anorexia nervosa is subdivided into two main groups:

1. Restricting Type: weight loss associated with dieting, fasting and excessive exercise.
2. Binge Eating/Purging Type: weight loss associated with a bingeing and purging cycle – self-induced vomiting; inappropriate use of laxatives or enemas. This is sometimes referred to as “bulimerexia” (Thiessen, 1983).

The term bulimia nervosa refers to a condition in which the individual has a combination of binge eating associated with compensatory purging – again this is often connected with an obsessive preoccupation with body weight and shape. In order to make the diagnosis, the purging and bingeing cycle, according to *DSM-IV* criteria, must occur at least twice a week for a period of at least three months. Bulimia nervosa is also divided into two main groups:

1. Purging Type: binge eating followed by self-induced vomiting, misuse of laxatives, diuretics or enemas.
2. Non-Purging Type: bingeing followed by fasting or excessive exercise.

*DSM-IV* also includes the category “Eating Disorders not Otherwise Specified” which is reserved for those patients who do not meet all the necessary criteria for the diagnosis of anorexia nervosa or bulimia nervosa. These are as follows:

1. Females who meet all the criteria for anorexia nervosa but who have regular periods.
2. Patients who starve themselves but maintain a normal body weight.
3. Individuals who meet all the criteria for bulimia nervosa but the binge/purge cycle occurs less than twice a week and for a period of time less than three months.
4. Individuals who binge and purge after eating a small amount of food.
5. Individuals who repeatedly chew, spit out, but do not swallow large amounts of food.
6. Individuals who binge without regular, inappropriate compensatory behaviour.

It is important to note that simple obesity is not classified as an eating disorder in *DSM-IV* because there is no clear association with a psychological disturbance in every instance; however, it is classified in *ICD-10* (World Health Organisation, 2003) as a general medical condition. For the purpose



of this paper, an account will be given of the aetiological factors and the clinical manifestations of anorexia nervosa and bulimia nervosa, focusing on the application of hypnosis in their treatment.

## **ANOREXIA NERVOSA**

The term anorexia nervosa was first used by Charles Lasègue (1873) and then by Gull (1874), who wrongly attributed this condition to hysterical apepsia to distinguish this from other causes of weight loss such as tuberculosis and organic gastrointestinal diseases (Chabrol & Corraze, 2001). At the beginning of the twentieth century, the French psychiatrist Pierre Janet gave a detailed account of patients suffering from this condition and he was the first to introduce hypnotherapy to treat what he described as “hysterical anorexia” (Janet, 1924). Janet emphasised the importance of the psychological factors in its aetiology; however, he did not make a clear distinction between anorexia nervosa and what is now known as bulimia nervosa (a condition which now might more accurately be described as “bulimerexia”). He used the expression “*idée(s) fixe*” to describe the patients’ preoccupation with self-starvation and body image, and he used hypnosis to address these problems in a process which he referred to as “mental synthesis” or “*la synthèse mentale*.” Vanderlinden and Vandereycken (1988) pointed out that, perhaps, Janet was one of the first to use a form of cognitive restructuring in the treatment of this condition.

In 2007, an epidemiological study was carried out to determine the incidence of anorexia nervosa in men and women. This research, a population-based study from the National Comorbidity Replication carried out by Harvard Medical School ( $N = 9,282$ ), showed an incidence of anorexia nervosa of 0.9% in women and 0.3% in men. This study was based on a house-to-house survey on a national level using the WHO Composite Diagnostic Interview (Hudson, Hirip, Pope, & Kessler, 2007). These figures indicate that there has been an increase in the number of men with anorexia nervosa; this may be due to a definite increase in the number of men suffering from this condition or, alternatively, that diagnostic tools have improved to such an extent that researchers have been able to locate more men suffering from this condition (ANRED, 2008).

A prominent feature in the aetiology of anorexia nervosa is that the patient is caught up in a highly complex and disturbed family structure; (s)he displays both obsessional and highly perfectionist features, and this is a product of the family’s psychopathology. A major component of anorexia nervosa is that

there are internal hostilities within the family structure, and the food restriction is a function of hostile feelings towards parental figures. This striving for perfectionism pervades the whole of their lives, including the home and work environments; individuals often have an encyclopaedic knowledge of calorie values and the precise constitution of foodstuffs. Some patients exercise excessively each day with the express purpose of losing weight: This has been termed “anorexia athletica” (Segal, 2001). The restriction of food intake can be of such severity that the patient may die of this condition. In order to prevent any weight gain, individuals will go to any length to hide food or lie about the quantity of food they have consumed.

Patients suffering from anorexia nervosa not only reduce their food intake to the point of starvation, but also have a distorted body image, so that they regard themselves as being fat when, in reality, they are already quite thin or even emaciated. A recurring feature in adolescent girls suffering from this condition is that they are unable to deal with their bodily contours in connection with their sexual development. Davis (1961) referred to this phenomenon as “psychological infantilism,” and often they present with a childlike appearance (Yapko, 1986). Similar mechanisms operate with young men who suffer from anorexia nervosa.

Further, these patients are able to suppress their hunger, suffer constipation, and are able to feel full after a small quantity of food (Gross, 1984). One of the very important mechanisms in anorexia nervosa, and a feature which is central to their condition, is that, by eating very small quantities of food they exercise an enormous amount of control; in addition, this has the effect of counteracting feelings of worthlessness or powerlessness in their everyday lives (Sours, 1969).

Patients with anorexia can suffer from a number of physical complications. Some patients suffer from bradycardia (Kollai, Bonyhay, Jokkel, & Szonyi, 1994) and in some cases this may be associated with electrocardiographic changes with an increase in the QT interval (Cooke et al., 1994). These cardiac abnormalities may be associated with hypophosphataemia and delirium (Beumont & Large, 1991). Patients frequently suffer from endocrine disturbances, the commonest of which, in women, is amenorrhoea. In addition, individuals may suffer from osteoporosis which, in turn, may result in an increased fracture risk throughout life (Munoz & Argente, 2002). Adolescent anorexics frequently show stunted growth during their illness, and this can be seen in both male patients (Moses-Modan et al., 2003) and in female patients (Swenne & Thurffjell, 2003). Patients may also develop hypothermia associated

with a thiamine deficiency (Smith, Ovesen, Chu, Sackel, & Howard, 1983). In adolescents suffering from anorexia, this may lead to a zinc deficiency, and supplements of zinc in the diet may be helpful in the recovery process (Katz et al., 1987). Frequently, patients have dry skin, chapped lips, skin pallor and sunken eyes (Gupta & Gupta, 2001); but, more seriously, they may reduce their food intake to such low levels that eventually they become cachectic (Sours, 1974). It is important to remember that anorexia nervosa may lead to sudden death: a meta-analysis has shown that the mortality rate of anorexia nervosa, with causes of death ranging from suicide to sudden death, was 5.9% (Neumaerker, 1997). In a retrospective study carried out in Southern Italy (Signorini et al., 2007), the total mortality rate was 5.25%, which included suicides (1.2%) and AN-unrelated deaths (0.98%). They concluded from this study that the mortality rate for females in Western society was very high.

The following headings have been used to emphasise particular approaches which employ hypnotherapy in the treatment of anorexia nervosa; however, it is important to note that these are not mutually exclusive and therapists may choose to incorporate several of these strategies with the same patient.

### **Encouraging Increased Food Intake**

The authors felt that it was necessary to draw attention to some of the earlier studies which, though dated, still have relevance in the present climate. Kroger and Fezler (1976) recommended a combination of behaviour therapy and hypnosis in order to help patients increase their weight, and this was achieved by the use of post-hypnotic suggestions in which food was associated with pleasant memories. A similar approach was used by Davis (1961), who used post-hypnotic suggestions to promote the fact that food tastes good and that one needs food to stay alive. However, he also used intravenous sodium amylal (amylobarbitone sodium) and ECT, both of which are no longer used in practice. Fourteen years later, Crasilneck and Hall (1975) treated 70 patients with hypnotherapy and they reported that over half of these patients made a good recovery. They gave direct suggestions of increased food intake, and once the patients had succeeded in achieving and stabilising a normal weight they used hypnoanalysis to uncover the psychodynamic conflicts underlying the anorexia nervosa.

An unusual approach was one used by Erickson (Bliss & Erickson-Klein, 1990; Erickson, 1985; Zeig, 1985), who used food as a “punishment.” Erickson gave a detailed account of a 14-year-old girl, Barbie, whose food intake

consisted of one oyster cracker and a glass of ginger ale per day. In a joint consultation with her mother, whenever Erickson asked Barbie a question, the mother replied. He did not deal with this problem straight away, but it was very clear from this one example that her mother was exerting an enormous amount of control over her daughter and interfered with her autonomy. On the third day, the mother complained that she couldn't get to sleep because her daughter had been whimpering all night. The daughter agreed with the therapist that she deserved to be punished for this, which meant having to eat scrambled eggs, and the mother was required to feed them to her. At the same time, Erickson was very critical of the mother, pointing out that she always replied to questions intended for Barbie. It was then that he told the mother to "keep her trap shut" and this had a powerful emotional effect on the daughter who, from then on, was forced to view her mother in a different light. He then used a number of complicated strategies, which included the use of long, elaborate stories and the extended use of metaphors; he also asked Barbie to spy on her mother's eating habits, and that failure to do so would result in further eating punishments. In addition, both mother and daughter gave realistic goals of proposed body weight. This course of treatment was highly successful: Barbie had achieved her desired body weight and was now eating normal meals during the course of the day. A long-term follow-up of 14 years duration showed that she had made an excellent recovery and that she was engaged to be married.

Another behavioural treatment approach was described by Georgiou (1995) in which an important component was the vivid recall of feeling hungry, and this was paired with eating a small delicious meal slowly. Direct suggestions were also given that the patient's appetite and weight would increase and that feelings of comfort and satiation would be a signal to stop eating.

### **The Nature Approach**

Gross (1984) gave a detailed account of a 15-year-old girl whose weight had dropped dramatically from 103 pounds to 50 pounds. On her admission to hospital, her fingers were blue and she fidgeted constantly. She learnt to carry out self-hypnosis for 15 minutes each day, and this had a beneficial effect of reducing her hyperactivity. In the hypnotherapy sessions, she was encouraged to imagine herself in a beautiful setting of her own invention. Having chosen the beach as her ideal setting, this scene was then utilised as a metaphor for the regulation of her bodily functions. For instance, the regularity of the

ebb and flow of the waves was equated to the rhythms of her heart beating, as well as the peristalsis of her gastrointestinal tract (Georgiou, 1995). This treatment approach is very similar to the river approach in the treatment of irritable bowel syndrome which has been used extensively by the Manchester team (Whorwell, 2006). On this system, she gained two pounds each week and eventually reached 100 pounds; and, during this time, she became much calmer and felt that she was able to explore some of the underlying causes for her anorexia.

Esplen (2003) emphasised the importance of using images from nature to provide patients with a soothing and warming environment. Her technique involves the use of guided imagery without attention being paid to the prevailing symptom. Three patients were described and all had a mixture of anorexia and bulimic symptoms. This approach is psychodynamic and differs markedly from the behavioural approaches outlined above. It is a non-directive approach. The great advantage of this form of treatment is that it concentrates solely on the underlying problems responsible for the eating disorder, and this gives the patient a better understanding of her family situation: The symptoms subside without dealing with them directly. Images include the use of meadows, outdoor water, the warmth of the sun and familiar places where the patient has felt safe in the past. The therapist constructs a protective and safe environment and this encourages patients to express their deep-rooted feelings spontaneously.

### **Correcting Body Image**

Gross (1984) also concentrated on changing what he described as, “a notoriously distorted body image.” During the course of the hypnosis, the patient was shown pictures of her emaciated body and it was then suggested that she should imagine a healthier body image. Another component of this approach involved the patient drawing a picture of herself, and it was here that the therapist concentrated on particular areas of distortion. Often, these patients drew over-sized hips. Gross (1984) described a case of a 17-year-old female patient, Cathy, who started losing weight after her boyfriend had commented about the size of her thighs. She had gone from 130 pounds to 80 pounds and was subsequently admitted to hospital. Cathy had a distorted body image: She believed her hips and thighs were huge even though, in reality, they were quite thin. She also was preoccupied with the notion of gaining weight. In the hypnosis, she was instructed to look at the picture of

herself on admission; she was then asked to project herself into the future and to model herself on a favourite film star. Also, the therapist suggested that she should touch her thighs, and gradually she began to view her body in a more realistic light. Concurrently, she started to put on weight and, in a period of four months, she reached 118 pounds; importantly, she was able to stabilise her weight and this was maintained over a three-year period.

Nash and Baker (1993) treated 36 female patients suffering from anorexia nervosa and reported that, at the 6- and 12-month follow-ups, 76% of the patients who had received a combination of hypnotherapy and psychotherapy had a remission of symptoms and had stabilised their weight; this compared favourably with the group who had psychotherapy only, where, the corresponding figure was 53%. Patients were asked to project their distorted body image onto a blackboard or an imaginary screen. Using this dissociative image, an age regression technique was then employed to elucidate the roots of the bodily distortions and then to explore them first during trance and then in the subsequent insight-orientated psychotherapy sessions. Patients were encouraged to erase and then re-draw parts of the body that were particularly distorted; this process often generated a great deal of anxiety, and this was counteracted by suggestions of calm and relaxation.

### **Approaches to Perfectionism**

Patients with anorexia nervosa invariably show powerful perfectionist traits and several authors have paid particular attention to this aspect of the disorder. Yapko (1986) encouraged his patients to make deliberate mistakes in order to show them that this did not lead to world-shattering consequences. He gave examples such as leaving the bed unmade, being late for meetings, and taking wrong turns off the motorway. Patients either comply with the instructions given to them by the therapist which involves making a mistake, or, alternatively, they fail to comply and therefore also make a mistake. Yapko refers to this as a “double bind effect,” where the patient is given the illusion of choice. This phrase differs from the psychoanalytic definition which refers to contradictory messages being given to a patient within the family context. A variant of this technique is to re-frame perfectionism as something which is negative or undesirable.

### **Correcting Faulty Sexual Maturity**

Many patients suffering from anorexia nervosa show a faulty sexual maturation and often have a child-like appearance. One treatment technique is to use

age progression in which the patient is encouraged to imagine herself in the future as a healthy individual. The patient is also given the opportunity to experience the intermediary stages leading to a successful recovery. Yapko used a homework strategy in the treatment of a 20-year-old patient. She was directed to go to the children's section of a department store and to try on the clothes with the express purpose of demonstrating to herself that she was small enough to fit into children's clothes. This had a disturbing effect on the patient because she now had objective proof that she had an abnormal body size. This approach forced her to face the fact that she had been in denial about her bodily contours and she then accepted that she needed to address these problems.

An alternative approach to developing sexual maturity is an Ericksonian-type strategy used by Thiessen (1983), who repeatedly recounted the story of the ugly duckling. He used this metaphor to promote healthy sexual maturation. The realisation that the ugly duckling – in fact, a signet – had been transformed into a really beautiful swan had a powerful effect on the patient. In the hypnosis, the symbol of the swan represented a sequence of important changes relating to the natural development of her adolescent life and becoming an adult woman. It suggested that she was capable of becoming a beautiful swan and that sexual maturity was a desirable outcome. Thiessen described a 22-year-old female patient who showed typical features of anorexia nervosa including perfectionist traits, secrecy, ambivalence to growing up, and a rejection of accepting her female identity. As it is frequently found in these patients, her problems were inextricably interconnected with a highly complex family structure. In addition, she showed bulimic symptoms including bingeing, vomiting, and the use of laxative pills. During the first five or six months of therapy, attention was focused on some of the important psychodynamic factors – namely, her father's excessively high expectations, a bad mother image, and a sexual incident at the age of seven – in the development of her disorder. No doubt, this was effective groundwork for the introduction of the ugly duckling fairytale. By using the story of the ugly duckling in the hypnosis, she was able to restore her normal body weight. At the end of the treatment, she was 118 pounds and had been able to refrain from her bingeing; this weight was maintained at the 6-month follow-up.

### **Use of the Healthy Voice and the Self-Defeating Voice**

Segal (2001) used a multi-faceted treatment approach in the treatment of a 22-year-old male patient who suffered from anorexia nervosa associated

with exercise addition. An important technique which was employed during the course of the therapy was the use of the “healthy voice” and “self-defeating voice”. This approach comes under the general heading of cognitive restructuring. In this treatment paradigm, the patient was encouraged to recount a number of sentences typical of his self-defeating voice (e.g., “I have no control over my exercise routine and diet”) followed by positive and adaptive counter statements of the healthy voice (e.g., “I can control my exercise routine and diet”). Then, in the hypnosis, he was encouraged to repeat silently the statements of the healthy voice.

### **Sibling Rivalry**

Gross (1984) described the role of sibling rivalry in an 18-year-old patient suffering from the purging variety of anorexia nervosa, sometimes referred to as bulimierexia (Thiessen, 1983). He described the onset of the condition following a chance remark from someone who referred to her as “fat,” and this acted as a trigger for her anorexic and bulimic symptoms. Sibling rivalry was an important component of her eating disorder. In the hypnosis, Gross asked her to concentrate on feeling hungry and to respond appropriately by eating small quantities of food to satisfy that need: In the abreaction which ensued, she was able to convey her feelings of jealousy about her younger sister, her constant need for parental approval, and her unconscious desire to be thinner than the sister. The treatment was successful. She reached her goal of 100 pounds and this was maintained at both the 18-month and two-year follow-up.

### **BULIMIA NERVOSA**

While the term bulimia was known as far back as the eighteenth century (Blankaart, 1708), it was Russell (1979) who pointed out that this condition was an “ominous variant” of anorexia nervosa, and intimated that bulimia nervosa could be regarded as a syndrome in its own right. An essential component of bulimia nervosa involves binge eating accompanied by some form of purging behaviour – intentional vomiting, use of laxatives, diuretics and enemas. However, there is also the non-purging variety, and here individuals fast or exercise excessively. Despite episodes of over eating, body weight is normally maintained as a result of these compensatory mechanisms coming into play. Frequently, patients describe their actions during the binge/purging cycle as being, “out of control” or, “as if another person is taking over



my body.” Some patients become so expert at vomiting that they can do this without having to insert fingers into the mouth.

Figures for bulimia seem to have increased over the last 20 years. The Harvard study (Hudson et al., 2007), quoted earlier in connection with anorexia nervosa, showed that the incidence for bulimia in women was 1.5% in the population, while the corresponding figure for men was 0.5%. It was also found that, with binge eating disorder – not included in this paper because it does not satisfy *DSM-IV* requirements for an eating disorder – the equivalent figures are 3.5% in women and 2.0% in men.

Patients suffering for bulimia nervosa frequently experience medical complications to a greater or lesser degree depending on the severity of the condition. One of the complications of bulimia is an electrolyte disturbance – notably, hypokalaemia, with its associated muscle weakness and cardiac arrhythmias. Indeed, some patients who are initially admitted to hospital with an electrolyte disturbance are in fact suffering from bulimia nervosa (Lam & Lee, 2000). Frequent vomiting may also lead to dental carries (Rytömaa, Järvinen, Kanerva, & Heinonen, 1998), lacerations in the mouth (Mendell & Logemann, 2001), gastric reflux and oesophagitis (El-Mallakh & Tasman, 1991), swelling of the salivary glands (Vavrina, Müller, & Gebbers, 1994), sclera haemorrhaging (Gorney, 2000), chronic dehydration (Sagar, 2005) and calcium deficiency causing loss of bone density (Sagar, 2000; Zipfel et al., 2001). In a 12-year longitudinal study of 196 female patients suffering from bulimia nervosa, there was an overall mortality rate of 2% (Fichter & Quadflieg, 2004); it is noteworthy, that the 12-year follow up revealed that 70.1% of these patients no longer showed evidence of an eating disorder as defined by *DSM-IV*. The mortality rate is significantly lower than the previously cited studies on anorexia nervosa (Neumaerker, 1997; Signorini et al., 2007).

A number of researchers have reported a significant correlation between bulimia nervosa and hypnotisability (Barabasz, 1991, 2007; Kranhold, Baumann, & Fichter, 1992; Pettinati, Horne, & Staats, 1985), and while there are slight differences between the various scales of hypnotisability, it has been established that these scales have high reliability and validity (Hutchinson-Phillips, Gow, & Jamieson, 2007). This has an important relevance to the treatment of bulimic patients as they have a high capacity for dissociation. They often experience time distortion, amnesia, and a feeling that the binge/purge cycle is beyond their control. It is argued that bulimic patients have a history of early trauma which cannot be integrated into the self, and both the bingeing and the purging are considered to be a variant of the dissociative state (Covino,

Jimerson, Wolfe, Franko, & Frankel, 1994; Sands, 1986; Vanderlinden, Norre, & Vandereycken, 1989). It is for this reason that ego-state therapy and other dissociative techniques may be particularly valuable for the treatment of bulimic patients.

### **Vanderlinden and Vandereycken's Three-Phase Treatment Approach**

Vanderlinden and Vandereycken (1990) reported a study of 50 young women (mean age = 24; range = 20–30); at the follow-up one and two years after admission, 50% made a complete recovery and a further 30% showed remarkable improvement, while 20% remained bulimic.

The first phase of treatment was aimed at preparing the patient for change. Having taught the patients self-hypnosis and given them a tape to use at home, the patients were asked to keep an accurate diary of their eating behaviour and to record the emotions before, during, and after each meal; due to the chaotic nature of their disorder, patients were encouraged to eat three meals a day at fixed times. In addition, the patients were required to make a list of all the negative consequences of their bulimia as well as the advantages of stopping this behaviour. In the hypnosis, the therapist emphasised both these negative and positive features. This approach can be combined with age progression in which the patient is asked to imagine a future time where they are no longer bulimic and are living a healthy life.

The second phase of treatment involves the exploration of the underlying factors which may have been responsible for the bulimia. Traumatic events in the patient's life might involve incestuous relationships, rape, violence, or abandonment. The authors point out that a useful way of uncovering traumatic events is to address, and negotiate with, the part of the self responsible for the bulimia, with the aim that the patients find more appropriate and adaptive ways of dealing with their problems. In the last phase (phase 3), the authors prepare the patients for this important life transition using age progression and ego-strengthening. They also stressed the importance of aftercare for one, two, and up to five years after admission, and recommend that the therapist should remain available for an extended period of time.

It is important to note that, in order to explore the psychological mechanisms responsible for the bulimia, age regression techniques or the use of the affect bridge may well reveal childhood traumas and other evidence of dysfunctional family dynamics. Before attempting to explore these experiences, the therapist would be well advised to ask permission to do this from the patient using

ideomotor signalling. Clinicians should bear in mind that this technique may produce a violent abreaction. Should this occur, the therapist must handle the situation with sensitivity, providing the patient with the appropriate support and encouragement.

### **Hypnobeavioural Treatment (HPT)**

In this treatment approach, the therapist aims to deal with the problem on behavioural lines associated with hypnosis. Griffiths (1995a) devised an 8-week HBT program consisting of two phases. In the first phase, patients were required to monitor their eating behaviour and were given advice about regulating their food intake and eating three meals a day. Patients were also given nutritional advice. In this stage, patients had three hypnotherapy sessions which focused on behaviour modification following the treatment manual suggested by Fairburn (1985). The second phase involved four weekly sessions during which the patient was encouraged to exercise control over his or her bingeing and purging. In the hypnosis, the therapist gave suggestions to reinforce healthy eating habits, to increase self-esteem, and to encourage more social interaction. Patients were also given suggestions that they would be able to exert control over the antecedent situations which had previously led to a binge/purge episode.

This treatment approach employed by Griffiths focuses solely on behaviour modification and does not pay any attention to the underlying emotional causes responsible for the bulimia. In a two-year follow-up report (Griffiths, 1995b), results showed that there was a significant reduction from pre-treatment to post-treatment bingeing and purging; however, it must be pointed out there was no change as regard to their general health, their psychiatric state, or their depression as measured by Goldberg's (1972) General Health Questionnaire (GHQ), the Eysenck Personality Inventory (EPI; Eysenck & Eysenck, 1963), and the Zung Depression Scale (Zung, 1963) respectively.

### **Stimulus Control Techniques**

This is a behavioural approach to treatment in which the patient is encouraged to take meals at set times of the day to increase the time interval between eating and purging (Kroger & Fezler, 1976). In the hypnosis sessions, guided imagery was used to establish a controlled eating routine; it also gave the patient the opportunity to rehearse eating normal meals (Coman, 1992). Patients were encouraged to enjoy tasting the food and, subsequently, to learn to relax

after the meal by taking a walk or reading a book. This was an important component of this procedure in that it had the effect of interrupting the binge/purge cycle. Other adjuvant techniques include storing a variety of low calorie foods and keeping food out of sight (Singh & Watson, 1986). Coman (1992) recommended that these newly acquired eating patterns should be reinforced during the hypnosis in order to give the patients control over their eating behaviour.

Barabasz (1990) reported three individual case studies in which she emphasised the patients' awareness preceding a binge/purging episode, establishing a new pattern of behaviour in which patients learnt to exercise control over their eating behaviour. Strong post-hypnotic suggestions were given to each patient and the therapist emphasised that the only person to have control over their eating behaviour was them. In this study, two of the three patients benefited considerably from this form of treatment intervention, while the third patient relapsed after a period of six months.

A variant of the behavioural approach towards controlling bouts of binge eating was described by Holgate (1984). In the hypnosis, the patients were asked to imagine walking along a beach or a country scene: These were used for purposes of relaxation as well as a way of controlling binge eating behaviour. The patients were asked to visualise a scene in which they were tempted to binge, and they were encouraged to walk away from this situation. The therapist then encouraged patients to feel proud and a sense of satisfaction that they were able to exercise control over their eating behaviour. In addition, a number of other treatment approaches were incorporated into the program including the use of a dietician, who was present during the course of the second and subsequent sessions, as well as cognitive restructuring. The therapist encouraged the maintenance of healthy eating patterns with the assistance of a record of their eating behaviour. Holgate reported the successful treatment of a 25-year-old schoolteacher with bulimia nervosa using this treatment approach.

### **Ego-State Therapy**

Torem (1986) described two bulimic patients' eating disorder as a manifestation of an underlying dissociative state. In both cases, there was a history of severe childhood abuse; and a dissociative mechanism was put in place to protect them from these traumas. He used a similar strategy for the treatment of both of these patients: With the assistance of hypnoanalysis, he was able to crystallise

the source of the dissociation and to use this effectively in treatment. In the first case, it was established that the ego state responsible for the binge/purge cycle was split off at the age of seven, at a time when her parents separated. It became clear that she had been physically and emotionally abused by both parents: She referred to her ego state as “the angry one.” Later, after a series of abreactions, she was able to work through this material so that her guilt feelings were alleviated; there was a significant reduction in her self-induced vomiting and she had been able to rename her ego state from “the angry one” to “the assertive one”

A similar approach was used in the second case. In the hypnoanalysis, it was revealed that the patient, a 27-year-old married woman with bulimia, had compartmentalised the abuse she had received as a child. Here, the treatment involved a series of abreactions, and also cognitive restructuring. At the time of writing the paper, Torem reported that the patient had been free of bingeing and purging for one month. In this treatment approach, the therapist aims to concentrate on that part of the ego which is responsible for the abnormal eating behaviour. Patients suffering from bulimia frequently experience feelings of helplessness and worthlessness in association with hidden anger and unresolved conflicts; ego state therapy is an effective way of dealing with these underlying, self-punishing mechanisms and feelings of guilt (Torem, 1987).

Torem (1987) reported a case of bulimia nervosa in a 17-year-old schoolgirl. The first stage of the therapy involved keeping a daily diary: She was required to record her eating patterns and her reflections before and after the binge/purge cycle. After 10 days, she noticed a significant change in her handwriting as she became more confused and anxiety-ridden. In one particular diary entry, she described that part of herself which was responsible for her bulimic behaviour and her self-defeating attitude. The author then used a hypnoanalytic technique in which he addressed the part of the ego responsible for the eating disorder: This ego state was then asked to communicate directly with the therapist. Torem stressed the value of this treatment approach for the treatment of patients suffering from bulimia.

### **Group Therapy Approach**

In this model, reported by Degun-Mather (1995), there are groups consisting of five clients and two co-therapists. The programs run for 12 weeks, each session lasting 90 minutes and carried out at weekly intervals. Degun-Mather produced a highly structured program for these clients. In the first session,

clients were given the Eating Disorder Inventory (Garner & Olmsted, 1984) and the Eating Inventory (Stunkard, 1983). Each client was given a few minutes to describe their symptoms, and, following this, they were told that the group would be mutually supportive and that they were no longer alone. In session 2, clients established their own personal goals using the Goal Attainment Evaluation Plan (Vanderlinden, Norre, & Vandereycken, 1989), while in session 3 they were given a chart to monitor their eating behaviour throughout the entire program. Clients were encouraged to eat three meals a day. During sessions 4 to 12, the therapists continued monitoring the clients' behaviour with an emphasis on the triggers which had led to the binge/purge cycle. The co-therapists also gave them assistance with coping strategies. Clients took it in turns to discuss their individual problems, coping strategies, and more complex issues relating to family dynamics. Group hypnosis was used to deal with difficult situations and to control urges to binge. Of note, age progression was employed to enable clients to experience the feeling of having achieved their goals. The treatment results would indicate that 60% of clients treated in this way make a good recovery. In the last session, the clients were told that, should they need further help, they could have individual psychotherapy.

## COMMENT

This paper has demonstrated quite clearly that hypnotherapy is a valuable tool in the treatment of eating disorders, a treatment approach which does not require any form of medication.

It has been established that many patients suffering from an eating disorder have a background of abuse in childhood, sexual or otherwise. Patients suffering from eating disorders are frequently enmeshed in a complex family dynamic. For this reason, many therapists (e.g., Nash & Baker, 1993) have used an age regression approach in order to address the negative emotions and body image related to the abuse; this trauma may also be compartmentalised and can then be utilised in ego-state therapy (e.g., Torem, 1986).

Having reviewed the world literature on eating disorders, it was apparent that some authors employed a behavioural approach, such as the regulation of eating times and speed of eating (Vanderlinden & Vandereycken, 1990), and changing patterns of behaviour following mealtime (Coman, 1992). In contrast, Epslen (2003) used a psychodynamically based form of treatment in which she focused on the underlying problems responsible for the symptoms without paying attention to the symptom itself; whereas other authors have

combined hypnoanalysis with a behavioural approach (Crasilneck & Hall, 1975) or with ego-state therapy (Torem, 1987).

The combination of a behavioural and a psychodynamic approach now comes under the heading of integrative psychotherapy, which is a fast evolving treatment approach (Kraft & Kraft, 2007). Hypnotherapy offers a rapid and cost-effective form of treatment for eating disorders, and it is recommended that these procedures are used on their own or in combination.

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## NINETEENTH-CENTURY HYSTERIA AND HYPNOSIS: A HISTORICAL NOTE ON BLANCHE WITTMANN

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*There were many patients and hypnotic subjects in the nineteenth century who influenced the development of psychology. An example was Blanche Wittmann, one of the star hysterical patients and hypnotic subjects at the Salpêtrière. In addition to producing phenomena for Jean-Martin Charcot, Wittmann performed for others such as Gilbert Ballet, Alfred Binet, Charles Féré, Jules Janet, and Paul Richer. Wittmann produced phenomena such as muscle contractions, transfer of symptoms from one side of the body to another, hysterogenic zones, hallucinations, and apparent secondary states or personalities. The performances of such individuals, together with the actual work of clinicians and researchers, contributed to the spread clinical and theoretical views of psychological phenomena. In fact, they worked together complementing each other.*

While we generally study the history of psychology through the contributions of clinicians and researchers – individuals such as Sigmund Freud (1856–1939), Pierre Janet (1859–1947), Edward B. Titchener (1867–1927), and Wilhelm Wundt (1832–1920) – it is also possible to focus on the performances of patients and research subjects as contributors to the field. Henri F. Ellenberger (1970) reminded us of this perspective. Since then there have been several discussions of the topic. A prominent example are writings about Freud's patients (e.g., Decker, 1991; Guttmann, 2001), and about famous cases of dissociation (e.g., Faure, Kersten, Koopman, & Van der Hart, 1997; Kenny, 1986).<sup>1</sup> These individuals did more than allow themselves to be studied.

<sup>1</sup> There is also a literature consisting of accounts of madness from the patient's point of view (e.g., Porter, 1987), feminist critiques of the study of cases (e.g., Bernheimer & Kahane, 1990), and discussions of hypnotic subjects (e.g., Carroy, 1991) and mediums (e.g., Alvarado, 1993).

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They interacted with clinicians and researchers in a joint process that contributed to the cataloguing of clinical symptoms and the developing of theoretical ideas. In this short paper I discuss Blanche Wittmann, whose hysteric and hypnotic performances contributed to the development of French psychology and psychiatry.

## FRENCH EXPLORATIONS OF HYSTERIA AND HYPNOSIS

The French specialised in the study of a variety of clinical conditions which showed that “the normal unity of consciousness is broken” (Binet, 1892, p. viii; this, and other translations, are mine).<sup>2</sup> Many explorations of dissociative phenomena were published during these years, including cases of amnesia, somnambulism, and double and multiple personality (e.g., Azam, 1887; Binet, 1892; Bourru & Burot, 1888; Burot, 1889). A particularly well-known case was that of Félicité X. (Azam, 1887), whose double existence influenced ideas of dissociation during the last quarter of the nineteenth century.

Another concern of late nineteenth-century French psychopathologists was hysteria, defined by a writer as an “ensemble of functional or dynamic problems of the nervous system, very numerous, very diverse,” manifesting in “thousands of ways” (Dutil, 1894, p. 1322). Neurologist Jean-Martin Charcot (1825–1893) embarked into the best known and most influential research program of this condition at the Salpêtrière Hospital at Paris, which was a woman’s hospital and insane asylum (Gauchet & Swain, 1997/2000). Some of his early lectures on the topic include hysterical ischuria, hemiplegia, and contractions, as well as ovarian hyperesthesia and hystero-epilepsy (Charcot, 1872–1873, chaps 9–13). Many followers of Charcot have described the proteic phenomenology of hysteria, while claiming that there were particular patterns and stages (e.g., Bourneville & Regnard, 1879–1880; Gilles de la Tourette, 1887; Pitres, 1891; Richer, 1881). Paul Richer (1849–1933) discussed the stages of grand hysteria in his influential study *Études Cliniques sur l’Hystéro-épilepsie ou Grande Hystérie* (1881). In addition to a prodromic period consisting of mood changes and a variety of problems of digestion, circulation, and sensibility, there were four stages. These were an epileptoid period (trembling, convulsions), and periods of contortions (large movements of the body, may

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<sup>2</sup> For overviews see Crabtree (1993), Ellenberger (1970), Gauld (1992), López Piñero and Morales Meseguer (1970), and Nicolas (2004). An overview of French psychology appears in Nicolas (2002).

include hallucinations), passionate attitudes (vivid hallucination and “plastic” poses expressing religious fervour and emotions), and delirium (hallucinatory and movement problems).

Hypnosis was also a French concern (Barrucand, 1967), and one studied as well by Charcot, who saw the phenomenon as a hysterical one (Bourneville, 1890, part 2, chaps 1–17; Charcot, 1882). In a famous communication to the Academy of Sciences, entitled “*Sur les Divers États Nerveux Déterminés par l’Hypnotisation chez les Hystériques*,” Charcot (1882) described hypnosis as a phenomenon frequently observed in women with hystero-epilepsy that presented three “nervous states.” These were the cataleptic, lethargic, and somnambulistic states. In addition to studies of hypnosis as a hysterical manifestation, something questioned by others (e.g., Bernheim, 1884, 1891), many used hypnotic techniques to learn about the making of the mind and its plasticity. As stated by physiologist Henri Beaunis (1830–1921), “hypnotism constitutes ... a true method of experimental psychology; it is for the philosopher what vivisection is for the physiologist” (Beaunis, 1887, p. 115). Some examples of this were the use of magnets on the hypnotised to transfer motor and mental phenomena such as paralyse and hallucinations from one side of the body to another (Binet & Féré, 1885, 1887), the exploration (Janet, 1889) and induction (Richet, 1883) of secondary personalities, and the effects of hypnosis on somatic processes such as heart rate, cutaneous congestion, and auditive acuity (Beaunis, 1887).

Most of this research was done with hysterics and particularly suggestible individuals. These were the individuals that physiologist Charles Richet (1850–1935) referred to as the “demoniacs of today,” by which he meant that the old descriptions of the possessed were “absolutely identical to today’s hystero-epileptic access” (Richet, 1880, p. 356). One of the “demoniacs” during Richet’s times was Blanche Wittmann.

## **WITTMANN’S EARLY HISTORY**

Writing in 1889, English classical scholar and psychical researcher Frederic W. H. Myers (1843–1901) stated:

Blanche Witt- is one of the best known personalities – or groups of personalities – in Paris. A hystero-epileptic of the most pronounced type, she has never been able for long together to meet the stresses of ordinary life. She has long been an inmate of the Salpêtrière; and some of my readers may have seen her exhibited there, at Prof. Charcot’s lectures, or by the kindness of Dr Féré or other physicians, as the

type – I may almost say the prototype – of the celebrated “three stages” of lethargy, catalepsy, and somnambulism, of which she realised every characteristic detail with marvellous precision. (Myers, 1889, p. 216)

Blanche Wittmann was immortalised in the famous 1887 painting by André Broulliet (1857–1914) representing a lecture on hypnosis by Charcot at the Salpêtrière.<sup>3</sup> In addition to Charcot and Wittmann, the painting includes 29 additional persons, most of them physicians. Some of them are Joseph Babinski (1857–1932), Charles Féré (1852–1907), Georges Gilles de la Tourette (1857–1904), and Théodule Ribot (1838–1916). At the time Charcot was at the heyday of his clinical and research work on hysteria and hypnotism (Gauchet & Swain, 1997/2000; Owen, 1971).

Wittmann was one of the star subjects of Charcot and his followers who displayed phenomena supporting the ideas of hysteria and hypnosis developed by the so-called Salpêtrière School.<sup>4</sup> Signoret (1983) has reminded us that her actual name is uncertain, and that she was referred to in the literature as Marie, W... W, Wit, Witt and as Blanche Witt. Archival research shows the existence of a record of a Marie Wittman, born on 15 April 1859 in Paris, who entered the hospital as an epileptic on 6 May 1877 (Signoret, 1983, p. 692). This is similar to a publication about BW, and contemporary with her, that stated that a 19-year-old woman “W ... Marie, seamstress ... entered the service of M. Charcot on May 5, 1877” (Bourneville & Regnard, 1879–1880, p. 5).

She was said to have a barely average intelligence, and a good memory. However, the patient thought her memory had diminished after the administration of ether. She was described as a woman with a large and strong body, weighing 70 kilograms (154 pounds). Another description read: “She is blond and of a lymphatic complexion. The skin is white and also presents several ephelides ... The bosom is very large” (Bourneville & Regnard, 1879–1880, p. 7).

In a volume of the famous *Iconographie Photographique de la Salpêtrière*, serial publications that articulated Charcot’s interest in objectifying hysteria as a medical phenomenon with specific symptoms and stages (Didi-Huberman, 1982/2003), Bourneville and Regnard (1879–1880, pp. 4–39) presented the early history of BW according to herself. Her father, a Swiss carpenter, had

<sup>3</sup> The painting can be seen in the web (“Psychosomatic Medicine: ‘The Puzzling Leap,’” n.d.) and has been discussed by Pérez-Rincón (1998, chaps 4–5) and by Signoret (1983).

<sup>4</sup> Other patients at the Salpêtrière mentioned in the first chapter of Richer’s (1881) book include Alphonsine Bar, Ang... , Gen..., Gl ..., Ler..., and Marc... . Another famous patient, Augustine, has been discussed by Didi-Huberman (1982/2003).

a violent character to the point that once he put Wittmann inside a coffin. Eventually he was institutionalised as insane. Her mother, a seamstress, who had died, suffered from nervous attacks. Wittmann had nine siblings, five of whom were deceased. One of them had convulsions and another suffered from possible epilepsy. She was the oldest of the surviving children, one of whom coughed blood and another who suffered from “weakness.”

When Wittmann was 22 months of age, she suffered from convulsions. In addition, she became unable to walk, left-handed, and speechless. Her conditions improved by the time she was seven years old. At 12 Wittmann had “nervous accidents” in which she lost consciousness and urinated on herself, while at 13 her condition included body tremors. In her own words: “Everything I had in my hands fell down” (Bourneville & Regnard, 1879–1880, p. 6). In later years she had sexual relations with her employer, having some “attacks” during intercourse, and once after the act. After she left this man she had two other lovers.

Alphonse Baudouin (1876–1956), who was an intern at the Salpêtrière in 1905, met Wittmann when she was no longer having her hysterical crises and was working at the hospital’s radiology laboratory. He described her as “authoritarian and capricious” (Baudouin, 1925, p. 519). Baudouin asked her about the possibility that her hysterical crises were purposely simulated, and she is reported to have said: “Do you believe that it was easy to deceive M. Charcot? Yes, there were fakes that tried it; he would throw a simple glance and say: ‘Be still’ ” (p. 520). Unfortunately, Baudouin observed that she had suffered several amputations due to the “abominable cancer of radiologists” (p. 519).

Wittmann had a long career of performances of hysterical and hypnotic phenomena, some of which is summarised below.

## **OBSERVATIONS OF AND PHENOMENA PRODUCED BY WITTMANN**

Wittmann worked with different clinicians and researchers. Her performances, sometimes quite dramatic, presented a wide variety of phenomena related to different sensory, motor, and cognitive functions.

### **Tactile and Visual Functions**

In an 1878 paper with other authors, Charcot stated: “Wittmann, 18 years old ... has painful points in the ovarian regions; she is anaesthetic in all parts of the

body” (Charcot, Luys, & Dumontpallier, 1878, p. x). Others observed changes in sensations: “1877. May 7.— *Hemianesthesia* of the right side; diminishment of the sensibility of the left arm. — *Right ovarian hyperesthesia*, magnified at the approach of the attacks” (Bourneville & Regnard, 1879–1880, p. 7).

Wittmann lost sensibility in the skin and those parts with membranes such as around the eyes and the vaginal area. She also had other problems: “The eyes closed, W... is incapable to indicate with exactitude the position of her members, to name the objects she holds on her hands, and to walk with confidence” (Bourneville & Regnard, 1879–1880, p. 25).

Sometimes the patient experienced the hysterical ball. In some circumstances the “ball oscillates from the pit of the stomach to the inferior part of the neck,” and cardiac palpitations appeared (Bourneville & Regnard, 1879–1880, p. 38).

In both the waking and the hypnotic state Wittmann showed anaesthesia, loss of muscular sense (such as awareness of the position of body members), colour blindness and poor vision in the left eye. Overall, the vision in the right eye was normal, but the report for the other eye read: “Left eye: complete achromatopsia for all colours, save for saturated red, normal luminous sense” (J. Janet, 1888, p. 617).

## Body Movements

Wittmann showed many of the classic stages and motor manifestations of “grand hysteria,” such as the following:

*Epileptoid period.* — Rigidity augments; breathing becomes faster, it is suspended, congestion of the face is accentuated more ... Sometimes there are tetanic tremblings.

*Clonic period.* — After a short rest, one observes the swinging movements of the head that, before long, is raised ...

*Delirium period.* — The breathing is very frequent; the pupils are dilated; small groans; movements of the lips; the patient talks in a low voice ... She complains of feeling bad in the head, that the vision is confused, and of being fatigued. (Bourneville & Regnard, 1879–1880, p. 8)

In addition, she showed an arched position in which “the body rests on the top of the head ... and on the point of the feet,” a position “W... keeps ... nearly a minute; afterwards she falls heavily on her bed” (Bourneville & Regnard, 1879–1880, p. 30).



## Physical Stimuli Affecting Hysterical and Hypnotic Phenomena

Charcot and others conducted research that supported the assertions that hysterics could be affected by metals applied externally as well as ingested internally (Charcot, Luys, & Dumontpallier, 1877, 1878). The later referred to solutions with different metals ingested for therapeutic purposes. As they wrote in a test with Wittmann: “With the internal administration of gold the patient recovered the peripheral sensibility and a good part of her muscular force. She did not have hysterical attacks during 9 months” (Charcot et al., 1878, p. xi).

One of the most interesting manifestations was the effect of touching or pressing the so-called hysterogenic zones of the body of the hysteric capable of causing or arresting manifestations. With Wittmann, and with other hysterics, the compression of the ovarian region was an effective zone. On one occasion, after compression of the right ovarian region it was noticed that “before long the eyelids move apart, the pupils are greatly dilated” (Bourneville & Regnard, 1879–1880, p. 10).

The patient was “wakened” from her hysterical attacks though the use of ovarian compressions (Bourneville & Regnard, 1879–1880, p. 17), and from hypnosis by blowing on her eyes (Ballet, 1891, p. 523). In 1890, as reported by Georges Guinon (1859–1932) and Sophie Woltke, Wittmann was asked to stare at a bright object until she fell into the hypnotic lethargic state (Guinon & Woltke, 1891, p. 78).

There were also examples in which attacks were arrested by the inhalation of ethylic iodine (Bourneville & Regnard, 1879–1880, p. 11). On another occasion, in January 1879 it was observed that: “Under the influence of static electricity ... the sensibility returns in all the right half of the body” (Bourneville & Regnard, 1879–1880, p. 13).

Gilbert Ballet (1853–1916) observed the patient in the hypnotic lethargic state and noticed that “it is enough to exert a slight rubbing of the vertex to throw Wit... into ... the somnambulistic state” (Ballet, 1891, p. 523).

In other tests reported by Guinon and Woltke (1891), Wittmann experienced different emotions when coloured glass was put in front of her eyes. For example, a red glass seemed to induce joy and pleasure (p. 78). Other observations were reported as follows:

*Blue glass.* – She frowned and her physiognomy showed sadness.

*Yellow glass.* – She showed all the signs of great fear.

*Dark green glass.* – Her physiognomy expressed astonishment followed by admiration ... The patient raised her arms and moved them apart [in admiration]. (p. 78)

Other stimuli included smells. Substances put under Wittmann's nose produced disgust (sulphur of carbon), contentment (cologne, and camphor of ether), and disgust and repulsion (chloroform) (pp. 78–79). Light drumming produced violent contractions (p. 79).

### **Neuromuscular Hyperexcitability**

Charcot (1882) described neuromuscular excitability as the tendency of “muscles to have a contraction under the influence of a mechanical excitation endured on the tendon, on the muscle itself, or on the nerve of which it is a tributary” (p. 404). The stimuli in question could be actions such as pressure or massage. While this phenomenon appeared during the lethargic state, it did not do so either during the cataleptic or the somnambulistic states. Richer (1881, p. 366) noted that it was easy to induce in “Witt ... contractions of facial muscles.” In a study published by Charcot and Richer (1881/1890) they observed that during the lethargic state of hypnosis, Wittmann presented “modifications of the reflex muscular contraction” (p. 320). They obtained instrumental graphic recordings of this muscular activity. It was normal during the waking state, but contracted during hypnosis.

### **Dermography**

“During the attacks,” Bourneville and Regnard (1879–1880, p. 19) wrote, “we traced on the chest, with the point of a pin, the name of the patient and the name Salpêtrière on the stomach. An erythemic band of several centimetres of elevation was produced and on this band the letters were drawn in relief, having about two centimetres in length; the erythema disappeared slowly, the letters lasted [longer].” While uncommon, similar phenomena have been reported with other persons (Mesnet, 1890).

### **Hallucinations**

Richer (1881) reported several interesting hallucinations. In one of them “W... saw a red lion on her left” (p. 10). Sometimes the hallucinations represented things from the patient's life: “She talked about a certain Alphonse, called him an ‘ingrate,’ and directed very bitter reproaches at him” (p. 116). According to Bourneville and Regnard (1879–1880, p. 7) one of Wittmann's former lovers was called Alphonse.

At other times hallucinations were suggested. Ballet (1891, p. 523) did this with a bird, which the patient saw and caressed.

While Wittmann was in the arch position she was brought out of her stupor through ovarian compressions and she seemed to have had “nightmares.” In one of these instances she recollected that she fell into a precipice, while in another she was persecuted by a villain (Richer, 1881, p. 92). Similarly, after the above-mentioned effect of drumming, Wittmann fell into a “bizarre state of semi-consciousness” (Guinon & Woltke, 1891, p. 79). She said that she saw extraordinary things during it. This included seeing herself in the arms of her lover, “full of contentment and pleasure” (p. 79). There were also images of the sea, a great fire, a ballroom, a place with dead bodies, and a garden with flowers. Finally, the scene changed and she perceived a smell like wet terrain and felt dead. She saw all of this but did not seem to take part in the visions.

## **Transfer**

Transfer phenomena referred to the act of “transferring” sensory, motor, or cognitive phenomena from one side of the body of a hypnotised person to the other through the use of magnets, which was one of the early specialties of Alfred Binet (1857–1911) and the previously mentioned Charles Féré (Binet & Féré, 1885, 1887). In Wittmann’s case they argued that it was “probable that the state of her nervous system favours the action of the magnet at a high degree” (Binet & Féré, 1885, p. 15).

An example of transfer of motor phenomena was the occasion when Binet and Féré had Wittmann under hypnosis and suggested to her to scratch the arm rest of an armchair with her left index finger. She started to do this and they placed a magnet some distance from her right hand. After about 30 seconds, not only the left index finger was doing the task, but the right one started to do so as well. The “movement was intensified in the right, while it declined at the left” (Binet & Féré, 1885, p. 8). Other observations focused on the transfer of acts, a “phenomenon not only formed from movement, but from thoughts, reasoning and will” (p. 9).

Myers (1886) wrote about transfer experiments he observed in Paris: “Witt-- is in the somnambulant state. The hypnotiser suggests to her to make figures, 1, 2, 3, &c., with her right hand. She is awakened; a magnet being hidden near her left hand. She writes the numerals up to twelve with her right hand, then hesitates, takes the pen in her other hand, and begins to write in mirror-writing with her left hand. I have witnessed this experiment, (Aug. 25th, 1885)” (p. 444).

## Secondary States

Following on the work of Pierre Janet (1859–1947) with hypnotic secondary states published in the *Revue philosophique* (Janet, 1886, 1887, 1888), and later in a book (Janet, 1889), Jules Janet (1861–1945), Pierre's brother, conducted explorations with Wittmann. Janet attempted to take his subject beyond the hypnotic lethargic stage. In that state, different from the somnambulistic one, she was cheerful, which was in contrast with her usual serious behaviour out of that state. While the "normal" state had problems such as anaesthesia and colour blindness, the secondary state was completely normal.

Janet described Wittmann's new hypnotic state as Blanche 2, and her usual state as Blanche 1. In his view: "Blanche 1 is incomplete. Blanche 2 is complete" (J. Janet, 1888, p. 619). This meant that the secondary state had access to the experiences and recollections of the other state, but not the other way around. Janet conducted tests in which he determined that when stimuli were presented to Blanche 1, she did not perceive them but Blanche 2 did. This included sensations of pricking and seeing colours. Communication with Blanche 2 while the stimuli were presented to Blanche 1 took place through ideomotor action, namely a prearranged response of raising a finger when something was felt or perceived.

In a review of Janet's paper, Myers (1889) wrote that: "M. Janet tells me that last year he kept Blanche Witt-- for months together in her second state, with much comfort to her; and that now, though he has ceased to attend her, he understands that her condition in the first state is much better than of old" (p. 219).

## CONCLUDING REMARKS

Like so many other patients and research subjects, Wittmann formed a partnership with clinicians and researchers that articulated the phenomenology of hysteria and hypnosis. While her case was not cited as often as that of Félicita X., the classic French example of "doubling" of personality (Azam, 1887), it was studied by more researchers than Félicita was. This allowed her to become a human laboratory in the French tradition of the study of single individuals as a method of exploration and knowledge-gathering. Brouillet's painting presents a visual representation of this process, one that had many examples in nineteenth-century French hypnosis work (for an overview see Carroy, 1991).

There is no question that Wittmann's performances, together with the performances of others, provided phenomena that sustained the existence

and illustrated the phenomenology of hysteria and hypnosis. Furthermore, her phenomena were used to support the ideas of Binet, Charcot, Féré, Janet, and Richer, ideas that influenced their generation when it came to pathology, hypnotic stages, and the workings of dissociation. This included the “usual” phenomena such as lack of sensibility, contractions, hallucinations, and hysterogenic zones, as well as less common ones such as dermatography and controversial issues including the therapeutic use of metals and the effectiveness of magnets to induce transfer phenomena.

Such developments, as has been argued before (Carroy, 1991; Didi-Huberman, 1982/2003), should not be interpreted simply as the results of objective observations. To start, we must be open to the possibility that some hysterics and hypnotic subjects were openly lying, as suggested in the past (e.g., Munthe, 1929, p. 302). It is conceivable that many of Wittmann’s phenomena could have been intentionally produced by her to obtain attention, or to comply with the desire of her investigators to observe hysteria and hypnosis. Fraudulent performances could have been instrumental to maintain her identity as a star patient/research subject, or to fulfil other needs.

But her performance could also have been genuine while still affected by the demand characteristics of the clinical-research context, including specific theoretical ideas and the suggestive influence of previous performances by other patients. This is what some nineteenth-century critics of the Salpêtrière referred to when they wrote about the influence of education and imitation in the production of hypnotic phenomena (Delboeuf, 1886).

Following Bernheim (1884, p. 5), who stated that his researches did not confirm the existence of Charcot’s hypnotic states and phases, the writer of a popular article about hypnosis described the Salpêtrière patients as “‘drilled’ hysterical subjects” (O’Connor, 1890, p. 579). Bernheim (1891) also proposed that the Salpêtrière hysterics were affected by suggestion, and by the example of other hysterics. The phenomena, he argued, showed a tendency for “imitation, acting through auto-suggestion” (p. 168). In Bernheim’s view the specific stages of hysteria were created by the theoretical environment of the Salpêtrière, what he referred to as “an hysteria of culture” (p. 169). In one way or another Wittmann responded to the conceptual “culture” of her surroundings and researchers when she produced her phenomena.

Another important variable to consider was the presence of a special individual such as Wittmann. Assuming some of the phenomena were not fraudulently produced, we need to remember that not everyone can have hallucinations, sensory, tactile and muscular changes, produce writing on

their bodies, or respond to the procedures to induce transfer. This suggests the presence of a high-level propensity for the production of imaginative-dissociative and psychophysiological phenomena such as that hypothesised to exist in high hypnotisable and fantasy-prone individuals (Wilson & Barber, 1983).

Finally, the above-mentioned variables probably interacted with Wittmann's personal makeup. Her motivations and needs, both as a person and as a Salpêtrière star performer, may have been involved in the production of either real or fraudulent phenomena.

In addition to these psychological considerations, there are other social aspects that probably affected Wittmann's interactions with her researchers. Charcot's physicians, Evans (1991) has argued, came from a higher social class than the patients did and this created authoritative attitudes in their treatment. This, in turn, "fed into the positivist mission of nineteenth-century French doctors and created an emphasis on scientific discovery that strangely elided the human existence of the patients" (p. 36).

In any case, Wittmann continues to serve as a reminder of the importance, and ambiguity, surrounding patients and research subjects in the development of psychology and psychiatry. Developments in nosography and theory would not have been possible without individuals like her. More than objects studied by past scholars and clinicians, persons such as Blanche Wittmann were active agents in the construction of the concepts of hysteria and hypnosis.

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## THE APPLICATION OF HYPNOSIS IN THE LONG-TERM TREATMENT OF A WOMAN WHO PRESENTED WITH PREMENSTRUAL DYSPHORIC DISORDER

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*This case study describes the inclusion of hypnosis in the long-term treatment of a woman who presented with symptoms consistent with a diagnosis of premenstrual dysphoric disorder (PDD). During the time it took to obtain a referral to a specialist endocrinologist / gynaecologist, treatment focused on the establishment of effective coping strategies. Through the addition of hypnosis she was more able to cope with her mood changes, develop a more optimistic outlook for the future, and be reassured in her role of mother and decide to have another child.*

### PRESENTING PROBLEM

Emma was self-referred for problems relating to work stress, premenstrual tension which was having a negative effect on her marital relationship, a lack of free time for herself, poor self-care behaviours, a tendency to put others' needs before her own, perfectionism, and family stress. She reported that she was dissatisfied in her current career and expressed much interest in becoming a naturopath. Emma described herself as a worrier her whole life, whereby her worry increased her expectation of negative outcomes and reduced her ability to solve problems. This worry seemed to be worse when premenstrual tension was particularly severe.

### HISTORY

Emma and I first met in August 2004. Emma was a well-groomed 27-year-old-woman who had been married for four years to a man she described as loving and caring but who also had definite ideas about how she should do things. As

the middle child, with two sisters three years apart, she described enjoying a close relationship with her sisters growing up, which continued into adulthood. She described her parents as loving, caring, and encouraging. Her mother was her primary support person other than her husband but lived two hours away by car, so much of their contact was by telephone. Her in-laws lived nearby and Emma had experienced a strained relationship with them since meeting her husband eight years ago. She had never felt fully accepted by them and was not permitted to call them by their first names until after her marriage to their son. She continued to experience them as critical, judgmental, and controlling of both herself and her husband.

Emma reported long-term health problems having been diagnosed with irritable bowel syndrome at the age of seven and had been on a gluten and dairy-free diet ever since. Since the onset of menstruation she experienced premenstrual tension (PMT) two days per month. She had been under the care of her GP for the previous five years for the IBS and PMT and prescribed Zolof 100 mg daily. Emma attended many medical appointments during her childhood and adolescence, which she hated. This led to her reluctance to seek medical advice or trust doctors in her adulthood. She preferred to use alternative therapies such as naturopathy, herbal remedies and flower essences, and did not like taking Zolof. During the previous two years she had a total of six counselling sessions with two different practitioners which she described as unhelpful.

Emma reported that symptoms of PMT were ruling and ruining her life. During part of each month she became depressed, confused and angry, frustrated, felt out of control, indecisive, had low self-esteem, lacked self-confidence, focused on past problems, and feared the future. At times she lashed out at her husband in anger and frustration when he criticised her for her lack of control and crazy behaviour.

She spent much time worrying about the next mood change during her menstrual cycle and wondered how she would cope. Emma and her husband had discussed when to start their family. They were both motivated to have a child in the near future but this generated much fear for Emma. She did not know how she would cope with the responsibility of raising a child and continued menstrual problems each month.

## **DIAGNOSIS**

Emma presented with symptoms consistent with a diagnosis of premenstrual dysphoric disorder (PDD):

in most menstrual cycles during the past year symptoms present during most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase and absent in the week post menses: markedly depressed mood, feelings of hopelessness or self-deprecating thoughts, marked anxiety, tension, feelings of being “keyed up” or “on edge,” marked affective lability (feeling suddenly sad, tearful or increased sensitivity to rejection, persistent and marked anger or irritability or increased interpersonal conflicts, decreased interest in usual activities, subjective sense or difficulty concentrating, lethargy, easily fatigued, or marked lack of energy, marked changes in appetite, insomnia, subjective sense of being overwhelmed or out of control. (*DSM-IV-TR*: American Psychiatric Association, 2000).

Results on the Depression Anxiety and Stress Scale (DASS) demonstrated extremely severe levels for depression, anxiety, and stress.

## **TREATMENT**

During a period of seven months Emma and I met weekly then fortnightly following initial assessment in August 2004. Referral to a GP who specialised in women’s health issues, and who used treatment methods including acupuncture and herbal medicine, were begun to address hormonal symptoms. This fitted with Emma’s interest in naturopathy and her premenstrual symptoms reduced to a more manageable level during this time. Emma met regularly with her GP and had regular acupuncture treatments which she reported as very helpful.

Emma identified the following treatment goals: become motivated, feel relaxed, improved relationship with her husband, enjoy work, see value and purpose in her life, see herself as a worthwhile person, have direction, be happy with her decisions, have a clearer picture of the future, be confident, and be successful. She further wanted to prepare for motherhood and believe in herself more.

Initial treatment focused on helping Emma to identify all the stressors that interfered with her wellbeing, in particular at difficult times of the month according to her menstrual cycle. She kept a record of her moods and menstrual symptoms which followed a fortnightly cycle (two weeks good and two weeks bad). She evaluated her working situation which increased her levels of stress and decided to become a contractor, which would give her more control and choice of when and how much work she could manage. She began studies in naturopathy, which she had been interested in for many years.

Using an integrative approach I utilised treatment protocols from solution-

focused therapy, cognitive-behavioural therapy (CBT), and interpersonal psychotherapy (IPT). Psycho education in problem-solving, stress management, and time management provided Emma with tools for gaining more control in her life. She developed more confidence in challenging many “should messages,” she increased her self-care behaviour, made time for herself, and challenged her perfectionistic thinking. Communication skills training assisted her to become more assertive and to express her needs and wants both at work and with her husband. Establishment of a daily routine, which included regular exercise, gave Emma a stronger belief in herself and her capacity to make positive changes in all areas of her life. Repeated DASS scores fluctuated with PDD symptom profile and as her PDD symptoms abated the DASS scores returned to normal.

Emma reported that the new working schedule was going well, her relationship with her husband had improved and she felt more consistently relaxed, with increased productivity both at work and home. She experienced increased self-respect and had more confidence in making decisions. Medication was reduced to Zoloft 25 mg daily. She was also more able to speak up with confidence when her in-laws made critical comments and this helped her to feel respected by other family members who gave her positive feedback.

In March 2005 we met for two consultations. Emma informed me that she was pregnant, very happy, and managing well. Zoloft had been ceased due to her pregnancy. She continued her studies and reported some lingering concerns about her ability to be a good mother. We also discussed her fears of developing post-natal depression. She was reassured by her confidence in her obstetrician and GP, who would monitor her closely during her pregnancy.

Treatment at this time focused on Emma preparing for her new role as a mother, having self-control, a positive expectation of the future, being relaxed, content and confident, and at ease becoming a mother. During her pregnancy Emma and I did not meet as she experienced no symptoms of PDD and occasional telephone calls to update progress indicated that all was going well.

Emma contacted me in January 2006 following the birth of her daughter the previous November. She reported experiencing a natural birth in which she felt in control, and empowered. Her relationship with her mother-in-law continued to be strained and she interpreted her advice as critical of her parenting. This caused Emma to question her ability to be a good mother. I recommended that she obtain extra support with the baby care nurse and

attend the mothers' group regularly where she would be able to normalise her role as a new mother. We met with her husband and baby to discuss her concerns regarding post-natal depression. Observation of Emma with her baby demonstrated secure attachment, the baby relaxed and doing well. My past experience as a registered nurse working in neonatal intensive care and normal newborn nursery gave me much credibility in Emma's eyes when I affirmed her parenting skills and healthy attachment to her baby.

In March 2006 Emma reported a significant change in her wellbeing. DASS scores showed a marked change with severe levels for depression, anxiety, and stress. Although her baby at four months of age continued to thrive, Emma reported that she was not coping and fears regarding her ability to be a good mother had become entrenched. The need for resumption of antidepressant medication was discussed. At this time she was unwilling to cease breast feeding as this would mean that she was a bad mother, so she refused to resume medication. I was concerned by her level of anxiety, which so far had not appeared to have a negative effect on her baby.

Emma's level of anxiety had increased and we discussed hypnosis as a treatment modality which could assist her to become more relaxed, and confident in her role as a mother. Emma needed a current experience that gave her some measure of control over her distress both physical and emotional (Yapko, 2003). Hypnosis has been demonstrated to be a very effective technique in people with anxiety due to their ability to imagine worst case scenarios often with great sensory detail and to experience a large number of unwanted intrusive thoughts (Bryant, 2008).

I suggested hypnosis at this time as it coincided with my training, and with Emma refusing medication I decided that hypnosis could enhance the efficacy of CBT and solution-focused therapy. As Emma had never been hypnotised before I provided a thorough explanation of hypnosis to allay any concerns she may have. Lynn, Kirsch, and Rhue (1996; cited in Yapko, 2003) stress that therapy becomes a meaningful collaboration when the client is well informed. We agreed that hypnosis would be started at the next session, planned for one week later, with a focus on her first learning progressive muscle relaxation with breathing control. The goal was to encourage a sense of self-mastery and a reduction in anxiety symptoms (Bryant, 2008).

A week later Emma presented to our scheduled consultation with her mother and husband. She was acutely distressed, tearful and anxious, and reported frequent mood swings. At this time she expressed an acute fear of failure at her inability to control her feelings and thoughts. We discussed her

attending Tresillian residential care to obtain much needed support, as well as the recommendation that she resume antidepressant medication. I also informed Emma and her family that I strongly recommended that she wean her baby in hospital under the care of medical practitioners and support of the nursing staff. I called her GP for an emergency appointment, which was booked for the same evening. Emma attended a psychiatric hospital for assessment after meeting with her GP and was admitted with her baby to the post-natal ward. Although she was advised to remain in hospital the next day, begin antidepressant medication, and wean her baby, she declined and discharged herself. She contacted me and told me that she could not follow the doctor's recommendations because she still believed it was the wrong decision. She wanted to see if she could manage better with the help of her mother, who had agreed to stay with her for a while.

### **First Hypnosis Session (One Week Later)**

As expected, Emma presented in a calmer mood having passed through the difficult two weeks of her menstrual cycle. Emma was unsure of her goals for the hypnosis session and we agreed that benefit would be obtained with her experiencing comfort and relaxation at this first hypnosis session. In order to minimise her fears of failure, no expectations were established other than her experiencing hypnosis as a pleasant state and see how she found it. Induction using progressive muscle relaxation was agreed, as discussed previously. As Bryant (2008) explains, the relaxation response is enhanced by embedding suggestions for focusing on specific muscle groups that are being relaxed each in turn.

Suggestions for relaxation, a pleasant experience, and ego-strengthening were agreed upon at the outset. It was important for Emma to feel in control as a lack of control in her life and in particular of her body was a major long-term cause of her distress. I stressed at the outset that she was indeed in control and that whatever happened during hypnosis was appropriate at that time. I reminded her that she could stop hypnosis at any time she felt uncomfortable.

Emma requested a directive approach in which she could just relax and follow suggestions without any pressure on her to perform. An eye fixation induction with instructed eye closure, focusing on breathing, music in the background, and counting 1 to 20 for deepening facilitated a smooth transition into relaxation. Emma described her pleasant place as a cliff top overlooking the sea, and a sunset as her symbol of peace. Belief in the suggested experience



is enhanced by using imagery that is subjectively meaningful to the client (Sheehan & McConkey, 1982).

Following deepening, a heavy arm challenge demonstrated good hypnotic response. As agreed, I provided detailed descriptions of the sea, the rocks on the shore, the waves, Emma sitting on the cliff top in a commanding position able to see all the way to the horizon in the distance. I hoped that Emma would be able to expand her awareness to see the bigger picture with all the issues she was facing in her life and see alternative solutions to her problems. Suggestions for flow, relaxation, and confidence, taking her time to complete tasks during the day and being a good mother were included. Suggestions affirming Emma's ability to exercise control over her body during labour and delivery were given to reinforce a natural strength which she had already demonstrated, a very powerful control experience.

Post-hypnotic suggestions were given to use her symbol of peace and help Emma experience increased ability to use coping strategies when needed and be able to follow a daily routine at home (Bryant, 2008). Counting backwards from 20 to 1 completed the hypnosis session, with Emma reorienting to the consulting room in a smooth fashion.

During the debriefing Emma reported enjoying the experience, feeling very relaxed and fully engaged in the visual and sensory imagery. She reported hearing the waves crashing on the rocks, and feeling the warmth of the sun on her skin. Powerful sensory experience further demonstrated that Emma was a good hypnotic subject. I also taught Emma self-hypnosis to use her breathing, focus on the imagery of the cliff-top scene, the sunset and positive self-statements to encourage a sense of control. She agreed to practice self-hypnosis each day while her baby was asleep.

The following session Emma was accompanied by her baby and reported feeling better after the hypnosis session. Utilising self-hypnosis, Emma had been focusing attention on her symbol of peace, deep breathing to reduce her anxiety and feel more in control.

### **Second Hypnosis Session (Two Weeks Later)**

Induction followed the original session which included music and eye fixation with instructed eye closure. Deepening with counting 1 to 20 was repeated, with Emma experiencing relaxation more easily and quickly. Her pleasant place with imagery included the rocks, waves, and now lavender growing on the cliff top. Emma had prepared for the hypnosis session by writing a list of goals for how she wanted to think and feel. She wanted to feel better about

taking antidepressant medication and weaning her baby if that still became necessary in the future. Her high level of motivation was a key factor in the outcome. She was able to clearly state her goals for the session and specific suggestions were given to that effect.

Specific suggestions were also made regarding the ability to make decisions about medication with confidence, taking control of health care by considering the options of what is best for her and her child, in particular the value and importance of being relaxed and calm to foster a similar state in her child. Emma had been fearful of disclosing her difficulties with others, so suggestions were made to feel relieved with people knowing what was happening, and be able to be more open and share with the mothers' group which she found very understanding and supportive.

I provided suggestions for positive parenting and reminded Emma that I had observed the secure attachment she had with daughter. Post-hypnotic suggestions consisted of Emma seeing her daughter growing up and thriving. Emma reported afterwards feeling very confident and happy as her baby kissed her during hypnosis and she felt her lips on her cheek. This had a profound positive effect on her and reinforced the belief that she was indeed a good mother as well as a very good hypnotic subject.

At this session Emma and I also discussed her second consultation with the psychiatrist at the hospital. We again discussed the potential benefits of hospital treatment, which she was unwilling to consider at this time. I believed that weaning her baby and resuming antidepressant medication was warranted for a more successful outcome of this stressful period.

### **The Next Three Sessions**

During the next three weeks Emma and I noted the negative hormonal effects resuming with a different pattern in mood from one week to the next. This pattern demonstrated that the PDD symptoms experienced prior to her pregnancy had become more regular. I requested that her husband come along to her next session to discuss her treatment, as I could see that Emma was once again experiencing a worsening of her PDD symptoms. He was also very concerned about her wellbeing. She had been in acute distress the previous few days, not coping with parenting, or home duties. She expressed thoughts of suicide and believed this would be the best thing for everyone including her child. At this final session she exhibited symptoms of an acute depressive episode (*DSM-IV-TR*). I stressed to both Emma and her husband

that hospitalisation was necessary, that the baby be weaned and antidepressant medication started. I contacted her GP, who concurred with my opinion and arrangements were made for Emma to be admitted to hospital.

Her husband admitted Emma to hospital the next day and she stayed there for four weeks. During that time her baby was successfully weaned, and Zoloft 100 mg daily was resumed. During regular telephone contact I reassured Emma that she was doing the best thing for herself and her baby and continued to recommend that she follow the doctor's advice even though she did not want to. I reminded her to use positive self-talk and include imagery from the hypnosis session. Engaging in self-hypnosis while in the hospital enabled her to further benefit from the formal hypnosis and believe in the power of her mind to experience relaxation and a sense of control.

### **Following Discharge From Hospital: Third Hypnosis Session**

Review of her hospital stay assisted Emma to better accept that she had done the right thing by following medical advice. Her daughter was thriving, her husband more supportive and understanding, and she had gained an increased awareness of the importance of self-care. Hypnosis was used following established protocols for induction and deepening to address feelings of guilt for weaning her baby, and failure at having to take medication. At this time it was very important for Emma to be confident that weaning her baby was the best decision to make under the circumstances. As Bryant (2008) states, "hypnosis leads to increased expectancy of success."

### **Continued Treatment Regime**

Emma and I continued to meet weekly and her daughter accompanied her to many of these sessions. Parenting education provided her with many skills and insights. Regular observations of mother and child allowed me many opportunities to affirm Emma in her role as a mother. This proved to be very effective in fostering increased confidence in her. Positive feedback from the mothers' group provided further reassurance.

Emma had also established a more organised and structured routine for her days, was more relaxed, and able to let go of some of her rigid ideas regarding housework. She continued to be treated by her GP for hormonal imbalances and obtained a new psychiatrist, with whom she developed a sound working relationship. With her approval I was able to discuss her treatment and progress with the psychiatrist.

Hypnosis was utilised on those occasions when Emma attended sessions alone. Following similar inductions and deepening protocols, Emma relaxed quickly and easily into a hypnotic trance. She had also selected another safe place which included a country scene in which she was riding her horse. The imagery and theme of riding a horse permitted suggestions for having control of a large animal as well as having more control over her feelings and thoughts. In this way utilising the power of hypnosis, Emma was more able to manage unwanted thoughts when they arose (Bryant, 2008).

Over the next two months and as her daughter approached her first birthday, Emma experienced a worsening of her hormonal symptoms with poor emotional regulation, angry outbursts, and conflict with her husband and family members. The medical treatment which had been effective in the past was no longer providing the symptomatic control required.

Fortunately for Emma, a locum GP referred her to a specialist gynaecologist/endocrinologist at Prince of Wales Hospital. He diagnosed Emma as having one of the most extreme cases of PDD he had seen. He informed her that such severity could only be successfully controlled by pregnancy or total hysterectomy. He advised Emma to consider the latter option once she had the number of children she wanted. He was able to prescribe a regime that could better manage her symptoms which included Lovan, Diazepam, fish oil, Premular, calcium, magnesium, vitamin B6 and multivitamins. Once established on this regime Emma improved rapidly with more stable moods, regular exercise, increased self-care, and a more positive outlook for the future.

## **OUTCOME**

Specific negative themes emerged as requiring attention for Emma. These included her fear of being a bad mother, lacking control of her body and her mind due to symptoms of PDD, feelings of guilt at weaning her baby, and future fears regarding her ability to be a good mother. A most important part of her treatment was obtaining the most effective medical management of her symptoms of PDD which came about through knowledge by the locum GP. Throughout her course of treatment I was the one constant professional and I am confident that the strong therapeutic relationship we enjoyed greatly assisted Emma to emerge from this very stressful period of her life.

In March 2008, four years following initial consultation, Emma informed me that she was six weeks pregnant with her second child. Her daughter now

aged two and a half had grown into a happy, healthy, and well-adjusted child, a credit to the excellent parenting skills and secure attachment provided by Emma. We agreed that we would meet monthly and as needed for ongoing support, reassurance, and management. Emma requested that we continue to have regular hypnosis sessions to further prepare her for the birth of her second child and encourage her confidence in caring for two young children.

## **CONCLUSION**

Emma and I established a strong therapeutic alliance and trusting relationship over the long term and during an extended time of significant distress. Her willingness to allow me to make some major decisions for her was essential in reaching the positive outcome of treatment today.

The introduction of hypnosis as a therapeutic technique was readily accepted by Emma, who proved to be an excellent hypnotic subject. People who present with symptoms of anxiety typically respond well to hypnosis as it targets the somatic symptoms as well as the cognitive. Clients gain a sense of control when they learn to separate the psychological and somatic components of their anxiety (Spiegel & Spiegel, 2004).

The primary issue for Emma was lacking control over her body with the PDD symptoms each month. Suggestions during hypnosis regarding the high level of control Emma demonstrated during her labour and delivery of her daughter were helpful in focusing her attention to a time when control over her natural bodily state was very effective.

The timing of using hypnosis coincided with my training with the Australian Society of Hypnosis and I would otherwise have considered adding hypnosis to the treatment plan earlier to enhance Emma's ability to cope with her mood swings, foster increased confidence in her decision making, and be willing to follow medical advice when needed.

Discussion with Emma regarding the style of hypnotic induction and protocol resulted in using a more directive approach, in which she was not required to make any decisions. As decision making was a particular difficulty, a more directive approach was appropriate at the time. I am reminded in this instance that the client usually knows what is going to work best for them. Emma's handing over control to me at such a vulnerable time when introducing hypnosis to a novice subject could have further influenced her compliance to hospital treatment when I once again took control on her behalf.

Adding hypnosis as part of an overall treatment plan in this case has generated much interest for me in exploring the benefits hypnosis may have over premenstrual symptoms generally, which for many women have a significant negative effect on their daily functioning. The reliance on medication to control symptoms could thus be reduced by teaching clients self-hypnosis at such times.

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## **PHASE-ORIENTATED HYPNOTHERAPY FOR COMPLEX PTSD IN BATTERED WOMEN: AN OVERVIEW AND CASE STUDIES FROM HONG KONG**

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*Violence against women by their intimate partners continues to be prevalent in Hong Kong. Trauma experts have developed phase-oriented hypnotherapy with clear treatment foci and procedures for recovery in response to complex trauma. Although hypnosis has been recognised as a promising intervention for ameliorating the suffering of victims of post-traumatic stress disorder (PTSD) or acute stress disorder, there has been no empirical investigation of its effectiveness on battered women with complex post-traumatic stress disorder (CPTSD). This report highlights evidence for the effectiveness of phase-oriented hypnotherapy for treating battered women with CPTSD within the Chinese population. The author recommends more rigorous local research in this area prior to widespread adoption in Hong Kong.*

### **BACKGROUND**

Complex trauma refers to a type of trauma that occurs repeatedly and cumulatively, usually over a period of time within an interpersonal context, such as displacement of populations through ethnic cleansing, child abuse, or domestic violence (Courtois, 2004; Kilpatrick, 2005; Taylor, Asmundson, & Carleton, 2006; Van der Kolk & Courtois, 2005; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Interpersonal trauma involves an imbalance of power between two or more parties, and the type of abuse can be of a

physical, sexual and/or psychological nature. Typically, one of the parties is tortured and rendered helpless by the force of the other party (or parties), evoking the responses of catastrophe. Psychological literature states that the negative repercussions of interpersonal trauma are more chronic than those of non-interpersonal trauma such as natural disasters (Detering, 2005; Herman, 1992a; Perkins, 2005; Salerno, 2005). Therefore, violence against women by their husbands or intimate partners is classified as an interpersonal trauma. Since the number of reported cases of battered women is growing within our community, treatment for battered women has become a matter of widespread concern among professionals.

### **CHARACTERISTICS OF BATTERED WOMEN'S SYNDROMES**

Violence against women by their husbands or intimate partners is not only a threat to the women's physical health and safety but also to their psychological well-being. Clinicians find that women exposed to long-term and repeated abuse by intimate partners may develop symptoms of complex PTSD. That is, aside from developing the core symptoms – the persistent and often intrusive re-experiencing of violent events, avoidance of the trauma reminders, physiological and psychological hyperarousal – which are described in *DSM-IV-TR* (American Psychiatric Association, 2000), victims also develop a multitude of ancillary problems. These may include negative self-perception, insecurity, helplessness, confusion, elevated levels of anger towards the abuser(s), self-blame, shame and guilt, lack of assertiveness and tolerance of disrespect, lack of trust in others, and poor physical health (Chaikin & Prout, 2004; Clements & Sawhney, 2000; Eli & Zvi, 2003; Jarvis, Gordon, & Novaco, 2005; Krause, Kaltman, Goodman, & Dutton, 2006; Miki, 2004; Tomasulo & McNamara, 2007). Some victims may also develop associated disorders such as substance abuse disorder or major depressive disorder (Clements & Sawhney, 2000; Cohen & Hien, 2006; Reed & Enright, 2006).

As domestic violence affects every aspect of a battered woman's functioning, the psychological reactions to battering can complicate the treatment process. Researchers and practitioners recognise that simple PTSD treatments, which focus on the core symptoms, often fail to remedy the needs of battered women. Under these circumstances, a multi-phase approach of intervention has been developed to help them rid themselves of their traumatic experiences and restructure their new lives (Chaikin & Prout, 2004; Chronister & McWhirter, 2006; Dawn & Caron, 2006; Grigsby & Nartman, 1997; Kubany et al., 2004).



## **PHASE-ORIENTED HYPNOTHERAPY**

Hypnosis is recognised as a promising intervention for ameliorating the suffering of victims of PTSD or acute stress disorder (Bryant, Guthrie, & Moulds, 2001; Bryant, Moulds, Guthrie, & Nixon, 2005; Bryant et al., 2006; Carter, 2005; Evans, 2003; Gravitz, 1994; Marica, 2002; Perkins, 2005; Salerno, 2005; Walters & Oakley, 2002). Likewise, there exists research demonstrating the efficacy of hypnosis as a primary modality in the treatment of other trauma-related problems, such as anxiety disorders, enhancing self-efficacy, instilling hope, reducing nightmares, etc. (Detering, 2005; Donatone, 2006; Gafner & Benson, 2001; Yu, 2005a, 2006;). Hypnosis is an effective treatment for trauma victims because it identifies and employs techniques which are similar to the trauma symptoms present in PTSD such as dissociation; and many PTSD sufferers show high hypnotisability (Bryant et al., 2001; Evans, 2003; Spiegel, Hunt, & Dondershine, 1988).

Phase-oriented hypnotherapy with clear treatment foci and procedures for recovery is not a new concept for treating trauma and there is much written about its necessity. When we look back to the nineteenth century, Pierre Janet had already developed a phase-oriented model to cure hysteria (Herman, 1992b; Phillips, & Frederick, 1995). He believed that the psychological reaction to trauma was basically a disorder of memory that interfered with effective action. Based on this theory, he created a phase-oriented treatment using hypnosis as the major technique to cure hysteria. He separated the treatment into three phases to help victims manage their traumatic memories and overcome their sense of helplessness. The stages consist of (a) forming a stable therapeutic relationship, (b) exploration of traumatic memories, and (c) personality reintegration or rehabilitation (Herman, 1992b; Van der Kolk, 1989). In subsequent years, Scurfield, Brown, Putnam, and Herman proposed different phase-oriented models for complex trauma, dissociation and multiple personality disorder (Herman, 1992b). Other experts like Maggie Phillips and Claire Frederick (Phillips & Frederick, 1995) initiated the four stages of SARI model for dissociative patients. Although the number of stages and the content of the stage models vary, the concepts and the progression of recovery are similar. For example, they all recognise that recovery should occur in gradual progressive stages, and that the establishment of a sense of internal and external safety is essential before helping the clients deal with their traumatic experiences (Herman, 1992b; Phillips & Frederick, 1995).

## **APPLICATION IN HONG KONG: CASE STUDIES**

Hypnosis is a relatively new treatment strategy in Hong Kong. Although there is a lack of research on hypnosis in Asian countries, the experiences of Hong Kong clinicians using hypnosis within the Chinese population for patients who suffer from simple PTSD, anxiety disorders, low self-esteem, depressive disorder, or pain disorder are positive (Kwan, 2006, 2007; Poon, 2007a, 2007b; Yu, 2005a, 2006). In these cases, the clients have shown no objections to this new treatment approach and are highly susceptible to hypnotic suggestions (Yu, 2005b). The author also finds phase-oriented hypnotherapy highly effective from her own clinical experiences, in which clients' trauma can be transformed into less stressful behaviour. This can also be noted from the case studies of Mrs B, who was an adult survivor of child physical and psychological abuse (Kwan, 2006) and Ms S, who suffered from CPTSD after being abused by her husband and father-in-law over a period of time, in addition to experiencing breast cancer pain (Kwan, 2007). They both have consequently recovered from their traumas within a year.

In addition to the above-mentioned cases, with a view to demonstrating the feasibility of phase-oriented hypnotherapy for battered women with CPTSD, a case is presented below in which hypnosis was successful in ameliorating the psychological distress of CPTSD.

### **CLINICAL CASE**

#### **Relevant Personal Background**

Ms T, 44 years old, a mother of two, suffered from CPTSD after having a long history of being abused by her husbands from two previous marriages in China and Hong Kong. The type of abuse involved was physical, sexual, and psychological in nature.

#### **Description of the Problems**

Through the years, Ms T complained of sleep deprivation, nightmares, anxiety attacks, and distress sporadically. In particular, when her two sons did not listen to her, all her traumatic memories related to her two unhappy marriages and her negative self-perception came to the fore (e.g., "they behave like their father," "I am an incapable mother," and "men are irresponsible"). She would become irritable and her two sons became the focus point of her negativity. Violent or erotic TV programs would also trigger traumatic past experiences

with respect to spousal abuse. In these situations, she would change the channel immediately or go back to her room. Sometimes she had intrusive flashbacks during household chores, but she managed to suppress these feelings by hitting her head or shifting her attention to doing something else. She spent most of her time in church or doing voluntary work because she did not want to be idle at home or stay with her two sons. She would also avoid people and places which could potentially elicit her negative experiences (e.g., her abode in mainland China).

### **Assessment**

Ms T's psychological condition was assessed before, during, and after therapy. The pre-treatment results on the Impact of Event Scale (IES: Horowitz, Wilner, & Alvarez, 1979), Beck Depression Inventory (BDI: Beck & Steer, 1993b), Beck Anxiety Inventory (BAI: Beck & Steer, 1993a), and Beck Hopelessness Scale (BHS: Beck and Steer, 1993c) indicated that the traumatic experiences had a moderate to severe impact on Ms T (IES = 47). Moreover, she had severe depression (BDI = 46), moderate anxiety (BAI = 21) and severe hopelessness (BHS = 17). Yet, no suicidal thoughts were noted.

### **Treatment**

Ms T needed resolution of the following CPTSD-related symptoms:

1. Intrusive reliving of acts of domestic violence and vivid flashbacks of the pitiless look of her two ex-husbands and of the mother of her first husband.
2. Negative feelings about the traumatic experiences.
3. Negative self-perception and identity. She described herself as lewd, a failure, inferior, and troublesome. She believed that she was solely responsible for the abuse because she was lewd and indecent.
4. Multiple ancillary problems. She was massively insecure (she did not trust others, especially men), experienced helplessness, shame, and a lack of assertiveness (she dared not to express herself before others).
5. Concerted steps to avoid some situations as a form of defence.

A phased-oriented treatment framework as suggested by trauma experts was used (Herman, 1992b; Philips & Frederick, 1995; Van der Kolk, 1989).

**First Stage: Building Resources**

Information was gathered from Ms T to help fully understand the root of her problems during hypnotherapy sessions. Since avoidance was her major way of coping with trauma, indirect induction techniques such as the confusion technique were practised with the aim of reducing her defensiveness and resistance to go into trance (Hammond, 1990). Using these techniques, Ms T was responsive to hypnosis.

**Second Stage: Mental Strengthening**

Traumatic events can shape a person's sense of self and challenge cherished world views. So the objective of this stage was to increase Ms T's positive self-image, sense of self-worth, and identity. As such this was actualised by restructuring her self-perception, reducing her resistance to dealing with her trauma; and finally (by the third stage) enhancing her ego-strength. The approach taken in restructuring her negative self-perception was to focus on successful experiences from her life history. Techniques such as split screen or age regression (Hammond, 1990) were used to help her recall successful experiences from her school days in China, her jobs, her voluntary work, and her trustful relationships with relatives and friends.

**Third Stage: Dealing With Traumatic Experiences**

Since the meaning ascribed to the trauma plays an important role in the continuation or chronicity of post-traumatic stress, the purpose of this phase was to restructure Ms T's perceptions of, and negative feelings about, her past traumatic experiences so as to facilitate her emotional processing and further deal with her multitude of ancillary problems. Techniques of age regression, hypermnesia and revivification (Hammond, 1990) were employed to help Ms T work through her traumatic experiences (i.e., restructuring her negative perception of incidents; increasing her positive attitude towards those incidents; understanding the rewards she has in those incidents). By adding new understandings and insights to her memory of them, she was able to re-shape her memory and reach new conclusions. In addition, helping her differentiate between her "past self" and her "present self" was an important technique to further enhance her self-confidence and work through her traumas.

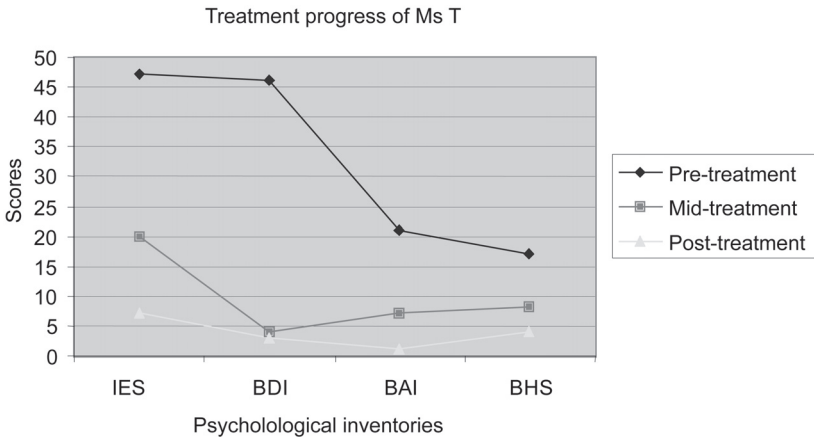
## Fourth Stage: Future Orientation

This phase focused on Ms T's personal growth and future development. Her positive self-perception and identity were further reinforced and therapeutic metaphors were used to enhance her confidence in facing the future.

## Results

A total of 16 sessions of hypnotherapy helped Ms T recover from her traumatic experiences. Her psychological condition was assessed before, during, and after treatment. The findings indicate that Ms T recovered progressively (Figure 1).

**Figure 1:** The progress of Ms T as reflected in the findings of psychological inventories in the pre-treatment, mid-treatment and post-treatment assessments.



The traumatic experiences did not bother her excessively after she received psychological treatment (IES = 7, subclinical stress response; BDI = 3, minimal depression; BAI = 1, minimal anxiety; BHS = 4, minimal hopelessness). Ms T was contacted by phone six months after the last session; no relapse had occurred. She has found a part-time job and is learning Chinese painting in her free time. Her relationship with her sons has also improved.

## DISCUSSION

These three published cases provide evidence of the effectiveness of phase-oriented hypnotherapy in treating complex trauma within the Chinese population, especially for battered women.

Several important principles are illustrated in treating battered women with CPTSD.

One: Due to the characteristics of complex trauma, the treatment should also be comprehensive. A multi-phase model is highly recommended to serve the needs of this population.

Two: Recovery from complex trauma occurs in progressive stages. As Herman (1992b, p.155) said, “in the course of successful recovery, it should be possible to recognise a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatised isolation to restored social connection.”

Three: Ego-strengthening is important before entering into the treatment of trauma stage, in order to avoid the resistance and treatment drop outs, which commonly occur among patients who have suffered traumatic experiences.

Four: A detailed developmental analysis of the formation of the CPTSD is important in order to understand the relationship between the overt difficulties and the underlying psychological mechanisms. By understanding the client’s core negative self-perceptions and her interpretation of the trauma, the client can overcome and restructure the dysfunctional thoughts that resulted from the traumatic event and replace negative thought patterns with more positive ones.

Statistics from the Hong Kong Social Welfare Department show that the number of reported battered spouse cases from January to June 2006 is 2,068, and over 85.9% of the victims are women. While the number of battered women has grown and the psychological consequences of battering and the treatment of women raise increased concern among our professional community, more rigorous local research in studying the efficacy of phase-oriented hypnotherapy within this population is required before its widespread adoption in Hong Kong.

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## AN INTEGRATIVE APPROACH TO THE PSYCHOTHERAPEUTIC TREATMENT OF VAGINISMUS INCORPORATING HYPNOSUGGESTION AND HYPNOANALYSIS

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*The case of Joan demonstrates how the effective use of hypnosis can bind multiple systems of therapy and form the core of the process of integration in the entire psychotherapeutic experience. Furthermore, utilisation of hypnotic phenomena embraces the essence of the whole psychotherapeutic experience and deepens the process of healing, by rapidly establishing a positive psychotherapeutic relationship. The initial phase of therapy assisted the patient with addressing her performance anxiety, breaking the muscular spasm causing vaginismus, as well as achieving a general level of insight relating to self-awareness. Further therapy sessions revealed underlying sexual aversion and anxiety related to family of origin, current marital relationships, interpersonal, social, cultural, and religious beliefs. Such an integrative approach embraces multiple domains including addressing the cognitive, emotional, behavioural, physiological, familial, social, occupational, developmental, and existential areas of functioning.*

### **INITIAL REFERRAL**

The patient, Joan, was a self-referred 32-year-old female who requested psychological therapy including hypnotic intervention for treatment of her sexual difficulties. During the initial session she expressed her anxiety and distress with “not being able to experience penetration during intercourse.” She expressed her embarrassment and shame at the fact that she required help with “something that should not be a problem.” Joan expressed disappointment with her own feelings and was desperate to remediate this problem. This was due to her perception that she was approaching the age where she “could not delay falling pregnant for much longer.”

## **PRESENTING PROBLEMS**

The presenting problem was fear of intercourse or any other vaginal intromission due to pain experienced during penetration. Joan was married and concerned that she had been unable to enjoy sexual intimacy with her husband since a gynaecological examination two years prior. She recalled experiencing extreme pain during a Pap smear administered by a female gynaecologist during this consultation. As a result of this painful experience and the “iatrogenic” (Clarke & Jackson, 1983, pp. 198–202; Platonov, 1959, pp. 262–271) nature of the medical process she avoided any further gynaecological examinations as well as vaginal intromissions. Her presenting concerns were related to her imminent desires to plan a family as well as the impact her sexual dysfunction may impose on her marital relationship. She noted that prior to the “Pap smear experience” she had not experienced pain during intercourse. However, apart from a display of affection and intimate moments there was never really a time where she found sexual intercourse and sexual foreplay to be an enjoyable experience.

Joan’s goal was to be able to change her feelings of negativity and rather “feel neutral towards sex,” as she believed that without this she would never be able to enjoy sexual intercourse. She was also extremely concerned about her marital relationship, and although her husband was described as being very patient she felt that after being married for five years he may become impatient and seek another relationship. Joan also requested assistance with addressing her problems related to “lifelong anxiety and low self-esteem especially at work.” She considered that she was unable to assert herself within her work environment and especially with her female manager. She also expressed feeling fearful when she was required to conduct corporate presentations.

## **INITIAL DIAGNOSTIC FORMULATION**

The tentative diagnosis was “Secondary Vaginismus” (Hlywa, 2000, pp. 7–8; McGuire & Hawton, 2001, p. 1) and raised levels of anxiety (Sadock & Sadock, 2003, pp. 591–592). “Vaginismus” (Hlywa, 2004, pp. 484–494; Masters & Johnson, 1970, pp. 243–258) is a condition which affects a woman’s ability to engage in any form of vaginal penetration, including sexual penetration, insertion of tampons, and the penetration involved in gynaecological examinations. This term, first described by Huguier in 1834 (cited in Kraft & Kraft, 2007, pp. 15–16), is the result of a conditioned reflex of the pubococcygeus muscle, which is sometimes referred to as the PC muscle.

This reflex causes the muscles in the vagina to tense suddenly, which makes any kind of vaginal penetration, including sexual penetration, either painful or impossible. A vaginistic woman does not consciously control the spasm. The vaginistic reflex can be compared to the response of the eye shutting when an object comes towards it. Secondary vaginismus occurs when a woman who has previously been able to achieve penetration is no longer capable of this action, due to involuntary muscle spasms.

Due to Joan's concerns that she "would never be able to enjoy sexual intercourse," a differential diagnosis included further sexual difficulties, namely, "sexual aversion disorder," "sexual arousal disorder (frigidity)," "orgasmic disorder," and "dyspareunia" (Kraft & Kraft, 2007). However, at this stage of the therapy, a few probing questions revealed that Joan denied previously experiencing any other sexual difficulties. As I sensed that an interrogative style of questioning would be contraindicated in her case, I chose to treat the presenting problem in order to facilitate a positive therapeutic relationship (Rogers, 1951, p. 266). A non-threatening approach to the history taking, which remains a continuous process throughout the whole therapeutic encounter, allows for fluent dialogue and facilitates a positive therapeutic relationship (Hlywa, 2000).

Patients suffering from sexual dysfunctions "are extremely sensitive and vulnerable to chance remarks" (Kroger & Fezler, 1976, p. 152) and therefore I considered it appropriate to listen carefully to Joan, only probing when absolutely necessary to elucidate the real state of her mind and the "genesis of the problem" (Hlywa, 1998, pp. 111–137). I thus considered the importance of understanding Joan as a whole person without separating the sexual dysfunction from her "total human existence" (Masters & Johnson, 1970, p. 23). This approach also planted the seed that would allow her to fully embrace her future sexually intimate encounters without the dysfunctional aspects common to many of the sexual difficulties such as maintaining a "spectator role" during intercourse and inhibiting personal communications inherent in healthy sexual encounters (Masters & Johnson, 1970, p. 10).

"The sexual response cycle is mediated by a delicate interplay between the sympathetic and parasympathetic nervous system, and may be easily inhibited by cortical influences, or by hormonal, neural or vascular mechanisms" (Hlywa, 2000, p. 2). Thus in order to exclude any medical conditions I recommended that Joan consult her doctor and/or specialist to be examined thoroughly in order to eliminate the possibility of "organic inhibitory conditions which may require treatment beyond the psychotherapeutic intervention" (Hlywa, 2000,

p. 2). These include hormonal, neurological, genito-urinary, and cardiovascular disorders. Joan noted that her doctor and specialist had already recently excluded any underlying organic conditions.

## **BACKGROUND INFORMATION**

Joan worked full-time in human resource management. After five years of marriage she and her husband were ready to have children, hence Joan's decision to enter psychological treatment to facilitate a successful pregnancy. Although she reported enjoying a close family support network Joan noted an inability to discuss this matter with either of her parents due to their extremely "religious" families of origin. Her parents' background originates from diverse cultural and religious belief systems, her father following an orthodox Christian religion while her mother, being of Eastern background, maintained her Eastern religion, with very strict chaperoning until marriage. Joan was raised in the orthodox faith during her early adulthood years and as a result of her marriage she was less involved in organised religion and preferred to adopt a more flexible lifestyle while continuing to respect her childhood experiences. Joan's husband follows his paternal orthodox religion and although he is apparently not an "active church goer," she expressed a conscious desire to support his wish to raise their children in accordance with his faith.

During the initial sessions and after an initial induction and orientation to hypnosis in the third session, Joan spontaneously revealed further background history. Joan described her childhood years as having been exposed to the ongoing physical and emotional abuse of her father toward her mother. Her father is an alcoholic and although he has never been formally diagnosed as such nor has he sought treatment for his problem, Joan felt that she was sufficiently experienced and educated to understand his condition.

Joan described her parents as being "rigid" in their approach. She was not exposed to any sexual education and was unable to discuss this subject or her difficulties with her mother. She recalled her father being extremely strict during her adolescent years and spontaneously recalled memories of him telling her that she should "stay away from boys as all they were interested in was to urinate over her and treat her like dirt." She described these memories of her father's voice while crying during a subsequent session of "spontaneous revivification/abreaction"<sup>1</sup> (Hlywa, 2008a; Kroger, 1977, p. 17; Watkins & Barabasz, 2008, pp. 57–94). Utilising hypnosis heightens and "intensifies the

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<sup>1</sup> The person relived the traumatic experience with semi-controlled emotional intensity.

therapeutic relationship” (Erickson, Rossi, & Rossi, 1976, p. 19) and provides the opportunity to incorporate “hypnoanalysis” (Brown & Fromm, 1986, pp. 196–224; Wolberg, 1964, pp. 5–23) within the psychotherapeutic treatment.

## **INITIAL PHASE OF TREATMENT**

During the first two sessions Joan was extremely anxious while expressing her difficulties with vaginal intromission. At onset of treatment I encouraged her that she and her husband should refrain from sexual intercourse until there was an absolute profound desire to fully enjoy the process (Kroger & Fezler, 1976, pp. 163–164). I spoke about the positive aspects of conceiving a child during the most profound moments of absolute enjoyment leading to a truly wonderful conception which would lay the seeds for a beautiful experience for both parents and child. A visual analogue scale (Duncan, Bushnell, & Lavigne, 1989) was introduced to allow the patient to view a graphic representation of her level of expectations. This is also a suitable way of grading the general level of exposure to threatening stimulus. Accordingly, on a scale of “1” through to “10” a list of expectations was discussed, “1” being the least threatening experience which for Joan was “general cuddling” and “10” being the most threatening, namely “full-on sexual penetration.”

## **FIRST HYPNOTIC INTERVENTION: THIRD SESSION**

As there were no contraindications for hypnosis (Brown & Fromm, 1986, pp. 117–123; Wolberg, 1964, pp. 23–29) and Joan had expressed her interest in experiencing hypnosis as part of the treatment, an orientation towards hypnosis was introduced during the third session. This was designed to help her to adopt a more relaxed approach during subsequent sessions. Hypnosis heightens and intensifies the therapeutic encounter and has been reported to be effective in the treatment of vaginismus (Kroger & Fezler, 1976). According to Burrows (1978, cited in Hlywa, 2000, p. 23), “hypnosis may catalyse every aspect of the psychotherapeutic process by helping to relieve tension and anxiety, to produce faith in the therapist, to overcome repression, to increase suggestibility and to produce transference.”

### **Pre-Induction Discussion**

During the third session Joan expressed intrigue and interest in hypnosis by indirectly requesting that I hypnotise her. This was the subliminal message. Her overt conscious message was acknowledgement of my use of hypnotic

interventions in my practice, which was one of the reasons she had consulted me. I then invited her to experience an orientation toward hypnosis if she so desired. Joan nodded and said she would “enjoy the opportunity to relax” as she felt very stressed and anxious due to the fact that she was to present a corporate workshop during the next few weeks. She mentioned that she was uncertain as to how to control the anticipatory anxiety related to this project.

I considered that an initial orientation to hypnosis using “hypnosuggestion” (Forel, 1970, pp. 545–567; Wolberg, 1948, pp. 1–137) and “symptom removal” (Clarke & Jackson, 1983, pp. 12–13, 198–199) to treat her physiological symptoms of performance anxiety was an ideal introduction for this patient for the following reasons:

One: Introducing hypnosis by addressing a problem which was obviously less threatening for her than the experience of vaginal penetration would potentially prevent the experience of personal failure in the *performance* aspects of hypnosis and increase her experience of *self-mastery*. From a behavioural perspective, systematic desensitisation (Wolpe, 1973) has been known to be a useful intervention for vaginismus (Dennerstein, 1978, cited in Hlywa, 2000, pp. 10–14).

Two: The use of hypnosis in this way would serve as an assessment tool for Joan’s level of hypnotisability, as well as to strengthen the therapeutic relationship. Assessing the patient’s response to hypnosis as well as their level of hypnotisability can be helpful in determining the patient’s attitude to psychotherapy as well as their general level of psychopathology, which is an important indicator in the choice of treatment (Spiegel & Spiegel, 2004).

## **Induction**

Eye fixation together with progressive muscle relaxation was used to facilitate a rapid induction and prevent the patient from overly analysing the situation and developing performance anxiety. A cautious and non-invasive approach was adopted as I sensed that the patient needed time and space to experience her “self” in the process. I had previously established that Joan had utilised progressive muscle relaxation, calming breathing and guided visualisation as a means of achieving deep relaxation.

## **Deepening Process**

“Fractionation” was used as a deepening process (Brown & Fromm, 1986, p. 105; Teitelbaum, 1965).

## **Hypnosuggestion, Symptom Substitution and Post-Hypnotic Suggestion**

Imagery was used to suggest to Joan that she take herself to an experience in her life where she felt happy, confident, and content. Ideomotor signals (“Your index finger will rise”) enabled Joan to communicate with me when she had achieved the suggested experience. I suggested to Joan that she take herself to a place where she felt raised levels of anxiety, using ideomotor signalling to indicate when she arrived in that space. I then suggested that when her thumb and forefinger touched, all the anxiety would dissipate and she would feel absolute calmness, perhaps even going to her happy experience. I suggested that Joan rehearse this quietly in private and signal when she had completed the process. The post-hypnotic suggestion was that she would automatically use this technique in the future whenever it was desirable for her to control feelings of anxiety.

## **Dehypnotising**

Ideomotor signalling was used to bring Joan out of hypnosis. I suggested that I would assist her to “come out of hypnosis” whenever she was ready. I requested her to communicate her readiness to me by raising her index finger. “Your index finger will rise when you are ready to come out of hypnosis. Take your time. You have plenty of time. Should you require a few moments of quietness please feel free to rest and when you are ready your index finger will rise ... Thank you. I will count from 1 to 10 and at the count of 7 your eyes will open and you will feel a little more refreshed, a little more alert, more reoriented so that by the count of 10 your eyes will fully open and you will feel fully refreshed, fully alert, fully in control of your reality with a wonderful sense of having accomplished something of tremendous importance just for you.”

## **Integrative Psychotherapy: Supportive, Educative and Hypnoanalysis**

As therapy progressed, Joan spontaneously revealed several traumatic life experiences which impacted on her current functioning. During subsequent sessions and after formal hypnosis, “hypnoanalytical” procedures of “spontaneous revivification” and “spontaneous regression” (Brown & Fromm, 1986, pp. 196–224; Wolberg, 1964, pp. 5–23) were incorporated within the psychotherapeutic treatment. An integrated approach to treatment facilitates



addressing “multiple” layers of the problem simultaneously (Ivey, Ivey, & Simek-Morgan, 1993, p. 85). Burrows (1978, cited in Hlywa, 2000, p. 22) emphasises that “sexual dysfunctions may require an integrated approach, using supportive, reeducative and reconstructive methods of psychotherapy, as well as physical, pharmacological and mechanical aids.”

Hypnosis may aid behavioural treatment by relaxing the patient, increasing visual imagery, and producing a state of increased suggestibility. “In the psychogenic group of disorders, hypnosis may be used as a method of psychotherapy itself, as in hypnoanalysis, or may be utilised in conjunction with other psychotherapeutic methods” (Hlywa, 2000, p. 22).

#### **FOURTH SESSION**

During her fourth session Joan revealed that she found her initial experience of hypnosis extremely helpful in treating her performance anxiety. She related the symptom substitution technique and how she had noticed its effectiveness in addressing her physiological symptoms of autonomic arousal including heartbeat and tremor. She requested further hypnosis to address her sexual difficulties and revealed how this had not as yet improved. Joan mentioned that she had set herself a time line to fall pregnant.

For the first time Joan revealed that her sexual difficulties were extremely disabling for her and prevented the insertion of tampons during menstruation. She found her lifelong use of sanitary pads to be “messy, primitive and restrictive.” This suggested to me that there may be deeper more primary related difficulties associated with vaginismus. She expressed her trust in the therapy and therefore her desire to be able to reveal more intimate and personal aspects of her problems. I therefore decided to introduce a second hypnotic intervention, which she had requested. During this phase of therapy hypnoanalytic procedures including spontaneous revivification, age regression (Wolberg, 1964, pp. 290–296) and affect bridge (Watkins, 1971) were utilised.

As further history was revealed, a deeper understanding of Joan’s problem emerged. She spoke about her positive experience of finding an empathic and gentle male gynaecologist who was a friend of her husband’s family. She shared her experience of being medically examined by the gynaecologist, who excluded the possibility of physical illnesses or abnormalities. She related the experience of both her and her husband undergoing fertility tests and investigative procedures, including blood tests, to exclude any possibilities of genetic defects. She described her feelings of shyness and embarrassment at

how frank the obstetrician was in his detailed descriptions of sexual techniques and the process of ovulation, conception, and fertilisation.

At this stage I felt as if the patient was rushing ahead of the process by proceeding with imminent plans to fall pregnant before she had addressed her sexual difficulties. In accordance with Kroger and Fezler (1976, pp. 163–164), a “durable satisfying sexual relationship” is inconceivable without the factor of “mutual love” and “affection.” However, I considered this to be Joan’s spontaneous attempts to desensitise herself and address her problem by not only initiating the psychotherapy but also attending to her other dimensions including the physiological, behavioural, marital, and teleological (Hlywa, 1998) aspects of her functioning. I developed the opinion that this was an active phase for Joan during which time she was energetically addressing her physiological domain of functioning by thoroughly investigating the medical issues, excluding the possibility of any organic illness and simultaneously preparing herself for the ultimate goal of falling pregnant. At the same time it was apparent that the therapeutic relationship was being consolidated and the deepening process had begun.

## **SECOND HYPNOTIC INTERVENTION: FIFTH SESSION**

### **Induction**

The Hypnotic Induction Profile (HIP: Spiegel & Spiegel, 2004, pp. 57–62) was used to intensify the therapeutic relationship and facilitate a positive transference. The HIP also serves as a tool to assess the levels of the person’s acceptance and their overall hypnotic responsiveness. This induction process required me as the therapist to sit next to the patient and firmly touch her arm and shoulder prior to facilitating the induction and deepening process. This close proximity and the appropriate use of touch prior to induction provide a containing and non-threatening approach that allows for any future necessity to introduce touch while the patient is under hypnosis without causing alarm. As Joan’s attitude towards the hypnosis was positive the use of the Hypnotic Induction Profile created the opportunity for her to freely experience the full spectrum of her hypnotic capacity at her own pace. By being with the patient and closely observing her it was possible for Joan to feel free to raise her arm as high as she wished and to experience the different sensations of “lightness ... floating ... floating downward” and feel “extremely comfortable effortlessly enjoying the experience.” She displayed obvious enjoyment, as indicated by her smile as her arm floated above.

## Deepening Process

Since Joan had previously responded positively to fractionation as a deepening process, I decided to utilise this once again to facilitate the deepening of her trance. I suggested further that she go as deeply as she could comfortably do at this time.

## The Use of Guided Imagery and Post-Hypnotic Suggestions

By using guided imagery, subtle and non-threatening reference to the senses would serve to prepare the patient for future more direct stimulation of the senses involved in “sensate focus” (Masters & Johnson, 1970, pp. 63–70), which is used as a technique to stimulate sexual interest.

Joan was invited to take herself to a space or experience where she felt profound contentment and joy. As she had previously described her love of nature, without trying to be too prescriptive I made general suggestions about possible places including a nature scene, a hammock, or some other place where she felt wonderful positive feelings. Joan was given the choice to enjoy her own experience, embracing all of her *senses* in the experience. She was invited to “enjoy the sensations of touch against your skin, face and hair, perhaps the soft gentle breeze brushing against your skin, or any other feeling that makes you feel absolute contentment ... enjoy the things you can *see* ... perhaps nature colours ... or other beautiful *sights* that make you feel such inner joy ... the greenness of the grass or the beautiful colours of the ocean ... enjoy the *smells* ... the *tastes* ... sensations of sweetness or moisture ... and the beautiful *sounds* all around you that make you feel wonderful, joyful and happy ...” Ideomotor signals were utilised to elicit communication from her.

The suggestion was made to Joan that she would have a few minutes of silent deep rest where her mind would continue to entertain her with the most wonderful joyful experiences ... perhaps she would even have a dream. Inducing a dream at this stage served as a preparation or “seeding” (Zeig, 1980, cited in Yapko, 2003, p. 411) for future hypnoanalytic work (Wolberg, 1964, pp. 265–276). Furthermore, the suggestion of “deep rest” was used to prepare Joan for future sessions that would incorporate “protracted hypnotic rest” (Hlywa, 2008b).

## Dehypnotising

Ideomotor signalling was suggested as a means for Joan to indicate when she was ready to “come out of hypnosis” and that she had “plenty of time and

space to enjoy her comfortable rest.” I suggested that her “index finger will rise” when she was ready to come out of her deep rest and this would be a signal for me to assist her with the process. I used the same process of counting from “1” to “10,” as in the third session.

### **SIXTH SESSION: SUPPORTIVE AND RE-EDUCATIVE THERAPY** (Wolberg, 1967)

Joan expressed her appreciation that the therapy was helping her feel more relaxed and less anxious at work. She informed me that her work colleagues had also commented on the fact that she appeared much happier and more relaxed. During this session Joan expressed her need to clarify some issues relating to the physiological aspects of sexuality. She spoke much more openly than previously about her body, sexual techniques, and sexual intimacy. Various probing questions were introduced by me in order to assist her to initiate some homework activities around self-exploration, body awareness, and sensate focus.

### **SEVENTH SESSION PROTRACTED HYPNOTIC REST** (Hlywa, 2008b)

Joan had initially presented with the specific problems of vaginismus as well as performance anxiety. During the seventh session she spontaneously revealed that she had planned to engage in sexual intercourse to conceive with her husband in three days time, on the eve of a significant day in her religious calendar. She requested a further session of hypnosis in order to “be able to relax and try to enjoy intimacy with [her] husband.” Protracted hypnotic rest (Hlywa, 2008b) was used to facilitate Joan’s process of gaining deeper insight into “her own self.” The client enjoyed the hypnotic rest and later expressed her positive feeling and appreciation of my giving her the chance to reflect on her inner self. My aim in utilising protracted hypnotic rest rather than to engage in prolonged conversations was to lead her to fulfil her goal of discovering her deep self and thus achieve her process of self-actualisation (Maslow, 1968; Rogers, 1951).

### **EIGHTH SESSION**

During the eighth session, Joan reported that her initial therapeutic goals were achieved. She requested a temporary break from attending the sessions and further requested that, should she experience any further difficulties, she

would return to treatment. I hypothesised that any underlying conditions may have been resolved subliminally during the hypnosis or that Joan was not yet ready to address the other deeper issues. It has been shown that, “in some cases (some women should be treated for other sexual dysfunctions) once the muscular spasm (that occurs in vaginismus) has been broken” (Hlywa, 2000, p. 13). For the time being, Joan had achieved her initial goals of experiencing sexual penetration, improving her performance difficulties at work, and achieving a neutral attitude towards sexual intimacy.

## **SUBSEQUENT SESSIONS**

Joan consulted me a few months later. She had little to report about her sexual activities but indicated that she would like to explore various outstanding problems. These related to the deeper issues surrounding her rigid upbringing in accordance with her parents’ religious belief systems and the ambivalence surrounding her desire to suitably adjust to her husband’s marital approach in accordance with orthodox tradition.

## **CONCLUSION**

Joan initially presented for treatment of secondary vaginismus and performance anxiety. As the therapy sessions progressed I considered a possible underlying sexual aversion as a result of her father’s warning about the dangers of sex. The initial eight sessions assisted her with addressing her performance anxiety, breaking the muscular spasm causing vaginismus, and achieving a general level of insight relating to her self-awareness. Further therapy sessions addressed issues related to family of origin, interpersonal, current marital relationship, social, cultural, and religious beliefs.

The use of hypnosis facilitated an integrative approach to Joan’s treatment incorporating multiple domains including addressing the cognitive, emotional, behavioural, physiological, familial, social, occupational, developmental, and existential areas of functioning. Furthermore, the establishment of a positive psychotherapeutic relationship that was heightened by the use of hypnosis formed the essence of success in Joan’s progress to understand the genesis of her problems, resulting in the integration of her present experiences into her personal matrix.

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