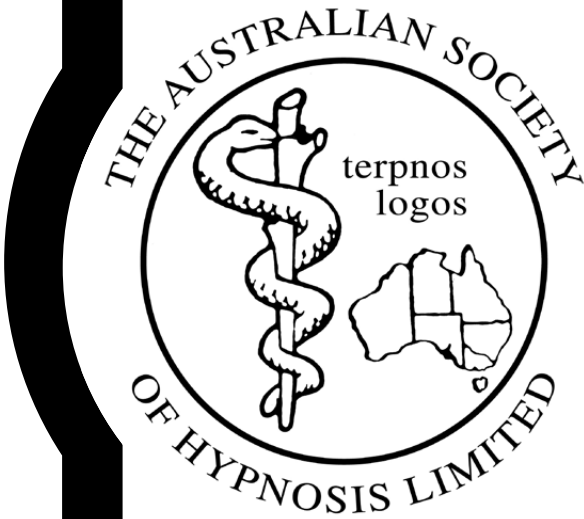


AUSTRALIAN JOURNAL  
OF CLINICAL AND  
EXPERIMENTAL  
HYPNOSIS



MAY 2016

VOLUME 41 (1)

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Published by

*Australian Society of Hypnosis*

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## THE PLACE OF HYPNOSIS IN PSYCHIATRY PART 6: TREATMENT OF SPECIFIC PHOBIAS — NATURAL ENVIRONMENT TYPE, BLOOD-INJECTION-INJURY TYPE, AND OTHER TYPES

David Kraft

Private practice, Harley Street, London

*Part 6 focuses on the use of hypnosis in the treatment of the following subtypes within the specific phobia category—natural environmental type, blood-injection-injury type, and other types. The author reviews a range of treatment strategies which have been shown to have been effective in clinical practice. The report examines the efficacy of hypnosis in the treatment of conditions such as wind phobia, heat phobia, balloon phobia and aquaphobia, while attention is given to the blood-injection-injury type which includes needle phobia, a problem which affects a large proportion of the population. Detailed accounts of each treatment strategy are given so that practitioners may incorporate these techniques both in a hospital setting and in private practice.*

Keywords: hypnosis, specific phobias, natural environment type, blood-injection-injury type.

The following study focuses its attention on three further subtypes within the specific phobia category—natural environment type, blood-injection-injury type and other types (American Psychiatric Association [APA], 1994). The report looks at the way hypnosis has been employed as an adjunct to psychodynamic psychotherapy, counselling and approaches which fall within the remit of cognitive-behavioural therapy. Table 1 does not represent a complete list of the studies which have employed hypnosis in treatment, but provides the reader with a cross section of approaches in the world-wide literature.

**Table 1:** Specific Phobias Treated With Hypnosis

Phobia type	Author(s)	Treatment strategy/experimental design
<b>Natural environment type</b>		
Thunderstorm phobia	Heap (1981)	Diary keeping; desensitization in vivo and in vitro; use of audiotapes
Wind phobia	Walters & Oakley (2003)	Cue-controlled relaxation and desensitization
Aquaphobia	DePiano (1985)	In vivo and in vitro desensitization
Phobia of bovine sounds	Cohen (1981)	Dissociation; visualization; use of humour (re-framing)
<b>Blood injection injury type</b>		
Blood phobia	Noble (2002)	Systematic desensitization
Injection <sup>1</sup> phobia	Daniels (1976)	Systematic desensitization; in vivo exposure
Injection phobia	Kraft (1984)	Systematic desensitization; safe place imagery; psychoanalytic investigation including dream analysis
Injection phobia	Medd (2001)	Client-centred counselling; time regression; reframing and use of affect bridge
Injection phobia	Abramowitz & Lichtenberg (2009)	Use of “hypnotherapeutic olfactory conditioning” (HOC)
Needle phobia	Morse & Cohen (1983)	“Meditation-hypnosis”; desensitization hierarchy
Needle phobia	Cyna, Tomkins, Maddock & Barker (2007)	Early learning set; “switch wire” imagery
Needle phobia	Brann (2012)	Special place imagery; silent abreaction; age regression; guided exposure
Chemotherapy phobia	Kraft (1993)	Special place imagery and desensitization in hypnosis

<sup>1</sup> It is difficult to distinguish between needle and injection phobia; however, the author has retained both terms in order to correspond with the terminology used in each study.

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Other type		
Bleach phobia	Deiker & Pollock (1975)	Systematic desensitization and guided imagery
Balloon phobia	Kraft (1994)	Systematic desensitization in vitro and in vivo; psychodynamic psychotherapy
Heat phobia	Kraft & Al-Issa (1965)	Systematic desensitization in vitro and in vivo
Vomiting phobia	Wijesinghe (1974)	Flooding in hypnosis
Vomiting phobia	Ritow (1979)	Paradoxical techniques; cognitive restructuring; emetic medication; psychotherapy

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These disorders will be elaborated now and the role of hypnosis in their treatment considered.

### **NATURAL ENVIRONMENT TYPE**

Some individuals fear their surrounding environment, although the phobia is often limited to a specific feature—for example, types of weather (e.g. a thunderstorm), the wind, heights and earthquakes. Those who suffer from a natural environment phobia develop safety behaviours in order to limit the chance of experiencing the feared stimulus; and, if the phobia develops, these avoidance or safety behaviours become more complex. Some patients become housebound for periods of time and this can lead to full-blown agoraphobia (Kraft, 2011). When using desensitization in treatment, it is helpful to re-create, as closely as possible, each scenario in the graded hierarchy in order to produce “maximum realism” (Heap, 1981); in cases where patients are unable sufficiently to imagine or be involved in a scene, external cues can be employed in order to increase verisimilitude (Heap, 1981).

A case study reported by Heap (1981), who successfully treated a 47-year-old with a life-long fear of thunderstorms, shows clearly how a patient’s ability to experience the feared event can play a significant part in the treatment process. Indeed, during the desensitization, minimal visual and auditory imagery were required; and yet, she had the feeling that she was actually experiencing a thunderstorm, and even sensed a “cooling sensation” which signified a drop in temperature as the storm progressed. During the initial stages of treatment,

it was revealed that she had equated her fear of thunderstorms to the sounds of bombs during the Blitz and these sounds brought on feelings of loneliness and a fear of abandonment.

The patient constantly checked the weather reports, and so Heap asked her to keep a record of these checks, writing down her feelings and experiences with regard to the weather. The stimulus hierarchy consisted of her experiencing a number of scenes in different weather conditions ranging from sunny to a full-blown thunderstorm. She also practised at home, and this treatment was continued for approximately six sessions. In the next phase, the therapist focused on her fear of thunderstorms at night and, in the hypnosis, he asked her to imagine lying on her bed, feeling comfortable and relaxed. Heap played her tape recordings of rain and thunder and gradually increased the volume during each session; further, lightning was simulated using two Xenon-filled flash tubes. Very early on in this phase, she reported that she had reduced her obsessive checking of the weather reports and, although she continued to experience some anxiety during thunderstorms, the effect they had on her were short-lived and they ceased to limit her daily activity.

An interesting approach to the treatment of a natural environment phobia—in this case, a fear of wind—was reported by Walters and Oakley (2003). Again, the patient's ability not only to visualize but also vividly to experience "being there," directly engaging in each imaginal situation, were key components in the success of the treatment. The patient, Sarah, also commented that it was helpful for her to be able to re-frame frightening sounds to noises that comforted her: for example, she imagined changing the sound of the wind near her home to a sound of a waterfall. The authors described an approach which used systematic desensitization, special place imagery and the use of coping strategies which, in combination, helped her to eliminate her safety behaviours. They also explained the rationale of the treatment to the patient—that is to say, her phobia had been learnt (Wolpe, 1958), and then exaggerated over the last two years, and that the hypnosis would help her to discover new and more appropriate ways of thinking about wind. However, it must be pointed out that, although a cognitive-behavioural framework provided the main thrust of the treatment, and the hypnosis enhanced this process by pairing the feared stimulus with pleasurable sensations (Kraft, 2012; Weitzenhoffer, 1972; Wolpe, 1958), a psychodynamic approach was also needed in order to reveal, and then help her to come to terms with, the source of the phobic anxiety. In this case, her fear may well have been closely connected with, and therefore triggered by, the death of



her previous partner and four other family members, as well as a particularly stressful Christmas period when the weather was very windy.

The source of the fear in the case reported by Walters and Oakley (2003) was a traumatic set of incidents approximately six years before the start of therapy; however, often environment phobia is developed in childhood (APA, 1994). In a case of aquaphobia, reported by DePiano (1985), the source consisted of the patient, Mrs A, being spanked for going near water as a child, while her mother's intense fear of water had also been transferred onto her. When using systematic desensitization, *in vitro*, it is often helpful to combine this with *in vivo* work (Kraft & Kraft, 2010); but it is important to make sure that patients work through each potentially anxiety-provoking situation gradually so that they build on their successes. This is more difficult to control when patients work on their own, outside the consulting room. However, one way of effecting therapeutic change is to encourage one's patient or client to begin with simple tasks and, like the graded hierarchy in the hypnosis, they should gradually work towards more difficult scenarios. In the treatment of aquaphobia, DePiano (1985) used systematic desensitization in hypnosis over a period of three sessions, while between appointments, the patient practised socializing by a swimming pool and worked towards being able to submerge herself under water. By the end of the fifth session, Mrs A was able to rehearse these scenarios without any anxiety. Nevertheless, her therapist urged her not to test her confidence; but, instead, he met her at the local swimming pool early in the morning and, using further hypnosis, helped her gradually to enter the pool. Over a period of two weeks, she moved from the side of the pool to being able to submerge herself in the shallow end. Mrs A was also encouraged to grade her anxiety levels (from 1–5) throughout the process. At the year follow-up, Mrs A admitted that she still felt uncomfortable swimming but that she was able to socialize near water, and both her anxiety and her avoidance behaviour had disappeared.

## **BLOOD-INJECTION-INJURY TYPE**

Blood-injection-injury (BII) phobia is a common condition and many sufferers avoid seeking medical treatment due to their uncontrollable fear. Over 75% of individuals have reported that they have fainted or have felt faint after having seen or even talked about blood, injuries or needles (APA, 2000; Ayala, Meurat, & Ritz, 2012). In these situations, often patients experience bradycardia and hypotension, while a sudden drop in blood pressure frequently

leads to fainting (Graham, Kabler, & Lunsford, 1961; Medd, 2001).

Probably the most common of the BII phobias is needle (or injection) phobia; although it is sometimes connected with dental phobia or dental anxiety, it should be considered as a distinct phobia (De Jongh et al., 1998; Medd, 2001). Needle phobia affects approximately 19% of children within the 4–6 age group, and about 10% of the general population (Hamilton, 1995; Majstorovic & Veerkamp, 2004).

A case study reported by Kraft (1984) has shown clearly how a specific phobia, although seemingly “simple” on the surface, is in fact a manifestation of a deeply-entrenched inner conflict; this study is also an example of how behavioural therapy and hypnosis can be used successfully within, principally, a psychoanalytic framework. The patient, Mrs T, suffered from injection phobia and also had problems listening to people talking about illness or operations; she had also fainted on numerous occasions while watching programmes on television—particularly themes related to childbirth.

During the psychotherapy, it became apparent that she had a difficult relationship with her father and was not close to him. When she was 15, her father, who was not a doctor, decided that she should have a blood test and, as he was working at a laboratory, he took the blood himself. Mrs T was given the opportunity to discuss her feelings of being let down by her father and the complications which arise when one sees one’s father in two opposing roles. The treatment initially focused on the presenting phobia, and both therapist and patient constructed a hierarchy which concentrated on complications associated with giving birth, including the actual delivery, having stitches and a transfusion. These situations were rehearsed in the hypnosis and, whenever she felt anxious, she was returned to her safe place. After disengagement, she spoke of her problems speaking to a friend who had a wired-up jaw, and her boss who was heavily pregnant. In the next session, Mrs T explored a series of scenarios in which she imagined possible causes for her friend’s fractured jaw. The aim of this was to increase her ability to cope with medical themes without fainting; indeed, she reported that, during the week, she had been able to talk to her boss about the complications of having raised blood pressure during pregnancy. She was also keen to learn more about obstetrics: she spoke to her therapist, asked his advice and began to read a book on the subject.

As the therapy continued, the transference relationship between therapist and patient grew stronger. She pointed out that her father had never qualified as a doctor and that had disappointed her; and yet, she found that she was able to talk to her therapist—who was, in fact a physician—about medical themes.

Her therapist, therefore, represented the father she had never had. Further, she stressed that having injections was a “question of penetrating.” During the next two sessions, Mrs T recounted two dreams. The first was a phantasy about having sex with her therapist on the couch and the second involved her making love to her boss at work. Indeed, her injection phobia was inextricably interconnected with her hostilities towards her father (Stoller, 1976); indeed, her sexual partners, including her husband, were always older men and were, she confessed, substitute father figures. As the injection phobia subsided, Mrs T continued to work through her inner conflicts and hostilities towards her husband and, at the year follow-up, she stated that she had had a baby and was able to describe the whole process without any difficulty. This example shows how a psychodynamic approach can be combined successfully with hypnosis. Interestingly, as the presenting phobia subsided, she began to discover and deal with more complex issues in her family life: in fact, it is possible that the earlier desensitization work, and the space given to her in the hypnosis, were important factors in helping her to develop these insights (Cautela, 1965).

Coming to terms with the source of the phobia can have immediate effects on treatment gains. In a case reported by Brann (2012), the patient, on establishing her safe place, was given the opportunity to search the “depths of her mind for the beginning of the problem.” This “unconscious search” (Erickson & Rossi, 1979) helped her to regress to a time at boarding school in which a girl repeatedly stuck sewing needles into her arm. The therapist helped her to deal with and resolve this trauma using the “dead tree” silent abreaction (Ibbotson, 2012; Ibbotson & Williamson, 2010), the “older wiser self” technique (Degun-Mather, 2001; Williamson, 2008) and graded in vitro exposure to seeing and touching hypodermic needles. At the end of the treatment, she was able to hold the needle herself.

The study by Kraft (1984) above demonstrates how hypnotic interventions can be used in conjunction with a psychoanalytic approach; but hypnosis can equally be employed in counselling. Medd (2001), for example, reported two cases of note which utilized this combined approach: both patients suffered from needle phobia and had other fears and anxieties. In the first case, the patient, who was constantly in pain as a result of a stroke, received client-centred counselling. This was followed by repeated hypnosis work which helped her to experience being pain free so that she could make “safe contact with [her] suppressed traumatic memories.” In the second case, relaxation, ego-strengthening and the use of the affect bridge helped the patient to reframe her traumatic experiences in the past relating to needles. Medd also

paired having injections with feelings of relaxation and this had the effect of reducing anxiety and building confidence.

Another useful technique for the treatment of needle phobia is the “switch wire approach” (Hammond, 1990), and this can be used in order to create analgesia and/or anaesthesia. Cyna, Tomkins, Maddock, and Barker (2007) used this technique successfully in the treatment of a five-year-old boy with severe needle phobia. The anaesthetist trained the boy in hypnosis and then explained the fact that all houses have a number of wires and switches which can be turned off and on at will and that, once a switch was off, the electrical device—light bulb or heater—does not work. The anaesthetist went onto explain that, like a house, the brain also consists of a number of switches and wires which can be turned off at will; he pointed out that one can even “turn off” the leg or arm so that it doesn’t work anymore. The boy responded excellently to these suggestions and was able to produce a fair amount of anaesthesia at will. Two days after this treatment, the boy received venepuncture without the need for a topical anaesthetic cream, and experienced no pain whatsoever. He was also able to cope with the i.v. injection without difficulty.

Blood phobia (haematophobia) is an interesting variant of the BII subtype. In a case reported by Noble (2002), the patient exhibited extreme safety and avoidance behaviours and her anxiety affected her daily life. For instance, she was unable to prepare steak for her husband because the mere sight or smell of any blood caused her to feel nauseous; she often experienced a gag reflex and avoided dental treatment to the extent that she had even extracted some of her teeth herself. When she came for treatment, her remaining eight teeth had advanced periodontitis and active caries, with evidence of periapical infection. It was decided that these teeth needed to be extracted and that dentures should be fitted; but this was impossible due to her fears, constant expectoration and retching. Thus, Noble, used a multi-modal approach to treatment with the aim that she could eventually tolerate dental surgery. In the first instance, she asked the patient to visualize a safe place and was told that she could return to it at any time. Ideomotor signalling was then set up so that non-verbal communication could take place during the procedure. Importantly, hypnosis was used during these initial stages to prepare her for the ensuing dental procedure and was also used during the treatment itself. An anchor was set up in order to reduce anxiety, and the patient was given an imaginary pebble in her hand which she could stroke whenever she became anxious. She also used this anchor to re-direct her choking from the throat to her hand. As her perception of control grew, the dentist cleverly

built on this success by working in stages. While her upper partial denture was relined, it was noticeable that her gagging had significantly reduced. She also opened her eyes during the hypnosis and sipped water to reduce her nausea. During rehearsal, Noble used a re-framing technique in which she compared having new dentures to wearing a new pair of shoes. The patient was further instructed to visualize preparing steak for the family and to enjoy watching them eating the meal. Noble also used a video-playback technique and the patient practised each dental scenario again and again in order to increase her mastery of being able to have dental surgery. As a result, she was able to proceed with full treatment, including impressions, extraction and the placement of dentures.

## **OTHER TYPE**

The literature search revealed four papers of note which fall within the Other subtype: all four studies employed hypnosis but they all used very different therapeutic regimes to resolve the phobic anxiety. In the first paper (Kraft, 1994), the therapist encouraged the patient to explore the associations between the feared object and early childhood experiences, and used both in vitro and in vivo desensitization. The second paper (Kraft & Al-Issa, 1965), by contrast, used a systematic approach, and the client made considerable progress without the need for a regressive psychoanalytic investigation. The third case, reported by Ritow (1979), utilized her motivation for change in order to eliminate her phobic anxiety, while the fourth study (Wijesinghe, 1974), employed a flooding technique in hypnosis.

Kraft (1994) reported the successful treatment of a 60-year-old lady with a lifelong fear of balloons. Due to the complex and deeply entrenched symbolic associations between balloons and her past history, the treatment lasted several months and she needed over 40 sessions. During the first four appointments, the therapist used systematic desensitization to reduce the amount of anxiety that she had. Her phobia was so severe that the desensitization hierarchy began by her imagining, in hypnosis, pictures of balloons in children's books, visualizing a sealed packet of balloons on a shelf and steadily working towards being able to tolerate an unopened packet on her lap. Next, she was encouraged to touch a balloon which was not inflated and to gradually blow it up, increasing its size—this was done first in hypnosis and then live in the consulting room. She practised touching these balloons at home with the help of her husband. During the in vivo work in the consulting room, the patient

revealed that touching, or even thinking about balloons, produced vaginal discharge and made her feel sexually aroused: further, at home, she insisted that her husband hold her during the process and this often led to sexual intercourse—which she initiated. Her therapist commented that there was a connection between the sound of the balloons bursting and early recollections of hearing her parents having sexual intercourse. However, he did not point out further associations between the blowing of a balloon and, for example, increasing sexual desire, the increase in the size of a man's penis from flaccid to erect and the development of her breasts at puberty.

By the eighth session, she was able to hold a fully inflated balloon, first, in the hypnosis and, secondly, during the *in vivo* work. However, she pointed out that she was still terrified of bursting balloons and was particularly sensitive to the noise it produced. During the next few sessions, the patient rehearsed the idea of the therapist bursting a balloon in the next room and gradually working his way towards the consulting room. After the hypnosis, the therapist repeated this work *in vivo*, and then prepared cassette tapes in 10 volumes for her to use at home: the importance of this was that she was able to control the volume herself. Using a noise hierarchy, the tapes consisted of a series of balloons being burst in the room next door, and gradually moving towards her. The patient wanted to talk about why the balloons were so frightening for her and, after a discussion, she realized that the sounds of the balloons bursting were symbolic of exploding bombs during the Second World War. The sounds at the time were closely connected with being separated from her parent and frequent changes of school. These more exploratory sessions were particularly emotional for her.

Over the course of the next few months, the systematic desensitization and mental rehearsal (*in vitro* and *in vivo*) continued and the patient became more confident in that she was able to burst balloons herself in the consulting room. It was also revealed that there was a connection between explosions and having an orgasm and this insight had the effect of reducing her anxiety still further. At the termination of therapy, she was able to burst balloons without any problems whatsoever, and she was also able to go into restaurants in which she knew that children would be playing with balloons.

The case of a female patient suffering from a lifelong fear of heat was reported by Kraft and Al-Issa (1965). The source of her phobia was described by her mother who explained that, aged 5, she witnessed a blazing fire and, terrified, she saw two charred bodies being carried out of a burning house. Throughout her life, the patient exhibited a great deal of avoidance behaviour:

she was reluctant to put her hands in warm water, she could not use an iron, she experienced problems eating and drinking hot food and became anxious whenever she saw burns on people's faces. The therapist (TK) constructed a hierarchy scale which comprised a list of 16 anxiety-provoking stimuli, and these focused on visual and tactile modalities. Each situation was further subdivided into temperature levels. For example, when the patient was asked to visualize "seeing water heated," he asked her to imagine it first at 55° F, in which she was anxiety free, and gradually worked up to 210° F. This same principle was used when she was asked to imagine safely "putting her hands into the oven." After eight sessions, the patient was able to enjoy taking a bath, use a hot iron and sit in the sun; and, as the therapy progressed, her perception of water began to change. By the end of the therapy, she was completely anxiety free and this was maintained at the year follow-up. Interestingly, there was no need to investigate the original trauma in the psychotherapy or include it in the stimulus hierarchy, and progress was made by systematic desensitization in hypnosis alone. This emphasizes the efficacy of using a graded hierarchy of potentially anxiety-provoking stimuli, *in vitro*, particularly when the patient is unable to recall the original source of the phobic anxiety.

Individuals who suffer from vomiting phobia are not only terrified of being sick themselves but also frequently fear anything that is associated with sickness in others (Ritow, 1979). So the phobia is a fear of sickness as well as a fear of being sick. As a result, patients develop elaborate avoidance behaviours in order to eliminate the possibility of coming across anybody being sick or even feeling sick. In 1979, Ritow reported a case of a 21-year-old female with vomiting phobia. She had previously received psychoanalysis and had not responded well to his non-directive approach. Her avoidance behaviour was severe: she was unable to eat chewing gum or large quantities of food, she was unable to go near sick people, she could not take care of her husband when he was ill, and, although she wanted children, she felt that she would be unable to care for them adequately. In the first session, the patient questioned the therapist's qualifications, challenged him on his competence to treat her, and transferred a huge amount of aggression towards him. Ritow explained that, in essence, the therapeutic strategy was to motivate her make the necessary changes for her to lead a fulfilled life and that this would be done seamlessly in the hypnosis and in the psychotherapy. Most of the session involved a discussion in which the patient explored how her phobia had limited her personal and social life. She also explored the role that she played in society and how her anxiety had often caused her to be aggressive towards others—

needless to say, this now included her recent hostility towards her therapist. Ritow prepared her for the necessary changes that would need to occur in her life in order significantly to reduce her phobic anxiety, and he seeded these suggestions before, during, and after the hypnosis (Erickson, 1954; Zeig, 1990; Geary, 1994; Williamson, 2004); furthermore, he pointed out that by removing the central symptom—her fear of vomiting—she would be able to eliminate further “constructs” which restricted her life. As the patient had not responded to a non-directive approach, Ritow asked her directly to confirm that (a) she was ready for this cognitive change and (b) she was willing to follow the therapist’s instructions. She agreed to both of these terms.

In the next session, the patient asked angrily, “Are you going to make me sick and throw up?” The therapist confirmed this intention but pointed out that there was only a 50% chance that she would succeed. He also said that, if she wanted to continue with therapy, she must provide him with her doctor’s contact details, and arrange for a further appointment. The therapist used a paradoxical technique in which he encouraged resistance: thus, she was unable to defeat the therapist because he had already pointed out that she might not continue with therapy. The patient did in fact call for a further appointment and, together with the physician, it was agreed that she could safely take an emetic in order to induce vomiting. In the next session, she angrily reported that she had been sick; again, she questioned the therapist’s competence but agreed that the experience “had not killed her.” Ritow reiterated the fact that a cognitive restructuring process would occur as a result of her being able to vomit, and that this would help her to make the necessary changes in her life. The following week she pointed out that this transition had indeed taken place: She was more positive about herself, less aggressive towards others, and had significantly reduced her avoidance behaviour—for example, she visited a sick person in hospital. She was again reminded that more cognitive readjustments would take place and, over the next three sessions towards termination, she began to eat normally, she helped change a baby’s nappies and was anxiety-free with regard to sickness and vomiting.

Flooding techniques have also been used in treatment. Wijesinghe (1974) reported a case of a 24-year-old woman with a 11-year history of vomiting phobia. At the beginning of treatment, using visualization only, he exposed her to the maximum threat situation which was being trapped on a crowded carriage on the underground. He also presented anxiety cues as follows: “becoming increasingly apprehensive,” “being surrounded by people,” “feeling sick in the pit of the stomach,” “hearing someone retching,” “vomiting



herself” and “being unable to escape.” The patient, however, was unable vividly to hold onto these images and failed to produce an anxiety response. Wijesinghe, therefore, decided to continue the flooding in hypnosis and, after induction and deepener, the patient was able to visualize the journey in detail and showed a great deal of discomfort: the emotional intensity was maintained by her being asked to describe the scene visually as well as her feelings towards the images presented to her. Gradually, her anxiety reduced and, after approximately 85 hours, she was able to tolerate the experience “with equanimity.” In the final session, she reported that she was free from anxiety and this was maintained at the year follow-up. Here, the hypnosis had two profound effects: first, it enabled her to maximize her visual and emotional capacity, and secondly, it reduced her anxiety to vomiting using the principles of reciprocal inhibition—that is to say, the pairing of the feared stimulus with relaxation eliminated the fear response (Kraft & Kraft, 2010; Wolpe, 1958).

This report has shown clearly that hypnosis is a powerful adjunctive tool for the treatment of a range of specific phobias and can be employed in conjunction with behavioural therapy as well as psychodynamic psychotherapy. In many of the examples illustrated during this paper, hypnosis has provided a platform by which patients or clients can eliminate their fears and gain more control and mastery in their lives. And, for patients who fear medical or dental intervention, it is hoped that more hospitals across the world will consider hypnosis so that individuals will be able to seek necessary treatment before conditions worsen or become irrevocable.

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## DR EUGENE HLYWA — A TRIBUTE TO A LONG AND DISTINGUISHED CAREER

In December 2015 Eugene Hlywa celebrated his 90th birthday and was the recipient of yet another medal for his achievements. This unique medal (“009”) was awarded to him in Sydney by the Ministry of Health of Ukraine, for his allegiance to the Oath of Hippocrates.

Eugene has been contributing with an open heart to the Australian Society of Hypnosis since its inception in the 1970s. He has lectured and supervised for ASH and graciously given of all his knowledge, experience and wisdom free of charge. For this he received a certificate of appreciation from the Chair of Education of the Society, Professor Wendy-Louise Walker, on 18 December 2002. He was also granted the status of Fellowship of ASH on 21 September 2010.

Eugene has been awarded several prestigious academic medals and achievements from the University in Ukraine for his generous contribution to the field of hypnosis and psychotherapy.

Eugene also holds the title of visiting Professor at the National University Ostroh Academy in Ukraine and the Bohomolcov School of Medicine in Kyiv, Ukraine.

He was granted the status of member of the Academy of Pedagogical Science of Ukraine for his continuous contribution to the science of psychology and hypnotherapy.

He has authored several textbooks on psychology, psychotherapy and hypnotherapy, which have been adopted as textbooks on the subject by the Ministry of Education of Ukraine.

He has authored several articles, both theoretical and clinical, published by the *Australian Journal of Clinical and Experimental Hypnosis*.

Eugene is currently supervising Lynda Dolan in her doctoral dissertation in his capacity as Emeritus Professor at the University of New England, N.S.W.

At the age of 90 he still offers some assistance to practising psychotherapists and hypnotherapists, both in the medical profession and allied health areas.

# HYPNOTHERAPEUTIC INTERVENTION INTO THE DEPTHS OF THE HUMAN MIND: THE ORIGINS OF INTERNAL TRAUMA AND ITS INFLUENCE UPON THE HUMAN BEING

Eugene Hlywa and Lynda Dolan

Clinical psychologists in private practice, Sydney

*The nature of trauma has been widely discussed, analysed and researched in the literature. In this conceptual paper the authors elaborate on the influences of external and internal traumas on the human being. The authors propose that internal trauma is fuelled by the spirituality of the human being, spirituality being defined as the human capacity for having ideals in life and striving or labouring in pursuit of them. Spiritual violation of the human being could be caused externally or internally. Externally caused spiritual violation or trauma could be dealt with through the possibility of the removal of external forces or stressor/s such as physical, socioeconomic, group or personal attacks. Internal trauma is much more complex to heal and requires skilled and concentrated effort for psychological professionals to uncover the genesis of the trauma, expose it and apply a healing analytical process. Internally caused spiritual violation or trauma is often hidden in the unconscious: It is frequently too threatening to the ego of the human being when it becomes actively and consciously visible or knowledgeable to the victim. The authors provide case studies and conclude that hypnoanalytic technique is an appropriate form of treatment in the psychotherapeutic management of internal trauma.*

Keywords: hypnotherapy, hypnosis, psychotherapy, internal trauma, case study.

It is natural for people to strive to discover themselves in their own environment. In such a process people uncover their *essence*, being their talents, potentials, and values, which form the core of their personal dynamics. Unfortunately, together with this they discover their weaknesses and internal traumas, which can have a direct or indirect influence on their life.

At the onset of this paper we want to accentuate that internal trauma has a lot to do with spirituality—with the inner voice which accompanies every sane human being. This occurs from the moment a person becomes self-aware and continues until their last breath. Such a voice is universal and reaches back to the very creation of the human being (Hlywa, 2006; Hlywa & Dolan, 2010; Jung, 1936, 1958a).

Furthermore, we have to appreciate that human beings face decision making every moment of their conscious life and are responsible for the quality of their decisions (Sartre, 1948, 1956). Van Kaam (1969a, 1969b) and Tillich (1952, 1953, 1954, 1955, 1958, 1959) pointed out that the benefit of a decision depends on the prevalence of values that human beings appreciate and adhere to. The Ukrainian philosopher, Hryhorii Skovoroda (1995) insisted that the pristine, authentic voice, is truly beneficial to human beings. This is the voice of the Creator, not the voice that is “stained by earthly dust.” By “staining” Skovoroda means the influence by earthly human institutions such as upbringing and brainwashing, as well as ideological, political and economic trends.

### **The Sources of Emanation of Internal Trauma**

When discussing internal trauma, we feel bound to explain the term “internal trauma” in depth. To do this, we must take into account that a student of psychology<sup>1</sup> may feel uncomfortable if they are accustomed to the notion that science deals with facts and events which can be qualitatively and quantitatively rearranged, changed and sorted. The student of psychology may even decide that such an approach to the investigation of the nature of the human being does not suit them as a scientist.

Skovoroda (1973) explained that it is impossible to grasp “in hand,” whatever is “within” a human being. It is invisible, but potentially exists always and everywhere—it is spiritual.

Since grey antiquity, historians of philosophy and psychology indicate that the psyche as a viable factor, which has no physical profile, dominates the thinking of those who have inquired about the essence of a person (Audi, 1996; Romenets, 1983; Russell, 1971).

In Europe, the student of psychology comes across such expressions as: self-ideal and self-real. A feeling of presence in the human mind is what stirs up self-actualization, self-growth, self-expression and other positive as well as negative traits. That internal concern, which is typical of human life, is defined by earlier investigators of the psyche as each person’s constant life anxiety.

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<sup>1</sup> Psychology defined here as the “the study of human behaviour.”

Without the psyche there would be no psychology, and at best, psychology would hold an “extra-marginal” (James, 1902, p. 223, in Jung, 1958b, p. 121) place among natural sciences and continue to exist only as a part of philosophy.

The philosophical trend of existentialism came to the assistance of psychologists in pursuing their exploration of human existence. Existentialists believed that addressing the question of the human essence was their main task, and the defining task of “authentic” existence. Skovoroda (1973) was one of the precursors of existentialism. Not only did he understand that the essence of the human being was their spirituality, but he also emphasized that theories and hypotheses are existentially valued only if validated by life experience.

A similar observation in studies on human spirituality was made by Adrian van Kaam (1975), who pointed out that human spirituality manifests itself in the person’s acts, through which the person labours to achieve value. He also pointed out that such activity could be noted and measured. Such measurement and observation meets the criteria of science.

Human essence is something so powerful that it lifts the human above their flesh, and leads towards the invisible and spiritual force, which possesses the world, and manifests itself especially powerfully within each individual person. It richly rewards the person’s worthy acts and harshly punishes the person’s immoral moves.

## **Psychotherapeutic Conceptualization and Management of Internal Trauma**

Trauma is defined as “a wound [or] mental instability due to shock” (Thatcher & McQueen, 1980, p. 890). The *Concise Oxford English Dictionary* defines trauma as “a deeply distressing experience ... emotional shock following a stressful event ... in medicine defined as physical injury.” According to that dictionary, the word “trauma” originates from the late seventeenth-century Greek, literally meaning “wound” (Soanes & Stevenson, 2009, p. 1534). Spiritually, any trauma may be considered as a brokenness or division lying within the heart of the person.

In this paper we distinguish internal from external trauma. We define internal trauma as that which emanates from the human collision within one’s own self and usually touches upon the person’s core values. External trauma is caused by external forces such as political, economic, legal, social and natural disasters, or attitudinal and other sources emanating from the person’s external environment.

The question of whether internal traumas are caused externally, if their genesis lay in the response to some event or situation, relates to the age-old question of “nature or nurture?” Skovoroda refers to such a situation as pollution by “earthly dust.” He points out that the Creator endowed the human being with a pristine human spirit that is injecting values into one’s psyche, which never collide with the absolute values and are always present to a human being and known as the Holy Spirit. Skovoroda’s views on the subject are contrary to the principles of British empiricists Locke and Hume, who proclaim that the human being is “tabula rasa” and that nothing exists in the human intellect without it having first existed in the senses—“nihil est in intellectu quod non prius fuerit in sensu.”

Once a person discovers the individual form of their trauma they must then look for the emanation or the origin of the trauma, and having made sure that a trauma originates from *external* factors the person can readily take adequate and appropriate steps towards help. In countries with a developed sense of social justice, such helpful steps are taken in the industrial, economic and social spheres and engage the quality of civil organizations, trade unions, and if necessary the justice system. It is very rare for such situations to require the intervention of a psychologist. According to Skovoroda (1973), each human being is born not as “tabula rasa” but is endowed with an inner voice, which guides the person through life. This inner voice is liable to be affected by external forces, upbringing, social, political and dogmatic institutions which may violate the pristine human values which have their origin according to Skovoroda in the Holy Spirit. This is more thoroughly outlined in the Holy Bible.

The question of “Does everyone carry trauma?” is answered in the affirmative in the Holy Bible, that points out that the only perfect entity is the creator Himself. Skovoroda says that the pristine human personality is free from any traumas but humans have the capacity to be influenced by “earthly dust,” meaning that the human being loses his pristine nature, thus traumatizing himself. This happens through the influence of upbringing, in a particular social and economic environment. The milieu of the person is capable of influencing the person to a great degree, thus the human being is capable of abandoning the inner voice. External influence has a capacity to precede internal trauma.

In practice, it appears that the centre of human life always evolves around the person’s relation with oneself and with close or distant environments. Heidegger (1982, 1996) refers to this as *Eigenwelt*, *Mitwelt* and *Umwelt*. It



appears that a person's relation to the world and to oneself is not always conscious or open. As such, it is not then available to one's own analyses, understanding and judgment. However, it remains very influential to the person's feelings, work, self-esteem, self-value and, as a result, to one's mental health.

Carl Gustav Jung (1936) has justly pointed to the role of the unconscious in this process, especially the powerful collective unconscious. He also remarked that the unconscious demands its presence to be recognized and dealt with appropriately, without ever attempting to convert it into the conscious. People coming from all parts of the world, suffering from internal trauma, have lost their connection with their religious foundations. Man is a spiritual entity. Modern man, according to Jung, disregards his spirituality, thus disregards his inner voice, or in our perspective the voice of the Holy Spirit.

Paul Tillich (1962) in his article "Existentialism and Psychotherapy" points out that a person is able to exist in a process of creation throughout one's whole life. The person positively "manifests" himself only when they have chosen *transcendental*, perfect, far-reaching goals, direction, specific meaning of identity, endurance and integrity. Naturally the person, as always, has their mind on absolute *human values*. According to Tillich, the absolute values originate from the creator, namely God, therefore the transcendental aim of the human being is to come as close as possible to one's creator. Thus spirituality is the main goal of the human being but since the human is free and capable of being influenced by earthly spheres, he/she thus injures his/her own pristine innocence and creates internal trauma. What is left for the human being is to conquer these difficulties and barriers in their earthly life. This is implicit in the Latin adage, "*per aspera ad astra*," meaning through thorny roads to the stars.

Skovoroda (1995) pointed out that, having failed to discover one's authenticity, the human being remains "blind in one's own house," because the person utilizes their own personality as a measurement tool with the help of which they assess their own surroundings. This statement by Skovoroda is based on the notion that the person's *inner-world* or "*inner person*" is invisible, and as such is not available to the five sensory organs. The five senses enable the scientific approach of human studies, which are particularly valued nowadays. We should not underestimate the achievements of science or scientific methodology; however, at the same time we should not remain silent regarding the *existence of the "inner person" because it is omnipresent within any living and sane human being.*

The person's inner-world is neither lethargic, nor passive, nor weak but in contrast it is dynamic, mighty and is able to elevate the person "towards heavens," far above one's physical abilities and strength. Every person is creative and possesses a God-like nature. The Creator requires from every person actions, creativity, beauty, goodness, love, justice, grace as well as protection of the human race and responsibility.

The abovementioned qualities are only a few of the requirements that the Creator expects people to fulfil. The Holy Bible lists far more requirements that are worthy of a person (Hlywa, 2013). However, many more such requirements are dictated by the person's inner voice—the Holy Spirit! Only then is the inner voice triumphant, when the person is *authentic*, when they follow the path that was laid by their Creator, or, in Skovoroda's words (in Bahalii, 1992), when a person follows a light that leads towards one's own harbour. One's own fulfilment in life offers just reward to a person in the form of happiness.

The voice of conscience never leaves a person, even for a moment. It remains with them even when the person, such as a thief, tries to hide from their inner-self and in such instances the voice of conscience "shouts loudly and harshly" demanding them to be on "the right pathway."

Living in a human society, we are fully aware that the reader can interpret the lines above as superfluous, unnecessary, alarming or premature. Therefore we feel it necessary to underline that they are very relevant and timely. Carl Gustav Jung (1917) has warned the world of the danger of a nuclear disaster, which can bring destruction to the Earth. With time, it has become clear that such an occurrence is a possible reality. It would take just one person who is "crazy enough" (and there are plenty of irresponsible people in the modern world) with access to nuclear weapons and the Earth would be burning.

It is assumed here that many somatic and mental illnesses have their origins in the spirituality of the human being. The prevalence of psychosomatic conditions including insomnia, migraine, neurodermatitis, colitis, obesity, cardiovascular inadequacies, and drug dependence indicate that mental illness has grown tremendously during the last century and is progressing rapidly. Nowadays, unfortunately, such conditions are prevalent in the economically secure population. Such situations can easily lead to disaster.

## **The Power of the Inner Voice: The McGregor Story**

Just to *highlight the power of the inner voice* we would like to cite a very recent and widely publicized case, without trying to interpret or evaluate it.

It is tremendously important to note that the phenomenon of “the internal power” is of colossal magnitude, capable of having profound influence on a human psyche, without being selective by way of gender, education, profession, social status, age and/or any other life factors. The case in question is from the top-ranking socioeconomic and educational spheres—from the National Defence Force. It is a well-established historical fact that the defence of the country has attracted some of the nation’s most capable people. Enormous attention and effort has been given to recruit and to train the most capable and brilliant people to the defence forces. Such is the case with its academy at Duntroon. Colonel McGregor is a respected senior officer who treats very seriously her own life and those of the citizens of her country.

On the day when these lines are written (07/07/2013), an ABC TV program *One Plus One* broadcast an interview with Colonel McGregor, who is “the right hand of a chief-commander of the Australian Army.” During the interview a very intelligent, logical, responsible and sophisticated lady calls herself by a woman’s name—“Katherine McGregor.” With great pietism, respect and love, Katherine related that her grandfather and father were outstanding and distinguished members of the Australian Army. Her father died when she was only nine years old. At that time she was of a *male gender*. Later on, she entered the Military Academy in Duntroon, where she spent 36 years, holding senior and influential posts. In addition, she possessed outstanding journalistic abilities, which deservedly earned her the award of the Order of Australia. Colonel McGregor was happily married to a woman for decades and spoke highly of her wife’s noble personality. Furthermore, McGregor said that her own life was enriched and complemented by their marital happiness.

Katherine McGregor said that throughout her life as a man, she was bothered by “mental and emotional restlessness” that rather often “deprived her of sleep.” She further indicated that she approached the relevant specialists and institutions for help. She stated that the neurologists, endocrinologist and psychiatrists she consulted were not able to offer her the help she needed and as a consequence she found herself on the verge of a profound internal conflict. In 2012 she made a decision to change her gender and informed the Chief of the Army. After listening to her story, part of which included offering

her resignation, which he refused to accept, he instead offered her proper understanding and support.

### **What is the Relevance of the Abovementioned Case to This Article on Internal Trauma?**

It is a clear example of a person who has been unable to find the genesis of their experience beyond the margins of self-consciousness. In the authors' model of internal trauma, much of her spiritual conflict is internal and covered by the unconscious. Such an experience is extremely potent and compulsively acts on the subject. It also has the capacity to overshadow reality.

In the temporal world, everything has a beginning and an end. This applies also to a person. As such, it is important to look for the *well of emanation* of the person's trauma state. We would not be at all surprised that, within the present scientific climate, while searching for reasons for the trauma, "the genes" are found to be responsible. Genetics, aided by computers and optical technologies, will try to find the genesis of such and similar states. Neurologists, endocrinologists and all the other "somatologists" are seeking answers to this very important question.

To begin with, Carl Gustav Jung (1960) detected *Anima* and *Animus* in the human psyche and this is probably a good place to start looking for "an internal human person." Being Skovoroda's (1973) loyal students, we believe that the beginning of internal trauma is the violation of the inside voice of a person; one's spirituality or mind. It often manifests itself with the help of "a light wave of air" (described by Skovoroda as "the human voice"), or some other means which cannot be clearly and logically identified (Chyzhevsky, 1946). Listening to Katherine McGregor's interview, it became clear to us that she does not know the cause of her condition, which is compulsive in nature and defies laws of natural reality.

A similar state was discussed by Plato (1974), who described it as the presence of "a wild beast" within the person, which cannot be eliminated, tamed or controlled. The "Unconscious" in human beings has often been deeply studied by students of psychology. Freud attributes all negative drives to the unconscious. However, Jung assigns a commendable role, especially to "the collective unconscious," which often finds solutions to important "mental and psychological problems." When asked what is the collective unconscious, Jung answered by saying that it is the human capacity to adhere to and utilize the wisdom of all ancestors. William James' reference to the unconscious is

implied in his terms “extra marginal” (James, 1902, p. 223, in Jung, 1958b, p. 121). Preceding Jung and James by many years, Skovoroda spoke of the “supra-conscious” [«над свідоме»]<sup>2</sup> (Skovoroda, 1973, in Hlywa, 2006) or the Holy Spirit that shines and shows a person the right way of life.

Please note that we avoid any criticism or analyses of Colonel McGregor in her male and female genders—we express joy about her survival in a very complicated, painful situation and furthermore about her courage and boldness to share publicly very painful and difficult personal experiences. Being consistent in our search of a person’s essence, we must say that Colonel McGregor, being sensitive and true to the voice of her conscience, to the voice of human feelings—which are described by Scripture as the Holy Spirit—followed the call of the two *Main Commandments of Love*. As a result, after half of her life, which she has lived as a man, she made a bodily transformation and became a woman. Together with the physical transformation, she embraced the feminine noble and gentle nature as well as the call for unconditional and unreserved love. Let us trust that, as a woman, Colonel McGregor has no cause for a conflict of feelings.

### **Pragmatic Intervention and Treatment Approach**

Discussing internal trauma, the main issues to be considered are its manifestations, consequences and treatment. Sharing our personal and professional experience, we would like this article to focus on the phenomenon, understanding and treatment of *internal trauma*. It is probably the most common type of trauma among humans, the most disturbing, annoying, reproachful and consistently persistent. Internal trauma comprehensively causes unbearable pain to the human psyche. In self-defence, the sufferer may come into therapy with psychosomatic illnesses, which protect them from insanity or even suicide. Such internal trauma has an erosive and vengeful nature.

When a trauma, even the most powerful one, is caused by *external factors*, its origins are different from *internal trauma*, and as a result it does not accompany its victim always and everywhere. The internal trauma never leaves an individual in any situation and remains with the person constantly and everywhere.

PTSD symptoms can be considered to be an expression of internal trauma. In accordance with the authors’ conceptualization of internal trauma, PTSD can be considered to be a violation of the voice of God within a human being.

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<sup>2</sup> Original phrase in Ukrainian

For example, a good honest brave soldier, who, upon receiving intelligence that a certain house contains enemy forces, bombards that house, and subsequently enters the house, discovering that he has killed several children and women. This may result in a typical case of PTSD linked to internal trauma.

Time, space and life circumstances very often play an important role in the treatment process. This is especially noticed during the use of hypnosis in psychotherapy procedures. In the minds of the trauma victims, external trauma very rarely “settles” in the unconscious. Therefore the patient’s history and the genesis of the illness are always useful in the relevant therapeutic process.

“Time cures the wound.”

Very often such trauma, with proper therapy, loses its destructive power in a relatively short time.

Another important point is that the *time* of the trauma’s genesis often plays an important role in the therapeutic process. For instance, if a person is traumatized recently, then it appears that they rarely have a need to find and use “defence mechanisms,” which become a compulsive habit. When trauma grows old, then, as a general rule, a destructive defence mechanism may develop that normally would require attention by a therapist.

It is undeniably important for a psychotherapist to have a certain concept of their patient. Without having the necessary concept of the patient’s essence, the therapist “blindly leads their patient.” Furthermore, very often, in such situations the therapist fails to achieve adequate and proper change, or even worse, may cause a fresh trauma.

### **Therapist’s Knowledge and Understanding of the Essence of the Human Being**

Paul Tillich (1962) shows that the essence, core and nature of a person are essential, important and necessary knowledge for a therapist, which, to some extent, authorizes them to take a responsible part in the treatment process of a person suffering from mental illness.

Therefore it is important to consider all investigations concerned with human essence, including those of the famous philosopher Hryhorii Skovoroda who stated: “discover the human being within yourself” (Skovoroda, 1995, in Hlywa, 2013, p. 357).

The complexity of the human essence becomes apparent from the very first pages of any book on personality theory. The reader will see that the history of studies concerning the human essence reaches into antiquity. It is

our opinion that as soon as self-consciousness dawned, the issue of human essence appeared.

Researchers of human nature include the best minds known to science, and among them there are existentialists and philosophers, who dedicate their work solely to the subject of human essence (Maksymenko, 2009).

Skovoroda points out that the books of the Holy Scriptures reveal human nature, including its spirituality. Centuries later, modern scholars of spirituality have also turned their attention to this notion. Adrian van Kaam (1975, pp. 347–369) even announced a new method of investigating spirituality, with the application of which he “opens a window” for studies of human spirituality and measuring of its intensity.

As part of the process of studying human nature, modern psychology, which zealously complies with the rules of natural sciences, has departed from philosophy and become a separate discipline. This discipline applies a method, which has extensively enriched the well of studies of the natural world. The intellectual world is entitled to be proud of its achievements and although it is clear that, unfortunately, not all its inventions are used for the benefit of humanity, still many inventions have improved human destiny.

“Discover human being in yourself”—to which the famous Skovoroda dedicated his whole hardworking life—is a rather ancient slogan, which appeared at the early age of mankind. The motto “*Nosce te ipsum!*”—“Know yourself”—was first perceived in the ancient world. It was imprinted on the front of the Delphi temple as evidence that humanity understood the meaning of self-knowledge even in that ancient time. Skovoroda adopted this slogan from the professors of the Kyiv academy. He considered that the main aim of self-actualization is to try one’s strength in practice. He thought that “experience is the father of art, knowledge and habit, from which all sciences, books and wisdom have flourished” (Hlywa, 2013, p. 219).

Every thinking person, especially in their old age, faces “*Nosce te ipsum!*” (Hlywa, 2013, pp. 53, 58, 219) and therefore philosophers have also dedicated a lot of work to the study of humans. We know that Socrates “was searching for a man” during the daytime with a candle in his hand. His philosophy was followed by Plato, Aristotle, Descartes, Rousseau, Augustine, Thomas Aquinas and thousands of others to this day.

British empiricists, including Hobbs and Locke, correctly pointed out that a person with the help of his sense organs is constantly in the process of forming a person throughout their whole life of self-awareness. However, their slogan:

“Nihil est in intellectu quod not apriori fuerit in sensu”<sup>3</sup> did not find any support among ontologists. Researchers, who style themselves as empiricists, who study the human essence, insist that the deep well of important and fundamental human life principles is hollow *at the beginning* of the journey (Aristotle’s “tabula rasa”), but that this well continues to be formed and filled with the data that is sent by sense organs up until the person’s last breath.

Psychologists face the importance and complexity of the issue of the person’s essence, in all its depth, because no science can offer a universal conception of a person. Perhaps this is the reason why seekers in the search for “truth” can be methodologically divided into naturalists, humanists and ontologists.

### **Naturalistic Approach**

The naturalistic approach in its search for human essence is based on the methods available to the natural sciences. Their reality is constricted by the information supplied by the sense organs, which can be measured in time and space. At the same time, internal experiences such as feelings, imagination, thinking and moral values are considered to be inferior and require checking with the help of sensory data.

The naturalistic approach comes down to empiricism—a trend in recognition theory which is opposed to rationalism and considers the sensory experience to be the only source and criterion of knowledge, diminishing the importance of logical analysis and theoretical generalizations. The level of knowledge in this process emerges via the analysis of direct observation data, which allows control of external influences, and at the same time makes the prediction of phenomena possible.

According to this method, thinking, concepts, ideas and inner feelings, are disregarded. Furthermore, when they are not supported empirically or by facts, they are considered to be errors or illusions.

The naturalists’ study methods are themselves an instrument of social evolution in the process of *survival and self-preservation*. Naturalistic accounts of human beings vehemently adhere to objective methods that strictly rely on data received by the five senses. The most consistent representatives of the naturalistic approach are probably Charles Darwin and B.F. Skinner.

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<sup>3</sup> Nothing is in the intellect of human beings that has not been previously perceived by the organs of perception



## **Humanistic Approach**

Humanists share the naturalists' belief that values, to some extent, derive from life experience and human nature. However, their views on human nature differ. Recognizing that a person can exceed his/her own biological capacity, humanists believe in human transcendence.<sup>4</sup> However, humanists do not accept God as a viable, fundamental and driving factor, but instead they put forward a theory of self-actualization. According to the theory, a person's self-realization occurs under the influence of wisdom of his/her body organs and physiological instincts.

It is necessary to emphasize that Skovoroda was one of the earlier philosophers who proposed the theory of the person's self-actualization (Khotkevych, 1921; Kostiuk, 1988). However, the major difference between Skovoroda's (1973) and humanists' theory is that the Ukrainian philosopher believed that a person reaches self-actualization only when he/she "discovers themselves," or in other words reveals the divinity within themselves—"neither flesh, nor perishable, nor garment, nor 'ashes,' but spirituality."

Humanists teach that a person's moral values are derived from human biological endowments. The person's self-actualization is stimulated by the natural tendency to grow and to be identified with integration, psychological health, individuation, creativity and productivity. Because the person acts in an effort to reach personal integration, spontaneous self-assertion and complete identity, he seeks to know the truth as opposed to acting blindly.

Humanists, as pointed out by Malcolm Jeeves (1968, 1976), ignore such well-known human features as aggression, destructiveness, hatred, selfishness, dominance, exploitation, crime and others. They recognize that with the power of memory, imagination, conscience, consciousness and intelligence that the person can rise above his/her biological or earthly nature. Therefore, a conflict is generated by antinomy, which is an integral part of the human essence. There exists an eternal struggle between material and ideal, between real and desired, between potential and actual.

There are views that the person's antinomian trends cannot be suppressed. They become the main source of the person's internal conflict. At the same time, they can be united by the power of love, which is a positive driving element even of biological evolution. Love saves the person from suicidal tendencies and feelings of loneliness. It strengthens and unites the community,

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<sup>4</sup> According to Immanuel Kant (1958), this knowledge is something beyond empirical consciousness and cognition. Thanks to his/her intuition, a person is able to apprehend the transcendental ideal—God; an ability of one's mind to know something without prior experience.

harmonizes contradictory tendencies within the person and enables his/her self-realization as well as acceptance of his/her environment.

### **Ontological Approach**

Ontologists reject naturalists' methods and views in the search for a foundation for human values. Philosophers and psychologists following an ontological approach include St Thomas Aquinas, St Augustine, Spinoza, Skovoroda, Kierkegaard and Adrian van Kaam. They seek to demonstrate that these values are derived from *the essence or the structure of being*. Jeeves (1976) indicates that a person has departed from himself/herself, that "Eidos (form or essence) cannot be grasped by pure observation and logical concepts, because it exists and manifests itself through an intuitively grasped image of the person's essence."

Idealistic understanding of human essence is the result of a rational process, which is close to, but not identical with, the empirical scientific method. "Eidos" is a part of the essential nature of existence. It is rooted in it. It has an objective, absolute and independent existence from natural and forming factors. It can be accepted by logical thinking and observation using ontological intuition and prudence—the faith that leads to being itself.

Ontologists believe that values are autonomous, because they are rooted in a human's essence and possess an imperative nature of moral right (Rousseau, 2002). Only the person's correct realization will lead them to an inherent knowledge of their nature, the nobility of which becomes the foundation of human values.

Skovoroda (1973) indicates that all known hypotheses are worthy of attention only when they are tested through life experience. The Ukrainian philosopher proves that even human intelligence, to which he gives an appropriate respect, is capable of making mistakes, while the voice of the Creator within the person is never wrong. This is the reason why Skovoroda differs from other researchers of the human's essence. Not only does he indicate that the person is happy when he can achieve self-realization, self-activation and self-expression, but he also argues that the Creator, through His everlasting voice within the person, serves as a guide in the person's life always and everywhere. According to scientific criteria it will take some time before any researcher of the human essence is able to positively complete this important task and unfailingly determine that essence, because, as postulated by Adrian van Kaam (1975), the human essence is an infinite depth.

The demarcation line between leading views on human nature is very clear. Nowadays Darwin's supporters, though in a very polite form, recognize that life is based on a struggle for survival: survival of the fittest or "homo homini lupus est" ("man is a wolf to man"). Supporters of the humanistic approach prefer to perceive a human as a noble creature; and are even willing to recognize the factor of love, though not in the biblical sense of *agape*, but often in a distorted form. The Bible states the two main commandments of love as follows:

"'Love the Lord your God with all your heart and with all your soul and with all your mind.' This is the first and greatest commandment. And the second is like it: 'Love your neighbour as yourself'" (Matthew 22:35–40).

These two main commandments of love are identified in other books of the Bible including Mark 12:28; Luke 20:40; I John 3:11 and II John 5. The phenomenon of love is also referred to in the Old Testament, for example in Deuteronomy 6:5 "Love the LORD your God with all your heart, with all your soul, and with all your strength."

However, that does not mean that the time that the psychotherapist spends with their patient is in vain. In order to avoid wandering in darkness, the therapist must have a prototype of a healthy and, at the same time, a frail human being. Their goal must reflect their patient's path and goal, because otherwise, unnecessary struggle will fail to bring about desired, healthy and appropriate progress. Psychotherapists should always keep in mind that they are neither teacher, nor coach, nor counsellor, nor doctor—but a person who is naturally gifted and trained to create appropriate conditions, in which his/her patient tests their personal relationship to the surrounding environment, to "the world" and to themselves, and being aware of the relevant responsibility, makes a decision.

People who eventually come to see a psychotherapist usually have previously received advice from family members, friends, pastors or doctors. Often they are prescribed medication appropriate to their condition. Logically, they expect and even demand "certain advice and help." As a result, they are often disappointed when the psychotherapist does not eradicate their ailments, sufferings and pain or does not answer their questions directly. Such patients' attitude towards their psychotherapist causes, or rather provokes them, to have uncertainty and doubts about the possibility of creating a positive psychotherapeutic relationship, which is the promoter of the curing process.

As was pointed out by Skovoroda, people are so accustomed to continuing institutional "control" that the concepts of free will and responsibility that

were gifted to human beings become alien to them. The jurisprudential institutions and governments usurped the rights and responsibilities that naturally belong only to each person individually. In Australia, even the closest marital relationships, as well as the relationship of parents to their children (and vice versa), are regulated by legal provisions.

The state administration, which is legally responsible for the citizens' life conditions, protection of their civil rights and obligations, must not and should not even dare to usurp responsibilities and privileges of individuals. This is because, having lost them, humans also lose their humanity and abandon the human privilege of free will and responsibility. The Creator gifted free will only to humans, and with that He gave them responsibility, which, unfortunately, is too often ignored in the human world.

The most important human responsibility, according to Skovoroda, is obedience to the voice within oneself, which is the voice of the Creator, the voice of conscience! The importance of the "Two Main Commandments of Love" must not be muted, but rather be a permanent "road-sign", pendulum and educator of the person during his/her whole life path.

Skovoroda appreciated the scientific approach to the study of the nature of human beings, but he differed from those who failed to recognize the prevalence of spirituality in human life, which according to him is the authentic, the original gift of the Creator and presented to humans to be regarded as the "Spiritual Rector" and adhered to throughout the path of life. Being a pragmatist, he recognizes that humans who become attracted to "earthly dust," such as power, fame, wealth, "palaces" and privileges, find they are in conflict with themselves and thus introduce chaos and destructiveness within themselves. They join a herd, which is not easy to abandon. A contradiction exists within each person between the ideal and real world, which not only depletes a person, but often leads him/her astray.

### **Examples of Internal Traumas in a Clinical Situation**

As we have already mentioned, Skovoroda, van Kaam and other researchers of the human essence indicate that only life experience is capable of testing the significance of theory and hypothesis. Our fundamental belief is that external trauma often heals with a change in environment and the flow of time. Furthermore, the absence of the factors which caused the trauma in the first place assures quick and steady recovery.

## **Account by Eugene Hlywa**

The first author, Eugene Hlywa (E.H.), relates the following story, which closely concerns the historical fate of the Ukrainian nation, to provide an example of the internal call that permeates and paves the path for the whole life span of an individual.

Several centuries of continuous destruction of Ukrainian national identity by the occupiers of Ukraine led to a point that Ukraine even disappeared from the political map of the world. I (E.H.) grew up in a patriotically conscientious family in which my father was a soldier during the first liberation movement and a member of the Ukrainian military organization. At an early age I joined the Youth division of Organization of Ukrainian Nationalists, the aim of which was a revival of the sovereign Ukrainian state. Thereafter, I underwent a secret service training course, after which I was “planted into” the Nazi army in order to learn their methods and means of their fight against liberation nationalist movements, as well as to obtain weapons and other things needed by the Ukrainian Insurgents Army (UIA).

There I was fortunate to see at first hand where the German troops hid their missiles, with which they terrorized London. With that secret information I was returning to UIA when Gestapo agents took me as a prisoner. I was subjected to all the tortures that the Third Reich applied to their prisoners in gaols and concentration camps, which were very severe due to their suspicion of me being involved in “espionage.” Without giving a detailed account of the tortures that were inflicted on me, I wish to assure the reader that they were horrible, painful and inhumane. They were extreme and daily *external traumas*.

Half a year after leaving the concentration camp I was restored physically and mentally. “I felt great.” Some years later, when I was a student of law and economics, I unexpectedly met the Gestapo officer who interrogated me in the Cracow prison Montelupich. He could not believe that I was not going to report him to the U.S. military authorities, and therefore he lived under constant fear of judicial punishment. In addition to that, he had the relentless and weighty reproaches of his own conscience. He told me about that in detail a decade after interrogating me in Cracow prison.

*“Man awake!” – appeals Skovoroda.*

During dozens of years of my practice as a psychotherapist I encountered hundreds of patients with traumas caused by *internal conflicts* that were often covered with the dust of time, psychosomatic illnesses, “defence mechanisms” and the “unconscious.” A number of them were related to external traumas in order to bring “spiritual relief.”

The reader can become acquainted with examples of our clinical cases during our seminars and workshops; some of them are included in a “Clinical Collection” which will be published in the near future. However, a few clinical cases, which have already been published in professional journals, are cited below.

### **Case of a Boy with Rheumatoid Arthritis (E.H.)**

In the 1950s, a physician-rheumatologist asked me that I, with the help of hypnosis, assist a 13-year-old young man to control his pain which was caused by rheumatoid arthritis. The patient’s prognosis at his age was very bad. At best, he faced an addiction to painkillers, with limited educational prospects and even the threat of a very short life span. In addition to pain, the patient’s body was deformed, which evoked in me “human compassion” and even some special sympathy. As a psychologist, I treat “a person” as opposed to “an illness”; however, being specifically tasked by the rheumatologist and patient, I could not ignore their wishes.

Children especially are often capable of quickly going into a deep trance. My first session with him confirmed that he was a “somnambulist.” Working around the possibility of disturbing the causes of his trauma, which may have caused him to abreact too soon in the therapeutic process, we had quite long conversations, from which I learned certain things about his life. However, most importantly we sealed the perfect psychotherapeutic relationship. I really felt that he wanted to see me as soon and as often as possible.

I faced very important and dangerous possibilities, which required serious consideration:

1. A premature rejection of the defence mechanism (characteristic pain of rheumatoid illness) in a traumatized person can cause psychosis or other, even more serious, mental disturbance; and
2. Very negative consequences, in the case when the patient is unable to perform his post-hypnotic suggestions. The patient may then experience a feeling of guilt before his psychotherapist for not being able to perform something that he does not even have awareness of. We must remember that a classic somnambulist has spontaneous and complete amnesia about everything that happens in a trance.

During the following session I decided to prepare him for the treatment process. I taught him how to place himself into and bring himself out of a deep trance during which he would be open to a suggestion that hypnotic

interventions have curative effects, and that he would not feel the fingers of his right hand, a technique known as “glove anaesthesia” which he mastered quickly.

In the following sessions I taught him how to take away pain from certain parts of his body, using his numb hand, while allowing the rest of his body parts to remain in a certain degree of tolerable pain. During our further sessions he, in a childlike way, without expressing himself verbally, showed me his abilities of self-hypnosis and self-treatment procedure. He proudly showed me his capability for controlling pain. I must admit that his progress was a pleasant and unexpectedly early surprise. I could see that he developed a strong attachment to me, always tried to get ahead and requested to have his next sessions as soon as possible.

During one of our intensive hypnotherapeutic sessions, while he was in trance, I dared to suggest him that he “is capable of discovering and understanding the cause of his illness” and that he will gladly share with me his findings. Later, when we spoke on the phone, he demanded to see me as soon as possible, and began to say that he had something to tell, but he wanted to talk to me in person. Expecting a possible revelation of the genesis of his trauma, I offered him the opportunity to share his thoughts with me while he was in a trance, to which he agreed. During his next session he started weeping and shouting “No ... No ... It was not me ...”

During abreaction, with strong emotions he re-lived a tragic episode from his life when, after swimming, he returned home without his younger brother. After the police informed his mother that his younger brother drowned, his mother said in tears “You drowned him.” That reproach—“You drowned him”—became the young man’s internal spiritual trauma, and the rheumatoid arthritis served him as defence mechanism against the terrible feelings of guilt.

Following appropriate treatment for elimination of severe pain as requested by the referring physician, I expected that the patient, through the appropriate process, would discover the genesis of guilt. Therefore, I suggested to him that when he felt that there is something puzzling to discuss he would ring me and come in to see me. Expecting that he would discover his traumatic experience, I suggested to him that we would have a discussion in hypnotic trance, exclusive to us. So in a follow-up session he hypnotized himself and in the process of abreaction he revealed that he felt guilty for drowning his brother. This process of induced and spontaneous abreaction has been described in Hlywa (2008). Today, the man in question is completely healthy and strong and has five grandchildren.

My next clinical case is typical of internal mental traumas. This case was previously published as “Hysterical Blindness” (Hlywa, 2008).

A very pleasant 40-year-old woman, mother of three children, suddenly lost her sight and was blind for eight months. At that stage she was treated in the university optical hospital by psychiatrists who contacted me regarding hypnotherapeutic intervention. My wife (who had a medical degree and protected my professional position) pleaded with me not to take that case, because if the best specialists in Australia could not cure the woman then I had no chance of saving her. The psychiatrists assured me that I had nothing to risk, and as a result her husband and son brought her to me.

It was an ordinary local family. The husband worked for the railway. He was an active Catholic and his whole parish prayed for the success of her treatment. The husband told me that she had previously undergone various medical tests and examinations. He told psychiatrists everything he knew, heard and thought. He constantly reassured me that his wife could not have done anything bad to deserve “such a severe punishment.”

Expecting that she might have had a severe internal trauma, I was preparing her for a hypnoanalytical procedure, which is why I conducted a close to two-hour session, placing her into and then deepening the trance. She was ready for a deep trance with the help of agreed signals and I proceeded to conduct the analysis as follows:

For extra care I decided to use the technique of automatic writing, which excludes the subject’s sense of personal responsibility. Among a number of personally neutral questions I asked: “can a hand write what caused the blindness?” and the hand wrote: “death.”

Except for some successful funeral homes in America and Australia, death brings joy to no one and furthermore it brings fear and anxiety to practitioners. Knowing that there was no death in her family, I continued asking “the hand”: “whose death?” The answer was “Peter’s” (the patient’s son). Later I discovered that my patient’s son, Peter, complained that he suffered from back pain. The orthopaedic surgeon ruled out any disorders with the boy’s skeleton, and referred him to a urologist, who prescribed certain pathology tests. The mother was to learn the results from the appropriate specialist on the appointed day.

She arrived at the hospital to consult the specialist earlier than her scheduled appointment, and was very nervous. This was noticed by a young doctor who asked her whether he could help. Here, an iatrogenic artefact, which unfortunately is a frequent phenomenon in Australia, took place. The doctor



retrieved Peter's medical file and with a serious concerned facial expression asked the woman about her son's illness. At that moment she felt that there could be a serious threat to her son's health. A minute later the urologist came in, and in a few words told her that Peter was well. She went home and on the next day suddenly lost her vision.

During the abreaction, my patient, sobbing, repeated: "I cannot see Peter die!" The question was: "When, how and why did she start to experience fear about her son's death?" Here I turned to Carl Rogers' personality theory, which I know quite well. According to Rogers (1951), a person's organism has an ability to intuitively feel threatened, and spontaneously react to the threat defensively, even when there is no objective evidence of an imminent threat.

In some way an experience could be recognized as threatening and prevented from entering awareness, without the person ever having been conscious of it, even momentarily... This type of finding appears to support our clinical and theoretical hypothesis that the individual may deny experiences to awareness without ever having been conscious of them. (Rogers, 1951, pp. 506–507)

As therapists we should realize that whatever a therapist thinks or knows does not equal his/her patient's thoughts or knowledge. Therefore I had to spend quite some time encouraging the patient to confront the specialist's opinion with an opinion of a young doctor. During protracted sessions with this patient, lasting several hours, the patient became aware that she feared the death of her son to the degree that she expressed by saying "I cannot see Peter dying." She then accepted that her inference required revision. After several confrontations in therapy, while reliving her experience in the hospital, and the present conditions of her son, she became aware that she had been fighting the unconscious inference that her son's life was under threat. Her faith (being a dedicated Catholic) and the prayers of her whole congregation for the restoration of her sight strengthened her hope that her son was going to live. The confrontation led her to the "realization" that she understood the young doctor, as the one who predicted a serious illness or even death of her son. She did not blame the doctor or her son for her illness. She and her family relied on faith and hope that her sight would return. During her sessions I encouraged and strengthened her faith and hope.

Some months after the abreaction and hypnoanalytical procedures, whilst her husband was away, she noticed that she could distinguish darkness from the light. She tested this by opening the doors and noticing the road. Because her house was some 200 metres away from my surgery, she entered the surgery

hysterically yelling that she could see. Naturally the atrophy, due to blindness for many months, prevented her from seeing clearly, but several months later she regained her sight completely.

## Conclusion

Longitudinal research strongly suggests that traumatic injuries are prevalent sources of damage to the human psyche, which eventually requires psychotherapeutic intervention. When dealing with traumatic experiences one should differentiate between external and internal trauma. External trauma is quicker and easier to treat and can often be positively addressed without psychotherapeutic intervention. Internal trauma is always and everywhere with the person and has profound and perpetual influence on the patient. In its essence internal trauma is spiritual in nature and unconscious to the patient. Therefore skilful hypnoanalytic technique is an appropriate form of treatment.

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## GUIDELINES FOR THE USE OF HYPNOSIS: WHEN TO USE HYPNOSIS AND WHEN NOT TO USE

Wendy-Louise Walker

Retired clinical and forensic psychologist, Sydney

*This paper sets out the guidelines for the use of hypnosis as successfully used by an experienced clinician for several decades. It was originally based in detail on the DSM-IV and in revision those general disorder headings were retained.*

Keywords: hypnosis, contraindications, guidelines, stress management.

In 2002 I conducted a training session for the Australian Society of Hypnosis entitled Patterns of Psychopathology and Relevance for the Use of Hypnosis in Treatment. It was essentially about when I use hypnosis with clients and when I do not—the contraindications about which very little is formally written. I did, however, make reference to this in an articles for *AJCEH* in May 2008.

As foundation President of the NSW Psychologists Registration Board I have always been especially mindful of our ethical principle of “do no harm” and hypnosis is a potentially harmful adjunct treatment. As I reflect now as a retired clinician with some decades of experience, I am thankful that I was careful, conservative and cautious as I was in my use of hypnosis. I never had a patient experience an abreaction in my clinical work and I am not aware of any of them having subsequently committed suicide.

So I have reworked my initial presentation which originally was based on the old DSM-IV which of course is no longer current. However, I have kept the original disorder headings which are still useful. I offer this as an exposition of how I have done hypnosis as this may be of benefit to some of you, especially students and those new to hypnosis. Thus what follows is a summary of how I have operated—my personal guidelines for the safe use of hypnosis.

## INTRODUCTORY COMMENTS

To use hypnosis with some creativity and common sense, one needs to be aware of what is going wrong with the patient (is his/her suffering a product of personal psychopathology or largely of outside pressures?) As I have said on many occasions, before one rushes in gung-ho with the use of hypnosis, one should spend the time working out what seems to be wrong and whether the use of hypnosis is appropriate. Remember, hypnosis is a way of manipulating consciousness and communicating, it is not a treatment modality in its own right and there are real contraindications to its use.

For the latter, one has to protect the client and (quite importantly) oneself in this increasingly litigious world. People come for help when they are feeling some persistent discomfort, worry or suffering. Hypnosis can help some, not change others, and can make a small subgroup worse.

Throughout its history, there has always been controversy about hypnosis (with its overtones of magic) and it has always attracted some experts with somewhat bloated egos (from good old Anton Mesmer on!) On learning what you have to offer your clients, beware of taking on unquestioningly (almost as a religious faith) the assertions of any expert who overemphasizes the almost universal effectiveness of any one technique or approach, or who brushes aside the increasing data bank of research data in the area (e.g., differences in hypnotic responsiveness). No technique is universally applicable and there are certainly persons with whom one should not use hypnosis. There are persons (e.g., those who are suffering an episode of Major Depression) who should be sent for psychiatric assessment and primary treatment, though the use of hypnosis later may be quite appropriate.

## AN OVERVIEW OF PSYCHOPATHOLOGY

Humans are shaped by an infinitely complex interaction between their genetics and their life experiences. I have no doubt that, over the last hundred years, we have grossly underestimated the role of inheritance (the “hard disk” of the brain) and overestimated the role of learning. For example, from psychoanalytic thought came the grim notion of the “schizophrenogenic mother,” that ambivalent, cold mother whose bleak parenting produced schizophrenia. I would not dare estimate the suffering this caused the wretched mothers of schizophrenics (but I do note the pervasive sexism, schizophrenogenic *mother* not *father*). Schizophrenia, in those genetically predisposed, may be triggered by stress and, these days, by the use of drugs, but maternal ambivalence has

not emerged as a risk factor in the literature.<sup>1</sup> Schizophrenia may, of course, just happen in a predisposed individual living in a pleasant and gentle family.

## COMMENTS ON SOME DISORDERS

### **Mental Retardation**

Hypnotic responsiveness is positively correlated with intelligence. While moving to music, singing and other components of relaxation/fun are appropriate, hypnosis is not.

### **Learning Disorders**

Hypnosis may or may not have any relevance. However, any work done would require specialized expertise by the hypnotist to work in the area without using hypnosis.

### **Motor Skills Disorder**

Again, hypnosis would only be used by someone who already has specialized expertise in the area. A qualification in hypnosis does not allow one to treat anything at all. Remember our old adage, do not treat *with* hypnosis what you cannot treat *without* it.

### **Communications Disorders**

The same holds. A person already expert in communication disorders may have limited use for hypnosis for lowering anxiety, for example, in stuttering.

### **Pervasive Developmental Disorders**

Hypnosis is not relevant or appropriate.

### **Attention-Deficit and Disruptive Behaviour Disorders**

Hypnosis may or may not have a limited role in the treatment of (predominantly young) sufferers of these disorders, but treatment should be carried out by an expert, or in collaboration with someone who is an expert.

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<sup>1</sup> However, I might speculate that having a schizophrenic offspring would certainly produce ambivalence in parents, as such offspring are difficult to connect with. One is reminded of the old issue of correlation and causality.

## **Feeding and Eating Disorders of Infancy or Early Childhood**

Hypnosis is obviously not relevant here.

## **TIC Disorders**

Hypnosis may or may not be relevant or useful, if used; it should be done in collaboration with medical experts.

## **Elimination Disorders**

Hypnosis may or may not be relevant; treatment would likely be done in collaboration with medical experts.

## **Other Disorders of Infancy, Childhood and Adolescence, Separation Anxiety Disorder**

Hypnosis may be relevant depending on expertise. With Selective Mutism and likewise Stereotyped Movement Disorder, it may be relevant if you also have the appropriate expertise to treat without hypnosis.

## **Delirium, Dementia and Amnesic and Other Cognitive Disorders**

Hypnosis is not relevant; it depends on a properly working brain.

## **Dementia**

Hypnosis depends on a properly working brain and cannot be produced in demented people. It may be that components of the hypnotic ritual (repeated comforting suggestions, with music perhaps) could be useful; hypnosis is not possible in my view.

## **Mental Disorders Due to a General Medical Condition Relating to Alcohol, Amphetamine, Caffeine, Cannabis, Cocaine, Hallucinogens, Inhalants, Nicotine, Opioid, Sedative, Hypnotic or Anxiolytic Use, Other or Unknown Substance-Induced Disorders**

In general, with this group, while hypnosis may have a role in the later rehabilitation of an individual, during the acute stage of substance abuse or withdrawal it cannot be produced.



## **Schizophrenia and Other Psychotic Disorders**

My advice is do not use hypnosis with psychotic people; I will not use hypnosis with people who *have been* psychotic. Psychosis involves huge distortion of reality, with lack of differentiation between one's own thoughts and external reality, flawed logical thinking and poor attribution of causality. Hypnosis blurs the boundaries of external reality; if someone has (even latent) paranoid tendencies, hypnosis is the way par excellence to foster the attribution of evil intent, undue control and a host of malevolent motives onto YOU THE THERAPIST. Even if the patient is not overly psychotic but has strong paranoid tendencies, I avoid the use of hypnosis for my own protection, safety and peace of mind. There are plenty of other techniques which do not foster fantasies or illusions/delusions of control by someone else.

## **Depressive Disorders**

When a patient is suffering a Major Depressive Episode, THE USE OF HYPNOSIS IS NOT APPROPRIATE. I heard recently from a colleague that a patient had committed suicide after a psychologist had done a session of hypnosis; this had followed attendance at a workshop given by an international figure who asserted that hypnosis could be used with any kind of depression. My view is that this is not the case. Major depression is a serious and life-threatening illness; thought processes and bodily functions are affected. One identified risk with the use of hypnosis is a short-term lifting of mood which can energize the patient just enough for him or her to get the energy to commit suicide. We can never be sure in an individual situation whether the session of hypnosis beforehand contributes to a suicide, but I was always prepared to testify in court as an expert witness that use of hypnosis in such situations is inappropriate. My advice is do not take the risk.

When a person has recovered from an episode of Major Depression, use of hypnosis is not precluded—as long as you have the proper training and experience! There may be a place for methods such as hypnosis in the treatment of people with Dysthymic Disorder, but again proper training, experience and expertise are relevant. One can work in collaboration with a treating psychiatrist. People suffering from this disorder may also suffer episodes of major depression and some diagnostic sophistication is needed in the treating professionals. I have used hypnosis with persons suffering this disorder, both early and late onset, in all cases in collaboration with treating psychiatrists. My focus has been on producing peaceful, pleasant and loving

feelings regularly (by training in self-hypnosis with the right kind of music) and self-hypnosis with the right kinds of self-talk, in the context of long-term and supportive therapeutic relationships (visits not frequent but the bond with me maintained for active support when needed). However, remember that I worked for 10 years in the Department of Psychiatry at the University of Sydney with Professor David Maddison as head of department, worked as an honorary psychologist in his Professorial Unit at the Royal Prince Alfred Hospital and attended clinical meetings and professorial rounds. Further, depression and bereavements were research foci for me.

### **Bipolar Disorders**

It is more relevant to look to family inheritance than family dynamics in understanding bipolar disorders. Modern medication makes a solid contribution to the management, especially in the absence of substance abuse (which is tragically common, especially, I have observed, in bipolar young males). Hypnosis is not of high relevance in the treatment of bipolar persons, who should have expert psychiatric treatment to maintain the most productive and pleasant lifestyle. Bipolar people live on an emotional roller coaster, and may become psychotic during both depressive and manic episodes. They are also often very bright and very creative (some of the great creative artists have been bipolar). As they may wander in and out of psychosis with the manic and depressive episodes, I do not choose hypnosis as part of their supportive therapy. Coming to understand and manage their condition with the best possible insight and grace is my goal with such people.

### **Anxiety Disorders**

This is where hypnosis really comes into its own!

Anxiety is one of the range of normal human emotions and, as I used to tell my medical students, if we did not have anxiety we would probably not survive. If we did survive we would be rather slothful, I suspect. It is excessive and inappropriate anxiety that plagues our population and it is in the treatment of anxiety in appropriately hypnotizable patients that we have a real field day with hypnosis.

After proper patient assessment, people suffering anxiety/panic based disorders can be (if willing, hypnotizable and otherwise suitable for hypnosis) treated effectively and often surprisingly quickly with imaginative use of hypnosis. In general, my own pattern is learning to go into hypnosis, learning

in hypnosis to experience strong emotion and then to simply drop it, then to experience graded levels of anxiety in hypnosis and to drop those, until actual panic is produced and then dropped. I then used graded exposure to the imagined feared situation/object. Often my emotion-dropping technique is very simple, to say to self (as I say during hypnotic induction and deepening) “breathe out, relax and let go”... and after all the practice going into hypnosis, this commonly works like a charm. The notion is not of fighting anxiety/panic but of dropping it; just letting it drain out of the body as you breathe out, leaving the mind still and clear. If it takes a few breaths out, so what? The good thing about hypnosis: (a) the active “dropping” of negative feelings as you breathe out, which means that it is OK to start to feel excessive fear because you know you can drop it (this stops that horrific spiral of fear of fear); (b) the skills are learned reasonably quickly by good to excellent subjects and there is a positive correlation between panic disorder and hypnotizability; and (c) instead of the rigours of in vivo practice, most fear-producing situations can be faced, experienced and coped with in the comfort of my room. It is very rare for me to traipse about with patients for in vivo practice, but my patients do very well!

People always need more than just hypnosis. They need education, problem-solving, support, modifications of self-concept, relationships, whatever. This can be done in the waking state or in hypnosis. Of course, duration and severity of the disorder and adequacy of personality are important factors in determining outcome. There is no magic. I find that the use of benzodiazepines really dulls the experience of hypnosis whereas antidepressants do not seem to have this effect. I have simply noticed this—that is, a hypothesis not a research finding.

### **Obsessive Compulsive Disorder**

It almost certainly has an inherited component (certain kinds of brains “circle” in this way). I have commonly found that I need to work in liaison with a psychiatrist and that certain antidepressants are very useful. Hypnosis has a role in treatment but often for me does not work until the antidepressant cuts in. I found the cognitive-behavioural literature useful in shaping hypnotic techniques for OCD.

### **Post-Traumatic Stress Disorder**

I find hypnosis most appropriate with PTSD but do not use it immediately. I have had wide experience with PTSD with stressed-out and bashed-up police

officers. I used to do a lot of work in the waking state and use hypnosis and music with the instruction that “as the bright music, your moving pathway of sound, carries you further and further into hypnosis, something rather marvellous happens. In the brightness and grace of the music, little bits of the emotional traumas from your traumas are dislodged and washed away, like dust swept away in bright running water...” With words like that some very interesting experiences begin to happen. Unlike EMDR (which reminds me a bit of a crosscut saw through the mind), this kind of approach is not invasive but it is cumulative. At the same time, I built up suggestions of feelings to the music of love, joy and involvement—especially love. And there is the casual suggestion that what is experienced in hypnosis—the joy, the love, the serenity, (sometimes to pieces of J.S. Bach) the glory—will quietly and cumulatively affect the quality of experience in everyday life ...

### **Acute Stress Disorder**

With due care for appropriateness and risk, hypnosis has a role in the expert treatment of this disorder.

### **Generalized Anxiety Disorder**

Likewise with this disorder, as long as you know what you are doing, have proper goals and do not push your patient too fast or foster unrealistic goals.

### **Other Anxiety Disorders (What Used to be NOS)**

Again, it depends on the persona and his/her personality, history and characteristics. If hypnosis is appropriate, it may be very successful. Increasingly I use hypnosis to music and hypnosis with suggested imagery, while I use the “breathe out and let go, let all the stress and tension drain out of your body like a wave receding down a beach” during induction and deepening to be used a bit later as my general, multipurpose anxiety/anger/misery dropper.

### **Somatoform Disorders**

These disorders, varying with individuals, may be appropriate for treatment with hypnosis. You need diagnostic expertise and expertise with hypnosis for this challenge.

## **Dissociative Disorders**

Dissociation being one of the mechanisms underlying the experience of hypnosis, hypnosis is often a central treatment modality for these patients. *HOWEVER*, the old wisdom remains—do not treat *with* hypnosis what you cannot treat *without* hypnosis. Dissociative disorders generally involve huge distortions of reality and are significant mental disorders.

## **Sexual Dysfunction Due to a General Medical Condition**

There is use for hypnosis in the area of sexual dysfunction, especially in managing anxiety and self-misperception areas.

## **Paraphilias**

There is a role for hypnosis in the treatment of these disorders *if you have the required expertise*.

## **Gender Identity Disorders**

If you have the necessary expertise without hypnosis, there is a role for hypnosis here.

## **Sleep Disorders**

There is a variable role for hypnosis in this area. Again you need to know *what you are trying to do and why*.

## **Impulse Control Disorders**

There can be a significant (though not magical) role for hypnosis in the acquisition of self-control skills needed to combat these disorders. Careful assessment and monitoring are required. These disorders are often related to criminality.

## **Adjustment Disorders**

In the past, these came under different classifications such as “reactive depression” or “nervous breakdown.”

There is variable utility for hypnosis here. However, it can certainly be applied to the anxiety component. Again, be careful with “reactive” depression. It is not only people with mood disorders who suicide. Do not use quick-fix

methods with people who are seriously depressed. Be cautious, supportive and carry out proper assessment. I have had considerable experience with depression in the context of adjustment disorders and PTSD in stressed and bashed-up police officers. Because of ready access to their handguns, suicide is a very significant risk (the statistics for New South Wales are not readily accessible but I am sure considerably more of our police officers die from suicide than in the course of their work).

### **Personality Disorders**

These are serious, long-term disorders of the structure of personality. Hypnosis has its place but not as a quick fix, rather as a treatment modality incorporated into longish term, “reconstructive” psychotherapy. For example: for anxiety management, for exploring and rehearsing more functional ways of responding, for exploring imaginative involvement sources of joy and love. Hypnosis, I have found, can greatly speed up “reconstructive” psychotherapy *where appropriate*. In general, remember to protect yourself as well. *Be very careful and generally do NOT use hypnosis with Paranoid or Antisocial*. Be careful with Borderline, Narcissistic and Dependent personality disorders.

### **Psychological Factors Affecting Medical Conditions**

There is a significant role for hypnosis in modifying symptoms, traits, patterns of behaviour and responding that affect medical conditions. Collaborate with treating medical practitioners.

### **Medication Induced Movement Disorders**

Medical expertise is required here, not hypnosis!

### **Relational Problems**

Hypnosis may have a limited role for acquisition of coping skills, controls etc. or for fostering a different perception of self and others.

### **Problems Relating to Abuse or Neglect**

Hypnosis may or may not have a limited role in treatment; expertise required.

## **SOME FURTHER THOUGHTS FOR THE CLINICIAN**

### **The Concepts of Stress and Coping**

The stress literature is a very useful framework in working with patients. Many of those coming for help are not “psychiatric” and do not fit into DSM classifications. They are ordinary people having difficulty in coping in a demanding and unpredictable world. Coping skills are not something we are born with, they are learned and it is very heartening that, if our parents did not foster them, our counsellor/therapist can! We are exposed to stressors throughout life. The notion of *stress* is rather too general, the notion of a simple, non-specific adaptation, but it is USEFUL to conceptualize the total strain on an individual’s coping. It is important to have one’s own *check list* and to remember that all the systems (the demands on an individual) interact.

### **“Physical” Stressors**

Illness, injury, fatigue, overload.

### **“Psychological” Stressors**

Anxiety.

Conflict—within the self, feelings, roles and motives, with others.

### **“External” Stressors**

Demands and needs of others.

Expectancies of others.

Bereavement, loss.

Failure.

### **Get an Understanding of the Lifestyle**

1. MARRIAGE/PARTNERSHIP, support, love, conflict, demands.
2. CHILDREN AND PARENTING, success and failure, joy and worry, problem areas.
3. WORK, satisfaction/dissatisfaction, demands/conflicts, sense of future, commitment.
4. LEISURE, is it adequate for the individual, is there need for development of more leisure skills?

5. LIFESTYLE, an individual balance between 1, 2, 3 and 4.

If stress seems to be a problem, check for: health, nutrition, substance use/abuse, exercise, major conflicts, other major stressors, areas that can be modified.

### **Coping Skills Can be Learned and Fostered**

Never doubt the impact of encouragement or the fact that something can be done.

Hypnosis provides an ideal medium to teach relaxation and anxiety-lowering skills. It also provides the opportunity for rapid, subjectively real practising of the skills of coping. The person can experience vividly feeling overwhelmed and then putting into practice the skills of coping which include:

1. A problem-solving approach, when overwhelmed making a list of what must be done, setting priorities, tackling tasks one at a time, delegating to available others.
2. Reassuring self about self-value, self-esteem; positive and sensible self-talk.
3. Developing good will and trust in relations and adequate communication skills, including adequate assertiveness and anger management. Hypnosis can be an excellent medium for acquisition of these.
4. Keeping in touch with one's own feelings. Hypnosis again is an excellent medium for developing self-awareness as well as self-acceptance.
5. Know one's own limits, realistic expectancies of self. This can be developed both in waking counselling and in rehearsal in hypnosis. Being able to pace oneself is one of the great skills of living.
6. A feeling of inner locus of control, being "captain of one's own ship." Different patterns of upbringing doubtless influence this, as does being born dominant or submissive, but any adult has to develop a certain sense of individuality and control; hypnosis provides a very flexible and creative medium to develop this quickly in those on whom life has trampled harshly, or even those who are born somewhat submissive.

### **Some Ideas on Stress Management, the Job of Your Patient With You as Coach**

Agree on a realistic plan which you can jointly modify. For example:

#### **Feelings**

- Resolution of conflict.
- Anxiety management (hypnosis, relaxation, drugs if necessary in the short term).



- Depression (depends on severity, psychiatrist, drugs, behavioural techniques, hypnosis possibly).
- Boredom, planning, time management, development of leisure life.
- Overload, cognitive strategies, plans, priority, and adequate leisure.
- Plus, of course, exercise, nutrition, play as well as work. Realistic guidelines on substance use, for example, alcohol.

### **Body Chemistry**

- Chemical or behavioural, other experts needed?

### **Habits to be Modified**

- Identify these, then change, hypnosis useful, as is the sense of collaborative problem-solving.
- Use hypnotically learned techniques.
- Self-monitoring.
- Positive self-talk.
- Encouragement.

### **Demands and Commitments and Reactions of Others**

- Patient can change patterns of response.
- Patient can negotiate change in others.
- *You* can jointly counsel others or counsel others alone.

### **The Benefits of an Overtly Problem-Solving Approach**

This approach, when absorbed by the patient, is transferred to life in general *and it works!* It gives a firm basis for development of self-esteem and competence. It is also interesting; it turns the sense of being overwhelmed by stress, anxiety and tension into a challenge to be solved. Increasingly over the decades I am impressed with the notion of education as a major component of effective therapy. And, of course, wherever possible, therapy should be interesting and enjoyable—*fun!* Why not?

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# THE USE OF HYPNOSIS AS AN ADJUNCT TO COGNITIVE-BEHAVIOURAL THERAPY IN THE TREATMENT OF A 10-YEAR-OLD BOY EXPERIENCING SLEEP DISTURBANCE AND CHRONIC FATIGUE SYNDROME

Stephen J. Hayes

Child psychologist, Victoria

*This case study describes the use of hypnosis in the treatment of a 10-year-old boy suffering sleep disturbance, severe migraine, and chronic fatigue syndrome. It demonstrates the effectiveness of hypnosis as an adjunct to cognitive-behavioural therapy in the treatment of a paediatric patient who was experiencing social isolation and depressed mood due to restricted activity (as a result of his chronic ill health). Initial CBT and hypnotherapy were aimed at improving the duration and quality of his sleep, in order to improve mood and overall levels of wellbeing. This then allowed the issues of social isolation and restricted activity to be addressed in therapy.*

Keywords: hypnosis, cognitive-behavioural therapy, chronic fatigue syndrome, sleep disturbance.

## PRESENTING PROBLEM

Jack is a 10-year-old boy who was referred to me by his paediatrician, Dr Mike North from the Royal Children's Hospital. Jack has a complex neurological medical condition that includes chronic fatigue syndrome, severe migraine and restless leg syndrome with periodic limb movement disorder. The impact of these conditions has resulted in Jack experiencing considerable "payback" when he engages in even small amounts of physical activity. Jack was referred for counselling to address some of the psychological issues that have arisen as a result of his chronic ill health, such as feelings of isolation (due to his lack of social contact with his school friends) and the emotional impact of his

inability to engage in simple “physical” activities (due to the “payback” he would inevitably experience when he did so).

### **Client’s Presentation**

Jack’s health problems (regular migraine headaches) meant that he had missed most of the first term of school. Jack’s overall health had worsened over the past 12 months. His school attendance has been limited, sometimes attending school for only a few hours a week. When he appeared to be physically well, he would sometimes attend for a slightly longer period of time. However, this would often result in a “payback” for Jack where he would become unwell again quickly and need additional time for recovery. His lack of attendance at school has had a major impact on his social relationships with his peers. Jack reported feeling quite isolated. His regular migraine headaches have left him feeling physically unwell much of the time. Jack had not had any previous counselling and his parents felt that he was “ready” to engage in a counselling relationship. Jack’s parents were concerned about the impact his health problems could have on his overall wellbeing. Jack’s parents completed the Child Behaviour Checklist (Achenbach, 2001). His results indicated “Affective Problems” to be the only scale within the clinical range—although many of the items related to difficulties with sleep and appetite, both a direct result of his health difficulties. As such, a diagnosis of depression was not warranted.

Jack was a tall boy for his age, with long shoulder-length hair. He was very polite and easy to engage in conversation. Jack demonstrated good concentration throughout each session and his overall mood was generally quite positive, although he expressed that his “problems” were causing him lots of frustration.

### **Relevant Past Psychosocial and Medical History**

Jack has a comprehensive medical history, dating back to about 17–18 months of age where he initially had a cold but became extremely lethargic; it took nearly six months for him to fully recover. He was described as a restless, “squirmy” baby who demonstrated problems with his speech and motor skills. He was quite “emotional” at 3-year-old preschool and as a 4-year-old Jack complained of headaches. He was diagnosed with migraine at four years of age but did not respond well to medication. His episodes of ill health lasted for weeks at a time. He consulted a neurologist shortly after commencing school,

and despite regular medical checks nothing conclusive was diagnosed. He has been trialled on numerous medications, with only one medication having a positive impact on improving his headaches.

### **Psychological Issues**

While Jack had formed a good network of friends at school, these friendships deteriorated due to his frequent absences. Some of his friends visited him at home for a while, but these visits diminished over time and he was rarely well enough for extended visits to their houses. When well enough to attend school, it was often only for an hour or two per day. This had left Jack feeling very lonely and isolated. Jack also expressed frustration at being unable to engage in many activities without feeling unwell afterwards, saying he “just wanted to be normal again.”

## **HYPNOTHERAPY**

### **Suitability**

The quality of one’s sleep usually has a profound influence on the ability to function effectively in day-to-day life. Sleep problems can occur at a number of levels—difficulty falling asleep, staying asleep, repeated awakening—leading to a lack of quality sleep, waking early, regular nightmares or night terrors. Treating sleep difficulties with hypnosis has been well researched (Perfect & Elkins, 2010; Spiegel & Spiegel, 1990). Treating sleep difficulties in children using hypnosis has also been the subject of considerable research (Hudson, 2009; Kohen & Olness, 2011; Tiffen, 2008).

Jack’s suitability for treatment with hypnosis was assessed using the *Stanford Hypnotic Clinical Scale for Children—Modified Form (Ages 6–16)* (Morgan & Hilgard, 1979). Jack was able to demonstrate many of the hypnotic phenomena assessed, such as the hand lowering, arm rigidity and the visual and auditory hallucinations (TV task). He responded appropriately to the post-hypnotic suggestion, but had some difficulty experiencing and recalling a dream. Nevertheless, his scores and responses on this scale indicated that he would be a good candidate for treatment using hypnosis.

### **Informed Consent**

Informed consent was obtained by discussing possible therapeutic outcomes with Jack’s parents. In particular, a discussion about realistic outcomes using cognitive–behavioural therapy alone was discussed. Jack was constantly feeling

over-tired due to having regular disrupted sleep. He was spending large amounts of the night and early morning awake. His regular limb movement during the night made getting comfortable difficult. It was felt that if some improvement could be made in this area, then he may be in a better frame of mind during the day. As such, the idea of using hypnosis to facilitate a more restful sleep was proposed. Jack's parents were keen to try the approach without reservation. I also discussed this with Jack. He did not have any pre-conceived ideas about what hypnosis would be like, and was agreeable that it was something he would willingly participate in.

### **Therapy Goals**

The main aim of Jack's therapy was to improve his overall level of emotional wellbeing—including decreasing his sense of isolation and his depressed mood due to his regular feelings of ill health. To assist him to achieve these goals, a combination of cognitive-behavioural therapy and hypnosis were the treatment methods chosen.

In particular, it was felt that hypnosis aimed at improving the duration and quality of Jack's sleep would be appropriate, as he was often very tired and this contributed to his heightened frustration and depressed mood. Jack's mother reported that his sleep quality was poor—he had difficulty falling asleep, frequently waking during the night and was often unable to settle back to sleep again. The hypnosis sessions aimed to improve Jack's quality of sleep in the following ways: to improve his ability to sufficiently relax before going to bed; to support him to feel comfortable in bed; to reduce "active thinking time" when in bed to allow him to fall asleep more quickly; and to decrease the amount of time required to fall back to sleep after waking during the night.

Cognitive-behavioural strategies were employed to help Jack understand the importance of a good bedtime routine to help him maximize his chances of a good night's sleep. CBT strategies such as setting aside a "worry time" earlier in the day to write down or discuss some of his anxieties with his mother were employed, rather than simply thinking about these when going to bed. Getting out of bed if he had not fallen asleep after 20 minutes (e.g., reading for a while before returning to bed) was another recommended strategy. Jack was able to achieve improved sleep quality very quickly using the combined hypnosis and CBT strategies. This then allowed the focus of therapy to change to address some of the other issues, such as his feelings of isolation.

## **Treatment Approaches and the Rationale for its Use**

Cognitive-behavioural therapy is considered by many to be an effective treatment for insomnia in adults and children (Harvey, Sharpley, Ree, Stinson, & Clark, 2007; Murtagh & Greenwood, 1995). For insomnia, CBT treatment often focuses on stimulus control (associating bed with sleep), sleep hygiene (controlling the environment and behaviours that precede sleep), sleep restriction (to avoid spending time in bed not sleeping) and relaxation training.

The approach taken in my CBT therapeutic work with Jack involved assisting him to develop a good bedtime routine by focusing on stimulus control, sleep hygiene and sleep restriction (as outlined above). Hypnosis complemented the cognitive-behavioural treatment by assisting him with the “relaxation” component—with suggestions for looking forward to bedtime; clearing his mind of any thoughts; feeling comfortable and relaxed in bed and easily drifting off to sleep; as well as being able to drift back to sleep should he awaken during the night; and the positive feeling of waking refreshed after a good night’s sleep.

Successful treatment of sleep disturbances has also been found to have positive effects on mood disorders (Ford & Kamerow, 1989). Many psychiatric conditions share a high rate of co-morbidity with insomnia and other sleep disorders. As such, it was felt that by treating the sleep disturbance first, this may have a positive impact on Jack’s overall mood and sense of wellbeing and may make Jack more receptive to other therapeutic strategies.

## **SESSION BY SESSION SUMMARY**

### **Session 1**

In the first session, I initially met with Jack’s parents, Don and Melinda. They were keen, given Jack’s comprehensive medical history, to provide me with as much background history as possible. They had also completed the Child Behaviour Checklist (Achenbach, 2001) and the Structured Developmental History questionnaire from the *Behaviour Assessment System for Children* (Reynolds & Kamphaus, 1992). This session also enabled a discussion of therapeutic outcomes with Don and Melinda. I briefly met Jack in this session. We completed a “getting to know you” activity where Jack discussed some of the important things in his life—friends, school, hobbies, etc. Rapport was established quite quickly and easily.

## **Session 2**

In this session, Jack was able to describe some of the things that were causing him frustration—often feeling tired and not sleeping well, having headaches, not being able to attend school very much, missing his friends, not being able to do much without feeling sick afterwards. Jack said that he would like to change all of these things. At the end of the session I discussed with Don and Melinda the possibility of using hypnosis to improve Jack's duration and quality of sleep. They were both agreeable that it seemed like a positive strategy. I suggested completing an assessment at the next session to determine Jack's suitability for treatment with hypnosis. This was then discussed with Jack and he was also keen to participate.

## **Session 3**

In this session, I initially spent time with Don and Melinda, reviewing Jack's bedtime routine, outlining the importance of working towards a good night's sleep. I was also able to discuss bedtime routine with Jack. He said that he sometimes became frustrated when not falling asleep after being in bed for a long time and he often had difficulty falling back to sleep after waking during the night. Sometimes he would worry about things when lying in bed "trying" to go to sleep. At other times, he couldn't seem to get comfortable. We discussed some strategies for managing some of these difficulties—such as finding a time during the day (rather than at bedtime) to talk to Mum about some of the things that might be worrying him; not watching TV for half an hour before bed; not "trying" to go to sleep (this only makes it more difficult to fall asleep) and getting out of bed after 15–20 minutes (and reading or doing some other quiet activity) if he has not fallen asleep. Towards the end of this session, I completed the *Stanford Clinical Hypnotic Scale for Children* (Morgan & Hilgard, 1979) with Jack. He demonstrated many of the hypnotic phenomena assessed (see Suitability section for details).

## **Session 4**

Jack reported that he had some mixed results using the strategies recommended at the previous session. He reported that he did get out of bed a few times when he couldn't fall asleep, but he was not worrying so much in bed. We then completed the hypnosis session. I used an eye fixation induction, then proceeded with progressive muscle relaxation and a deepener (walking

through the clouds to rest on a soft, fluffy cloud where Jack could feel very relaxed and comfortable). Suggestions included that Jack not fall asleep now, but enjoy the sensation of dreaming; that when in bed he would be able to allow any unwanted thoughts to drift out of his mind; that if he should wake briefly during the night he'd immediately drift back to sleep; and he'd wake feeling very refreshed. After the session, Jack reported that he felt very comfortable and relaxed. We also reviewed the recommended bedtime/sleep strategies from the previous session. I asked Jack to record how well he slept during the next week and let me know at the next session. Feedback regarding the session was provided to Don and Melinda.

### **Session 5**

Melinda reported that Jack had “the best night’s sleep ever” the night after the first hypnosis session. He awoke refreshed and seemed to be in a very positive frame of mind the following day. He continued to sleep well for the rest of the week, although had felt unwell most of the previous day and had a disturbed night’s sleep the previous night. I discussed the possibility of recording a session for Jack to listen to during the week if needed. Melinda felt this would be useful. In the hypnosis session today, we completed a different induction and deepener, although many of the suggestions were similar, in terms of improving the quality and duration of Jack’s sleep. Jack reported that he felt happier after sleeping so well during the week and had more energy. During this session, we also explored various strategies to increase Jack’s opportunities for connectedness to his peers. It was suggested that, rather than attending school for an hour during instructional time, it might be better for Jack to attend during lunchtime so that he could play with some of his friends (i.e., when he was well enough to attend). The possibility of using Skype to “tune into the classroom” with his laptop computer was also explored. Jack was excited by these possibilities.

### **Session 6**

Jack reported that he was consistently sleeping better during the week. His bedtime routine was becoming more established and he was not “thinking about things” as much when he went to bed. He had used the recording that I had made on two occasions and reported that it had helped him to fall asleep again. Jack returned to school for two lunchtimes during the week and said that he really enjoyed being back at school with his friends, although he had



to take things easy and not run around too much. Jack was not too concerned about this as he mainly walked around the school or sat and had a chat with a few friends. His parents and the school were investigating the Skype possibility. During this session, we also discussed the types of activities Jack could do that would not result in significant “payback” for him. Jack lived close to a park and felt that he was able to walk the short distance to the park each day.

### **Session 7 and Therapeutic Outcomes**

I saw Jack two weeks later. He reported that he had had a very good fortnight and was feeling much better overall. He was sleeping well and only used his hypnosis recording once during the fortnight. Jack was attending school regularly, although still only for an hour or two per day (including the lunch break). He was enjoying the social interaction with his peers and had a few children over for short “play” sessions at his house. He reported that he was not as lonely, now. While his “restricted activity” was still an issue, Jack reported that he was happier because at least he could see some of his friends more regularly, but he just had to be careful not to “overdo” things. He was still walking to the park regularly. Jack reported that he had migraine headaches a few times a week and he understood that he just had to rest when these occurred. Therapy was discontinued at this point, although a follow-up session was recommended in two months time to review progress.

### **COMMENTS ON CONCLUSIONS AND RETROSPECT**

Overall, the outcomes for Jack were very positive. There were a number of possible reasons for this. First, Jack was keen to find some relief from his physical health issues and the impact of these issues on his social relationships with peers and on his depressed mood. As such, he was highly motivated. Don and Melinda were also very supportive and assisted Jack to implement the recommended strategies, especially the bedtime routine strategies. A positive therapeutic alliance was formed between Jack, his parents and myself. I believe the therapeutic methods employed were also a significant factor in Jack’s success. While the CBT strategies were a key component of the therapy, I believe the hypnosis also played a significant role in assisting to resolve some of the sleep difficulties. This then contributed to Jack’s overall sense of wellbeing and allowed other issues to be addressed within the therapy. Each of the methods was employed for a specific purpose, yet CBT and hypnosis were complementary, and each played an important role in his overall success.

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# THE USE OF HYPNOSIS AS AN ADJUNCT TO MINDFULNESS BASED CBT AND PSYCHODYNAMIC THEORY TO TREAT ANXIETY AND MIGRAINES

Alexandra Bowring  
Registered psychologist, Melbourne

*This case provides an overview of psychological interventions including hypnosis to treat John, a 22-year-old man presenting with a recent history of anxiety with panic attacks and migraines. He presented for therapy after a traumatic incident involving his mother, an abusive alcoholic. Since the episode he had developed some avoidant behaviours (avoiding socializing and driving) which he wanted to address. A treatment plan that included mindfulness-based cognitive-behaviour therapy (MBCT) and hypnosis was employed. MBCT helped John learn to be in the moment with fear-based thoughts and feelings without judgment while correcting cognitive distortions. The hypnotic process allowed John to learn the benefits of arousal reduction and pain management, it also assisted and enhanced positive cognitive restructuring, ego-strengthening and an opportunity to process long-held grief regarding his relationship with his mother. At the end of treatment John no longer suffered from debilitating anxiety or disabling migraines. He had ceased pain medication which he had been dependent on for some years. In the last session he reflected on his full and active social life and was planning an overseas trip.*

Keywords: MBCT, hypnosis, panic attacks, migraines, anxiety.

## PRESENTING PROBLEM

John, a 22-year-old university student, presented with anxiety, panic disorder and migraines. He did not have a history of substance abuse and was avoiding alcohol and caffeine in an attempt to minimize his anxiety. He had been prescribed pain medication but was finding the side effects intolerable and

wanted to explore non-pharmaceutical options. In recent months he had started to avoid social situations. He was also reluctant to drive, fearing that he would have another panic attack, having experienced his first one while driving to university two months earlier. It being John's final year of studies he was determined to overcome his fears and regain his confidence. He was also motivated to start socializing more as he was starting to feel isolated.

## **RELEVANT PERSONAL HISTORY**

John lived at home with his parents and three younger siblings. He recalled that throughout his childhood his mother had been an emotionally abusive alcoholic. John sought treatment after his mother pulled him across the dinner table and repeatedly hit him. Although this marked the first physically violent episode, John had suffered from anxiety-related symptoms since his early teens.

Being the eldest, John had taken on a protective role towards his younger siblings. After the traumatic incident John became anxious when leaving the family home as he feared for the safety of his siblings in the event of another violent outburst. Once a socially active young man, John had become increasingly withdrawn, stating that he had "stopped bringing friends home and going out." His reluctance to drive (and at times avoidance of it) was impacting on his ability to attend university which required a two-hour commute. He became increasingly clingy and dependent on his father and girlfriend, expressing a desire for one of them to accompany him socially or when he needed to drive somewhere. This made him feel incredibly vulnerable and dependent. He had also started to avoid social engagements in case he felt "unwell." These responses to threat and trauma were considered within the context of wanting to prevent the onset of acute stress disorder, or deep-seated anxiety and avoidance patterns.

Although not the primary presenting issue, further exploration revealed the debilitating nature of John's migraines which he had suffered since his early teens. Referred by his general practitioner (GP) for anxiety and panic disorder, the referral stated that he was "crying, depressed and miserable" and listed other symptoms including: lethargy, sleep disturbances, dizziness and migraines. The GP queried as to the cause of John's migraines, suspecting they were anxiety related. The GP prescribed sertraline hydrochloride (Zoloft), an antidepressant, and referred John to a neurologist for an MRI. These pain symptoms may also have been indicative of co-morbid depression.

## **SUITABILITY OF THE SUBJECT FOR HYPNOTICALLY BASED TREATMENT**

John was motivated to overcome his anxiety and to cease pain medication to manage his migraines. Hammond (1990, p. 46) reminds us of the complexity of the pain disorder, he states that “we must not neglect thorough medical or psychological (behavioural, cognitive, emotional, affective) evaluation with the pain client.” A detailed description was taken of John’s pain experience and possible causative factors. Since organic factors had been ruled out (MRI showed negative results) and further medical treatment had been deemed unnecessary, hypnosis was considered to be a suitable intervention (Hammond, 1990, p. 46).

People with chronic physical illnesses, especially those with conditions that produce a lot of pain, restriction of activity or a poor outlook, are prone to developing co-morbid depression (Hammond, 1990). Given that antidepressant medication can mask symptoms a Beck Depression Inventory (BDI-II) was administered to measure the depth and severity of depressive symptoms. With severe depression ruled out, a risk assessment was conducted. No suicidal thoughts, plan or intent were shown. However, depression was considered as a co-morbid presentation.

John presented as the ideal subject for hypnosis. Good therapeutic rapport was established quickly and easily. He was highly motivated to overcome his anxiety and pain so he could resume a “normal life.” When I mentioned hypnosis as a possible intervention John responded enthusiastically and positively. A positive attitude towards hypnosis, coupled with high levels of motivation, are considered to be important prerequisites for suggestions to be effective (Hammond, 1990, p. 11). Furthermore, John was a graphics student and capable of vivid imagery in the non-hypnotic (waking) state, a trait shown to correlate with hypnotic susceptibility (Wilson & Barber, 1981, p. 133). Contraindications such as a personality disorder, clinical depression or major psychiatric disorder were absent.

## **INFORMED CONSENT**

In accordance with good practice procedures and the Australian Psychological Society (APS) Code of Ethics, John was fully informed about the nature and purpose of treatment. To dispel any misconceptions and myths John was asked to share any concerns, worries or queries he may have had about hypnosis (Walker, 2010). Once verbal consent was obtained John was asked to sit in the hypnosis chair. This he did willingly and enthusiastically.

## **THERAPY GOALS**

Given John's history and presenting issue, therapeutic goals involved strategies for ego-strengthening, arousal reduction and positive self-affirmations. Due to the intensity and severity of John's migraines the first goal of therapy focused on pain reduction and management. A desire to cease medication meant John was open and willing to try various tools and techniques. It was decided that hypnosis would be used primarily to assist in pain reduction and management.

In the first session it was evident that John had learnt to use avoidant strategies in an attempt to manage unpleasant symptoms and minimize the onset of a panic attack. These avoidant behaviours were increasingly impacting on his social/work life and attendance at university. Given the negative impact that John's anxiety was having on many aspects of his life, the second goal of therapy aimed to help him manage arousal more effectively. This was coupled with psycho-education so that John was aware of what his body was doing and why (i.e., fight/flight response). John was also taught abdominal breathing techniques which he was encouraged to practise daily. It was also decided that hypnosis would be used to assist with reducing anxiety and lowering arousal.

The third goal of therapy focused on helping John re-engage in all aspects of his life (social, work, student, driving). This part of treatment focused on incorporating arousal reduction strategies (i.e., mindfulness-based cognitive behaviour therapy—MBCT) with behavioural techniques (i.e., graded exposure therapy).

The final treatment goal was to build confidence and self-esteem. Loss of independence, which led to feelings of isolation and being out of control of one's life, destabilized John's sense of self-identity and self-worth. This along with the traumatic incident with his mother compounded these negative and unhelpful self-perceptions. Providing John with a safe space to grieve and process the feelings he held towards his mother enabled him to re-frame the experience in a way that promoted healing and growth.

### **Summary of Goals**

1. To reduce migraine pain, intensity and severity.
2. To reduce symptoms of anxiety (psycho-education/breath work).
3. To actively re-engage in all aspects of life (social, work, student, driving).
4. To increase confidence.

## **TECHNIQUES AND THEIR RELATIONSHIP WITH OTHER TREATMENTS**

Priority was given to hypnotic techniques that targeted pain reduction for a number of reasons:

1. Hypnosis has been proven to be an effective tool in the management and perception of pain (Rose, 1990).
2. Pain was persisting after anxiety reduction.
3. A full and complete physical and psychological evaluation was undertaken (i.e., results of an MRI showed no organic causes). Given that the perception of pain almost always includes a strong emotional component, hypnosis was considered an appropriate intervention (Sarafino, 1998).
4. John was able to provide a detailed sensory description of the pain, providing invaluable clues for hypnotic strategies and techniques that would be most useful (Hammond, 1990, pp. 45, 46). Not surprisingly, techniques that used imaginative involvement and transformed the pain into images were prioritized to align with John's visual abilities.

### **Anxiety Management**

For several reasons, prior to engaging in hypnosis the first few sessions focused on MBCT. Residing with a mother who was an abusive alcoholic meant John had been living in an unsafe environment. This sense of psychological and physical unsafety was compounded by the recent (and first) physically violent episode.

In response to ongoing psychological and/or physical threat, John's body was in a constant state of physiological arousal (higher adrenalin levels). When this state of arousal is prolonged the body eventually begins to lose its adaptive capacity, giving rise to pathologies (i.e., anxiety present in the absence of a "stressor") (Riisik, 2010). MBCT was employed as a technique to help alleviate such symptoms.

Often people with anxiety have learnt to associate bodily sensations negatively as a cue to enter the fight or flight response. MBCT has been shown to benefit people with anxiety by teaching them how to remain non-reactive to physiological arousal experienced within one's body and to observe thoughts from a place of non-judgment or detachment (Cayoun, 2006). John was encouraged to perceive bodily reactions as bodily sensations, nothing more or less, and to perceive thoughts merely as words passing through conscious awareness.

*Treatment for anxiety also included:*

- Psycho-education re: anxiety.
- Asserting healthy boundaries.
- Breathing techniques.
- Graded exposure therapy/desensitization therapy (i.e., driving).
- Building independence (scheduling social activities alone).
- Exploration of secondary gains (since the incident, John's mother had expressed concern regarding his health and would respect his space when feeling unwell).
- Build protective behaviours, especially in dealing with his relationship with his mother (i.e., assertiveness; develop a safety plan).
- Counselling re: grief/trauma (i.e., write a letter to mum, role play "empty chair" etc.).

*Reported Changes Pre-Hypnosis (four sessions), from aforementioned interventions:*

- Considerable reduction in anxiety.
- Driving and attending university, etc.
- Socializing with friends.
- Pain medication under review.
- Headaches still persisting.
- K10: 31 to 14.

## **THERAPY**

Each hypnosis session was recorded and John was encouraged to listen regularly.

### **Session 1 (Soothing the Pain Using Visual Imagery)**

*Problem identification* John was asked to rate his pain intensity and pain distress on a scale from 0 (no pain) to 10 (severe pain). Sharp stabbing pain in his right temple was given a pain rating of: Intensity 3, Distress: 3. Utilizing colour, John chose red to describe his pain and yellow to describe calming, peaceful, soothing energy.

*Induction* Breath awareness.

*Deepener* After a simple "Count Down Induction" (Allen, 2004, p. 16), John was guided to inhale yellow energy and to exhale red energy. The mantra "breathing in calm and peace" and "exhaling discomfort" were used rhythmically.



*Content* Transforming pain into images. Continuing to focus on imaginative involvement John was asked to picture a dial in his inner mind (utilizing the pain rating scale, 0 to 10). He was told that by turning down the dial he would experience a softening, a soothing, and an easing of the sensation of pain.

*Post-hypnotic suggestion* The word *calm* was given to help evoke a softening/easing of pain when recalled in the waking state.

*Feedback* Post-treatment: Pain: Intensity 1, Distress, 1. At two-weeks, John reported an overall decrease in headaches stating that he had experienced less pain than he could remember for some time.

## **Session 2 (Once Again Focused on Soothing the Pain Using Visual Imagery)**

*Information gathering* In the last two weeks John's headaches returned, and coincided with the commencement of a new pain medication. John presented with a headache which he was asked to rate: Intensity 7, Distress 4.

*Induction* The same "Count Down Induction" from Allen (2004, p. 16) was employed because of its effectiveness in the first session.

*Deepener* The use of visual imagery and "The Garden" (Allen, 2004, p. 35) deepener was chosen because it combined counting and imagery of a beautiful country garden which appealed to John's love of nature; thus incorporating the client's interests.

*Content* Allen's "Pain and Discomfort" (2004, pp. 141–153) script was modified to align with John's presenting issues (it was originally written for people with a terminal illness) which combined visual imagery with the sensation of warm water to relax and soothe. It also focused on the whole body as opposed to just the pain area. John had spoken of his love of water and how he specifically associated warm water with having healing properties.

John was asked to picture his body on a screen floating in a "*Cloud—seeing warm water easing through the body as you focus on the image, enabling you to clearly see the areas of the body that cause distress. Picture them soften as they are bathed in a warm and gentle soft yellow light. With each breath the pain and discomfort eases, pools of light reflecting the shrinking areas of discomfort ...*"

*Feedback* Post-treatment: Headaches were gone and anxiety reduced. Three-week feedback: In the first week after hypnosis, John reported that his headaches and anxiety had virtually gone; however, he noted that they "returned with a vengeance." John planned to see his neurologist, to review medication and discuss unpleasant side effects (i.e., lethargy).

### **Session 3 (Strengthening and Reinforcing Emotional Safety)**

*Information gathering* Explored possible secondary gains for pain (i.e., protection from mother: being left alone when unwell; positive attention: mother enquires about his health, expresses concern/care).

*Induction/deepener* “Count Down Induction”, modified from Allen (2004, p. 16).

*Content* John had been living in an environment that lacked emotional stability; this session focused on building his sense of safety and letting go of the stress and tension that he had been carrying around especially since the traumatic incident. Using imaginative involvement John was instructed to create a special place in his inner mind, a place just for him, a place where he could feel safe in both his mind and body, happy and relaxed, leading to a sense of feeling empowered ... *Feeling every muscle in your body relax, every cell relaxing and softening ...*

Identifying the function of the pain and to establish its protective as well as disabling purpose prompted ego-strengthening. This was achieved by asking the painful part to step forward and inquiring as to whether part of its role was to *protect* John. Using ideomotor signalling, John indicated, “Yes.” When asked whether this part would be willing to step aside or have a less dominant role, if other more productive parts were willing to resume greater responsibility (i.e., confident, happy, social, energetic), John also indicated, “Yes.”

*Feedback* Post-treatment: John felt more energized, happier and calmer. Three-week feedback: John continued to report significant changes towards his wellbeing, namely feeling happier, more energized and confident. He was socializing more and driving unaccompanied. He stated that he had experienced “minimal pain since the last session ... a mild headache here and there but nothing debilitating.” After consulting with his neurologist it was decided to cease pain medication (at this stage he had been medication free for 10 days).

### **Session 4 (Reinforced Physical and Emotional Strength and Confidence)**

*Information gathering* John decided to resume part-time work.

*Content* Ego strengthening: *John can take care of himself, that he is capable, independent, strong, assertive, etc...that pain no longer needs to play the role of the protector ...* John was invited to ask the parts of himself that he wished would play a more dominant role to step forward (being more adventurous and happy came up).

*Feedback* Three-week feedback: More improvement, still medication free. Organized an overseas trip. Fully engaged in all aspects of his life: social, work and university.

### **Sessions 5 and 6 (Reinforce Prior Session Content, etc.)**

John was taught self-hypnosis. This is considered an integral part of pain management that gives pain sufferers a sense of mastery and control, allowing them to build independence from the therapist (Rose, 1990).

### **OUTCOMES**

The focus on counselling interventions was to identify the stressors and trauma associated with John's relationship with his mother. Hypnosis was utilized to reduce hyper-arousal, promote ego strength and build protective behaviours.

After the first session John's response to hypnosis was encouraging. As the weeks progressed the positive benefits were evident. Despite migraines returning one week post treatment, subsequent pain-free periods at the outset suggested hypnosis was proving to be an effective intervention. John enthusiastically embraced hypnosis and eagerly did his homework (listening to taped sessions) which reinforced the work and probably contributed to the speed at which he reaped the benefits.

John presented as a worried, tired and unhappy young man who had started to avoid life in an attempt to manage his anxiety/panic attacks. Within several weeks of treatment John had started to participate in the activities he had been avoiding and within a couple of months was fully engaged in life.

### **CONCLUSIONS AND RETROSPECT**

Although John initially presented for the treatment of anxiety and panic an assessment highlighted the severity of his migraines, the debilitating effects of which he had been suffering for many years. Providing John with pain management techniques and other interventions including hypnosis, which may offer some relief, seemed worth exploring.

John's enthusiasm for hypnosis enabled him to reap the benefits quickly and to notice dramatic physical and emotional changes. Hypnosis combined with behavioural interventions and MBCT reinforced John's ability to cope with stress. Mind-body relaxation helped him learn to focus on accepting thoughts and feelings without judgment. Activity scheduling and graded exposure tasks

enabled him to confront situations that caused unease.

Self-hypnosis is a valuable resource for the ongoing management of anxiety. As this case illustrates, hypnosis can be used to strengthen other interventions and help empower the client to feel independent, in control and develop a greater sense of self-mastery.

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# USING HYPNOSIS AS A VEHICLE TO DEEPEN EMOTION FOCUSED RELAXATION AND ENHANCE THE HEALING EXPERIENCE IN THE TREATMENT OF ANXIETY IN A CLIENT DIAGNOSED WITH IMMUNE THROMBOCYTOPENIC PURPURA (ITP)

Stephen Theiler

Swinburne University of Technology

*This case study presents a client who was diagnosed with anxiety with panic attacks, hypertension and idiopathic or immune thrombocytopenic purpura (ITP). He was referred to counselling by his doctor. Using hypnosis to enhance cognitive-behavioural therapy, relaxation, imagery and positive emotions, the client's physical and psychological wellbeing improved. His platelet count increased and his anxiety reduced as measured by his sympathetic and parasympathetic activity during his 18 therapy sessions.*

Keywords: hypnosis, cognitive-behavioural therapy, relaxation, anxiety disorder not otherwise specified.

## **Presenting Problem**

Mr T is a 61-year-old male who was referred to counselling by his medical practitioner who believed he was suffering from anxiety. In gathering information from Mr T, in counselling it was found that he had also experienced panic attacks. The client believed that his symptoms of panic may have an underlying physical cause that was related to his ITP. His mental status examination that was included in the doctor's referral notes indicated mood swings, insomnia, negative thoughts and pessimism at times. There was no suicidal intent and he did not have major depression. His anxiety over his ITP diagnosis and his feelings of life moving out of his control are what brought him to psychological counselling for the first time.

## **Client's Presentation**

Initially, Mr T presented well. He was confident and spoke with authority. However, once he began talking about his feelings of anxiety, pessimism about the future, concerns about his health and confusion as to whether he was experiencing a medical or psychological condition, his demeanour changed to that of a vulnerable and anxious person. For a man who liked to feel in control, at this point in time he felt that his life, and life expectancy, were under threat.

## **Relevant Past Psychosocial and Medical History**

Mr T was 61 years of age and in a long-term marriage with two adult boys in their twenties who still lived at home. He managed a successful business in a medical area and had a number of staff to manage. Mr T had an active social life and was often requested to give lectures in his area of expertise. He reported drinking up to three glasses of wine a night. His father had suffered from Post Traumatic Stress Disorder (PTSD) and depression after the Second World War and was periodically hospitalized in psychiatric hospitals from when Mr T was about 12 years old.

Mr T had been diagnosed with ITP (two years ago) and this was confirmed in the doctor's notes. This condition, which may be terminal, results in a decrease in the number of circulating platelets and the cause is unknown at this stage (Millward et al., 2005). He was taking medication Mabthera which has an active ingredient called rituximab, which is also used to treat non-Hodgkin's lymphoma and chronic lymphocytic leukaemia and are both types of blood cancer. Research (e.g., Poterucha, Westberg, Nerheim, & Lovell, 2010) into this medication has revealed that it had side effects such as tachycardia, which also can be associated with anxiety.

Mr T reported symptoms that had occurred around six weeks previously that I recognized as fitting a panic attack. The criteria for a diagnosis of panic disorder according to the DSM-5 (American Psychiatric Association, 2013) include an unexpected period of intense fear and four or more physical or psychological symptoms out of 13, such as an increased or irregular heart rate, shortness of breath, chest pain, tingling sensations, nausea and fear of dying or losing control. These symptoms need to become worse within a 10 minute period. In this case, the client had enough of these symptoms to warrant considering a diagnosis of panic disorder with agoraphobia. He was preoccupied for at least a month with having another panic attack and the

attacks were spread beyond a four week period and mostly took place in confined spaces (a restaurant, a convention centre, and a car).

He was also diagnosed with hypertension and was taking medication for it which may have affected his heart rate and symptoms of tachycardia. Therefore, his anxiety symptoms may also have been caused by his medical condition and medication, and thus a diagnosis of Unspecified Anxiety Disorder from the DSM-5 (see APA, 2013) seemed to be the most accurate clinical diagnosis.

## **HYPNOTHERAPY**

### **Suitability**

Mr T had previously tried hypnosis in order to stop smoking. This experience was a positive one and he said that he was easily hypnotized. I asked the client about his experience of hypnosis, the induction that was used and whether he had any fears or concerns about hypnosis. The previous hypnotherapist had implemented guided relaxation and imagery. I then asked whether he would be willing to have some hypnosis sessions as a way of deepening his ability to calm himself when he felt the symptoms of anxiety and panic. I also suggested that hypnosis may also help with the facilitation of activating his immune system that was out of balance (with ITP). I asked Mr T about his safe place and checked for any phobias with the image he had decided upon, which was bushwalking and cross-country skiing. As the doctor's notes mentioned mood swings, I also asked about depression. Although there was some depression at times, it was low and there was no suicidal ideation. As Mr T said that he was easily hypnotizable, I tested his ability by adapting the Stanford Hypnotic Clinical Scale by using some of Morgan and Hilgard's (1975) induction and getting the client to either speak to me or notify me by raising his finger during the session. He proved to be moderately hypnotizable. There is good support in research findings that clients with anxiety are more hypnotizable than clients with many other disorders and that using hypnosis is associated with positive results in treatment (Bryant, 2008).

### **Informed Consent**

As Mr T had positive associations with hypnosis, he was eager to incorporate hypnosis into the counselling. We scheduled this for his third visit, whereupon informed consent was obtained. We discussed a script that would include suggestions that he felt safe on the bushwalk and that the forest was full of

gifts of healing that he could easily access in this calm environment. I also included the idea of acceptance and that some things were out of a person's control but that this was fine in the order of things. His negative thinking was also combated with principles drawn from cognitive therapy. Notions such as "your thoughts are not you" and that you can "just let thoughts go without getting attached to them" were included in the script.

### **Therapy Goals**

The primary aim of the therapy sessions was to build a therapeutic alliance that was founded on trust. Mr T was a successful professional and well respected in the community. However, he needed to be comfortable enough with me to reveal his fears, concerns and failings, as in this state he became vulnerable and conveyed feelings of helplessness. Therefore, building trust in me and the therapy was essential.

It was also a goal to help reduce Mr T's stress and anxiety. Therefore, it was planned to incorporate some psycho-education about anxiety and the mind-body connection between thoughts, feelings and behaviours and in particular their link with panic. Additionally, it was important for Mr T to develop strategies to self-soothe and self-calm when anxiety was triggered, especially to combat relapse in the future. In this regard, Mr T was open to scheduling regular relaxation sessions with hypnosis and to periodically monitor his progress using a heart rate variability monitor (EmWave) which measures the level of parasympathetic activity that is related to being in a relaxed state. The final goal was to prepare for the possibility that Mr T may die from his ITP at some time in the future. It was important therefore to develop acceptance and enjoyment in his life with what time he had left.

### **Treatment Approaches and the Rationale for its Use**

Cognitive-behavioural therapy (CBT), emotion focused relaxation enhanced with some hypnosis sessions was selected to treat Mr T. Once identified, the prognosis for panic attacks is generally good (Clum, Clum, & Surls, 1993), especially if cognitive-behavioural therapy (CBT) is implemented in the treatment plan (Elkins & Moore, 2010). Heuzenroeder et al. (2004) found that CBT was the most efficacious intervention for anxiety and panic. CBT in particular has been found to be more economical in the long run when compared to pharmacological interventions for anxiety disorders (Heuzenroeder et al., 2004) and CBT in particular has received widespread



empirical support for leading to significant improvement in worry and anxiety by post-treatment (Elkins & Moore, 2010; Gosselin, Ladouceur, Morin, Dugas, & Baillargeon, 2006). CBT and applied relaxation (AR) are often similar in efficacy (Donegan & Dugas, 2012) and research evidence strongly endorses the superiority of incorporating both interventions when compared to other treatments for anxiety (Wolfe, 2005). This combination can also be enhanced with the use of hypnosis (Yapko, 2011).

## **Session 1**

In the first session I sought background information and evidence for the most pressing concerns to focus on in therapy. The predominant issue seemed to be Mr T's ITP and the possibility of dying. ITP is an immunodeficiency disease whereby there is a low platelet count and at this stage there is no known cause (Cines, Blanchette, & Chir, 2002). It is a rare autoimmune disorder whereby the person's blood does not clot properly because the blood-clotting platelets are destroyed by antibodies. Symptoms include bruising easily, bleeding either internally or externally, and a rash of small red dots (Psaila & Bussel, 2007). This diagnosis brought up issues of mortality and also a sense of pessimism. Life seemed out of control for a man who likes to be a "control freak" over his own life. However, he did have hope as he was being treated in a clinical trial with a new drug called Mabthera.

He also reported that two months ago he felt hot in a restaurant and also a bit dizzy. He thought that he should get some fresh air and his thoughts were that he did not want to collapse in the restaurant. After coming back into the restaurant after getting some fresh air he was able to resume the meal. However, the anxiety symptoms lasted about 1½ hours. He also felt a little dissociated after the attack. After the restaurant occurrence, Mr T admitted himself to hospital. He remembered having a racing heart and an accompanying fear of dying. His test results did not reveal anything conclusive.

As this was his first counselling session, I empathized with the client's feelings and sense of losing control and reflected his concerns which seemed to strengthen the therapeutic alliance.

The client reported that his second anxiety attack happened in a lecture theatre at the police academy while looking at slides on cyber fraud and a murder. I raised a possible connection between the unfairness of what was happening to him (ITP; anxiety; feeling of he was out of control) in his life and the themes of random injustice and death in the lecture which may have

triggered his panic. Towards the end of the session we discussed the negative mind sets he held in relation to some of his concerns. We then spoke of using hypnosis with relaxation. This would include him visualizing or imagining his platelet count increasing and his immune system becoming stronger through healing light flowing through his system.

## **Session 2**

Mr T reported that he was feeling better this week. He said that he was feeling less dizzy and that his blood pressure had dropped a little this week when tested. He said that he had gone to a stress management program that trains the participants in mindfulness meditation. However, he reported starting to feel anxious when he went into the doctor's surgery where the class was taking place. His heart was beating faster and he then attempted to talk himself through his stress with attitudes like "get a grip." His thoughts were that "I will make a fool of myself." Having heard the client relate this tendency, I did some psycho-education based on CBT principles, such as teaching him about the mind/body link and his tendency towards "catastrophizing" and holding a negative expectation or pessimistic outlook at times, especially in regard to his health. Importantly, this experience also helped me to plant the seed that it was possible that there was a connection between his anxiety and his thinking rather than it coming solely from his medical condition. He said that the guided imagery during the mindfulness class was especially helpful in calming him down, which he found profound given that it directly reduced his anxiety. Yapko (2011) argues that mindfulness techniques have very strong parallels with hypnosis and this was taken as more evidence that hypnosis could fit well with this client.

At this session, Mr T also mentioned a recent anxiety attack where he was stuck in traffic on a dark and rainy night. He was late for a dinner appointment and in the traffic he began to feel "claustrophobic—out of control—trapped." He pulled over to the curb and eventually the panic symptoms subsided. In the same session he related to me that his father suffered from "shell shock," possibly PTSD. He recalled that his father seemed to border on "madness." I asked Mr T if he felt he was going mad in relation to the anxiety attacks and he said that it did cross his mind. To complete this session, we scheduled some hypnosis for the following session and agreed on elements in the script, including a safe place and some suggestions to reduce his anxiety and increase his platelet cells in his blood count.

### **Session 3**

Mr T came with a blood-pressure (BP) machine this week, because he said that he was nervous about what the reading might be and thus wanted to take the reading in the therapy session. I recalled that his doctor had said he may have “White Coat Syndrome,” which is an increase in BP due to an expectation of evaluation, so this was an interesting test. His reading was 212/80 which was higher than he was expecting. When I asked him what he was thinking, he said that there was a fleeting thought that maybe “I [the therapist] won’t know what to do.” Or, “Maybe this [therapy] won’t help and it is beyond my control.” We then talked about the link between these thoughts and becoming more anxious in a feedback loop. I mentioned that he was probably activating his flight or fight signals. Therefore, I suggested that we begin a relaxation session with hypnosis just to ascertain whether he could relax and decrease his BP. Mr T was able to relax and his BP did reduce; however, when I tried to take him deeper, he reported that his mind and heart were racing. I felt that it was important that he was able to talk to me about his feelings. He said part of him felt like a child and stupid (about not stilling his mind) but he was glad that he was able to voice his concerns. Although this session did not radically change anything such as his BP, trust was developing and he was able to be vulnerable (child-like). He was also keen to go into hypnosis again the following week. I believed that it was difficult for him to let go and the thought of his health being out of control was a big factor.

### **Session 4**

Mr T reported that he felt relaxed but that his thoughts were still racing. He also reported that his medication was able to eradicate the attack on his platelets but that his platelets were almost zero at his last check-up. He believed that they should be around 150 and no lower than 50. The low platelet count was naturally worrying him and he associated the low levels with being sick. He said that when you are sick you cannot do all the things you once used to do. He equated this with “doom and gloom, death, being out of control, having less quality of life, and being hemmed in.” We discussed his thoughts and feelings surrounding his health and this also led to his feeling that imminent retirement was an issue because he saw that his job held status and that his identity was wrapped up in his job. I was able to make the links between his negative thoughts and worries about his health situation and his stage of life. It was possible to empathize with his situation and at the same time explore more positive alternatives.

In the hypnosis session I asked Mr T to visualize a positive future that we had discussed in terms of his health concerns. I also had him visualize the platelets having a protective coating that stops them being attacked, which we had discussed prior to the hypnosis. This seemed to work well in that the client became much calmer, which was also reflected in his EmWave recording and his general demeanour.

### **Session 5**

Mr T said that he had three 90 minute PET scan appointments scheduled. He said that the thought of going inside a PET machine to check his system was anxiety provoking and was compounded by his claustrophobia. He said that he was starting to believe that there was a feedback loop between his thinking and physiological reactions that his doctors did not account for with his physical symptoms, such as his flushed face. He understood that it was possible that his attributions tended to accentuate the racing heart and elevated blood pressure. I did some hypnosis with him and he said that he found it more difficult to visualize the bush walk. However, when he went into the cross-country skiing section of his visualization he experienced a strong vertigo sensation and he opened his eyes and seemed to come out of trance. He said that he felt profoundly in an altered state, deeper than before, and that it may have been the feeling of going deeper that he was resisting. He did not remember me saying that he “was floating” but he did get the sensation of weightlessness and this scared him a little in the same way the vertigo did. After checking with him about going back into trance, I gently took him back into a deeply relaxed state and this time he did not bring himself out of trance but just experienced this feeling of being on the edge of a deeper experience. I had him raise his finger to let me know that all was well during this phase. At one point in this state, I asked him to visualize a room with the PET scan machine and to experience himself as relaxed and calm and that he could use this time in the PET scan environment to relax deeply without any fear. I made a recording of this session that he was then able to listen to, right up to entering the PET facility.

### **Session 6**

Mr T reported feeling a lot more relaxed this week, as though a weight had been lifted from him. He said that he was proud of his ability to go through the PET scan procedure on his own without a panic response. (I believed

the hypnosis suggestions were probably very effective, but I responded to his success from a position that would empower him and his ability to relax and not panic, rather than attributing the success to hypnosis.) His scan findings indicated that they could not find anything abnormal. He also talked about the relationship between his thoughts and blood pressure and heart. He was convinced of the relationship between them and that his physiological responses were more psychological rather than physical. We also talked about his goals for the year, which were regular exercise such as walking and a bicycle ride on weekends.

### **Sessions 7 to 18**

I ended up having 18 sessions with Mr T over a 5-month period. After session 6 we continued to work on his beliefs about retirement and the idea that he could ease into retirement and modify his identity to one of a traveller who could enjoy life. We continued to do hypnosis with a focus on his health but not in every session. When Mr T talked about his “illness” and what meaning this had for him, he realized that he associated illness with inferiority, being a lesser person. We worked on “acceptance” of the “cards he had been dealt” in life, which was a different stance to his previous one of resignation that bad things happened to him. Although Mr T had some ups and downs, he progressively became more confident about his health situation, his ability to control his thinking and consequently his ability to control his anxiety. He did not experience another panic attack during this time. There was also a focus on Mr T’s resilience and strength factors. For example, Mr T said that he still felt young and strong. I suggested that his vocation was about healing and helping people. Discussing these areas and his options to continue helping people as a volunteer was helpful for the client.

### **Final Session and Therapy Outcome**

At his last session, Mr T related recently doing his tax return and finding himself getting frustrated. When he took his BP it was 180/70. He then did some relaxation, and modifying his thinking to be more positive. His BP dropped to 140/70.

Mr T said that he had been feeling physically well and interestingly his blood-pressure monitor readings had generally been relatively normal. I took Mr T into hypnosis and he said that this took him into a deeper state of relaxation than when when he meditates. I also took a heart rate variability

reading before the trance where his parasympathetic reading was low (higher stress) in contrast to after the hypnosis session where it was much higher (lower stress). This indicated quite a change from our beginning sessions. He said that he was now working three days a week and going to the gym and working out with a personal trainer. He had reduced his alcohol intake and was now enjoying the transition to retirement.

## CONCLUSION AND RETROSPECT

Although this case was multifaceted in terms of the client's health concerns and the impact of his psychological issues, the treatment for Mr T needed to focus primarily on his thinking with cognitive interventions and some psycho-education. Secondly there was a need to explore his health issues and the existential concerns that living with a potentially fatal illness brought up for him. Mr T was open to hypnosis and I believe that this helped to facilitate the psychological and physical healing that enabled him to continue his life with a positive and healthy outlook. It is hard to know the contribution of each intervention, but his ITP did go into remission, his wellbeing increased and although he still had times of feeling anxious he was able to control these feelings without further panic attacks. In retrospect, I learnt a lot from this client and I found hypnosis gave me a way of working with a very rational man in a very creative way.

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# THE USE OF HYPNOSIS AS AN ADJUNCT TO COGNITIVE–BEHAVIOURAL THERAPY IN TREATMENT OF PROBLEM GAMBLING DEVELOPED AS STRESS MANAGEMENT FOLLOWING A WORKPLACE INJURY

Trish Earle

*Psychologist and problem gambling therapeutic counsellor, Melbourne*

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*This case study describes the effectiveness of hypnosis in treating problem gambling, which developed as a means of stress management following a workplace injury. It demonstrates the effectiveness of hypnosis as an adjunct to cognitive–behavioural therapy in supporting this client in her recovery. Therapy was aimed at developing her awareness and regulation of stress and anxiety, achieving sustained abstinence from gambling, solution-focused recovery and relapse prevention. The client reported positive coping, repair to relationships, and sustained abstinence from gambling, three months post treatment.*

Keywords: hypnosis, cognitive–behavioural therapy, problem gambling.

## PRESENTING PROBLEM

Sarah, a 50-year-old female, was referred by a colleague following her request for hypnosis. Problem gambling had developed over the last seven years, following a workplace injury. She had made progress with cognitive–behavioural therapy (CBT) and reduced her gambling, but wished to try hypnosis to assist her further in gaining control over her gambling.

## CLIENT'S PRESENTATION

Sarah and her current psychologist attended a case meeting to discuss her request for hypnosis.



She presented as a well-groomed and articulate, unemployed health industry worker. Sarah reported that she commenced gambling while recovering from a workplace injury. She described surgery, medical treatment and the legal process following the injury as a “traumatic experience.” She advised that all legal proceedings were complete and final. She reflected that gambling had become her replacement workplace; however, she had run out of money well before the equivalent salary cover of her payout, and eventually became homeless.

She had recently moved into supported housing, had reduced her gambling, and despite huge relief, remained distressed that she was still unable to control her urges to gamble and had not repaired the damage done to her relationship with one of her daughters.

## **RELEVANT PERSONAL REPORT**

### **Medical**

No relevant medical history was reported prior to her work injury in 2005. Back surgery and a painful recovery followed; she remained reliant on pain patches and medication to cope. At presentation, her GP was monitoring reduction of pain medication, and had referred her for review with a pain specialist.

### **Psychiatric**

No prior psychiatric history.

### **Social**

Until her work injury, Sarah described a busy and satisfying professional life; she socialized regularly with colleagues, friends and family. Sarah presented as socially able and inclusive, describing her empathy and friendly attempts to get to know her new neighbours in her new supported housing. She described herself as fortunate but finding the transition hard.

### **Psychological**

Sarah had divorced her husband who was physically abusive to her and her youngest son. She was proud that she raised three children as a single, working

mother and reported them a close loving family. She described her abused son as “troubled” and with alcohol problems. Her eldest daughter remained estranged since physically restraining Sarah from going out to the pokies<sup>1</sup>; this rift remains a major ongoing stressor.

Hawkes (1998) espouses that the first step of gambling addiction counselling is “to determine the purposes of the addiction”; Sarah described the purpose of her gambling, while recovering from medical treatment, as filling the gap left by the abrupt loss of her very busy and stimulating work life. The loss of her work status, income and occupation was compounded by her sense of betrayal by a work manager who witnessed her accident and later denied this in the legal proceedings. She acknowledged huge grief at ending her career without acknowledgement, or apology; the financial payout the only validation of her injury and loss. Gambling further exacerbated her loss, resulting in loss of her comfortable lifestyle and housing, and breakdown in relationship with her eldest daughter.

She described urges to gamble at that time as “out of her control” and when the gambling was at its worst, 12 months previously, and a close friend tried to intervene, she had contemplated suicide. She had not acted on her suicidal thoughts and instead had talked through the matter with her friend, who supported her, until arrangements for supported accommodation were made.

She described being “lost in gambling” and reported this behaviour as “out of character.”

### **Suitability for Hypnotically Based Treatment**

Intrinsic motivation and self-efficacy are key strengths in supporting change (Marlatt & Gordon, 1985). Sarah was self-motivated to work with hypnosis. She had no experience of hypnosis, but was familiar with meditation, and when prompted to imagine she was able to bring a vivid visual picture to mind. She was encouraged by the therapist’s assessment that she demonstrated a capacity to work with hypnosis.

Sarah’s description of “losing herself” in gambling is identified, in related studies, with the term “dissociation,” which is often used as a generic description of a player’s sense of losing their sense of time and capacity for rational decision making while focused intently on playing the pokies (Kuley & Jacobs, 1988).

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<sup>1</sup> In Australia, “pokies” is the colloquial description given to “poker machines” or “electronic gaming machines.”

For Sarah, playing the pokies had become a very expensive “avoidance” or “time out” from her various worries and anxieties. Her descriptions are in keeping with some core factors of the anxiety disorders, reviewed by Evans and Coman (1998), including anxiety and worry precipitated by sudden onset of injury, illness or surgery (Beck & Emery, 1985), or triggered by life events outside a person’s control. In trying to deal with such anxiety and worry, there is support for the “efficacy” of problem gambling behaviour as a form of “self-medication,” in the sense of self-treatment, or escape from negative mood states, and to forget troubles, as identified by Dickerson, Walker, Legg England, and Hinchy (1990). Further, Legg England, and Gotestam (1991) identified loneliness, depression, or stress precipitated problem gambling. As with all problem gambling, the temporary benefits of gambling as a distraction or coping outlet, for Sarah, were far outweighed by the negative consequences of financial loss, and the fact that her personal worries and anxieties remained unresolved, and continued to trigger her.

Gambling clients also report experiencing hyper- or hypo-arousal as a precipitant, and consequence, of “going to the pokies” and readily identify with the “Window of Tolerance Framework” (Ogden & Minton, 2000; Siegel, 1999). Supporting such clients in identifying and managing autonomic arousal is positively treated with deep relaxation, focusing and self-hypnosis (Evans & Coman, 1998).

It was expected, therefore, that Sarah would benefit from a range of effective uses of hypnosis to support her current goals of anxiety management (Evans & Coman, 1998) with the aim of making gambling redundant as a coping outlet. Discussions about how this could be achieved (Clarke, 1992; Clarke & Jackson, 1983) supported her expectations of recovery and reconnection to family and friends.

## **Informed Consent**

Following Schefflin’s (2001) recommendation that a client be knowledgeable enough to make a conscious decision when giving informed consent, a general discussion was had about the hypnotic process<sup>2</sup> and the varying experience and benefit across the distribution curve of the general community. It was discussed how hypnosis could be introduced as an adjunct to CBT, to support Sarah in replacing gambling with other ways of managing her stress

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<sup>2</sup> Explanation in keeping with “About Hypnosis”, the Australian Society of Hypnosis Victoria website, May 2013.

and anxieties (Evans & Coman, 1998) and free up her attention to positive ways of adjusting to the changes in her life (Jackson, 1995; Stanley, 1995).

Sarah reported no current indicators of suicidal ideation. Given her report of past ideation, she recommitted to a safety plan. At assessment, she was clear in her statement that she could guarantee her safety.

Sarah confirmed no ongoing legal or “work safe” matters and gave her verbal consent for hypnosis and the handover for treatment. She completed a final session with her current psychologist, to review and honour her success to date in stabilizing her situation and reducing her gambling.

### **Rationale Overview for the Techniques Chosen**

Cognitive-behavioural therapy (CBT) is evidence-based practice for treatment of problem gambling (Thomas et al., 2011). Where people are in a “committed stage of readiness for change” (Prochaska & DiClemente, 1992), CBT gives a structured framework to mobilize and support the change required to establish and sustain abstinence from problem gambling. In addition to habituated gambling behaviour, clients present with a range of underlying and contributing issues that drive that behaviour. Sarah’s history placed her in Blaszczynski’s second pathway or the “emotionally vulnerable” group, who gamble as a response to “emotional or psychological distress,” resulting from backgrounds of abuse, grief, trauma and attachment issues (Blaszczynski & Nower, 2002).

Over several sessions of history taking, assessment and review, it was clear that Sarah had benefited from treatment with an experienced CBT therapist by reducing the frequency of gambling. My hypothesis that Sarah would benefit further from hypnosis as an adjunct to consolidate and deepen the benefits of CBT and trauma work (Evans & Coman, 1998) was strengthened by Sarah’s conviction that she had plateaued with CBT alone and needed more assistance to achieve abstinence. She had initiated enquiries about hypnosis with a sense that this would assist her further. The power of self-efficacy, belief that one will succeed, is well documented (Marlatt & Gordon, 1985).

### **Therapy Goals**

Therapy aimed to support Sarah in strengthening her means of coping with the anxieties surrounding her recovery and adjustment to life changes, which continued to trigger her gambling.

This would include deepening her ability to identify and self-soothe

autonomic arousal and consolidate sustainable and wellbeing enhancing coping strategies. Sarah believed that she would then be in a position to reconnect to family and friends alienated by what she identified as her “out of character” behaviour of habituated gambling. Sarah hoped that hypnosis could also support her in better pain management.

Sarah’s pre-counselling assessment included self-reports of her gambling behaviour and coping. The Problem Gambling Severity Index (PGSI) (Ferris & Wynn, 2001) is a recommended tool for screening and assessment (Problem Gambling Treatment Centre [PGRTC], 2011). Four items assess problem gambling behaviours (e.g., “How often have you bet more than you can afford to lose?”) and five items assess adverse consequences of gambling (e.g., “How often has your gambling caused you any health problems, including stress or anxiety?”). A score of 8 or more achieves the categorization of “problem gambling with negative consequences and a possible loss of control” (Holtgraves, 2009). Over the last 12 months, Sarah self-rated her gambling behaviour as 21/27 on the PGSI, reflecting the serious behavioural, financial and health impacts of her gambling.

Kessler Psychological Distress Scale: K6, is used to assess the presence of non-specific psychological distress experienced over the previous four weeks. Six K6 items cover symptoms of nervousness, hopelessness, restlessness, depression, worthlessness, and effort. Scores estimate the prevalence of serious psychological distress (SPD) and indicate functional limitations (Kessler et al., 2002). Sarah’s K6 score indicated high psychological distress. In the non-clinical gambling population, such scores are associated with clients who generally present as functioning but struggling (Dowling, [PGRTC], 2010).

The assessment of her recent functioning, in contrast to her history of previous high functioning, indicated that Sarah would benefit from developing an increased awareness of how, over recent (traumatic) years, her body had come to automatically respond with “fight, flight or freeze” symptoms when anxiety was triggered. Using “talking” therapy and interweaving hypnosis, it was proposed to build rapport over several sessions, to work with ego strengthening, and increase her awareness and confidence by helping her to experience that she could self-soothe emotionally and physically and orient to the future and positive aspirations, and so replace gambling with other life-enhancing interests. Such change is underpinned by strengthened negative affect tolerance (Ogden & Minton, 2000; Siegel, 1999).

No formal demonstration of trance depth or hypnotic responsiveness was assessed given Sarah’s self-motivation for hypnosis treatment, and her positive

response to guided relaxation and imagery. Guided relaxation was chosen as the initial induction to support building rapport, and the establishment of a safe place, as a foundation for continuing sessions.

## **SESSIONS' CONTENT**

Each session used hypnosis to reinforce and enhance the “talking” /therapeutic focus of the session (Evans & Coman, 1998; McConkey, 1984).

### **Session 1**

The focus was on building rapport, debriefing and reviewing the discussions held in the case meeting and further history taking. Sarah reported no gambling since our case meeting. She put this down to feeling very positive in her expectation of the effects of using hypnosis (Goldstein, 1981; Vanderlinden & Vandereycken, 1990), and that she had taken up the referral made to financial counselling.

We spent time discussing and validating her distressing experience of betrayal by her manager, and the abrupt loss of her work life amidst the ordeal of medical and legal proceedings and the development of her problem gambling. We discussed how gambling can serve as an outlet for coping when one needs time out in the context of grief and trauma. We clarified the evolution of her use of gambling. It was clear from her descriptions that gambling evolved from socializing with friends while recovering, to becoming a sole “time out” experience when lonely and feeling isolated or distressed, and she sought distraction and relaxation.

The agreed hypnosis focus for this session was the need for safe respite. Sarah was very responsive to a relaxation-focused induction, and I introduced a “yes set” (see de Shazer, 1985) which “helps to get the client into a frame of mind to accept something new” (p. 91). Sarah created a safe place, sitting on a bench under a tree. She responded well to cues to experience through each of her senses. She described a beautiful scene by a lake with a gentle breeze. Time was allowed for her to “soak up the calm and relaxation”; and she was cued for recall to this experience whenever she wanted to take time out for herself in self-hypnosis. Gave hypnotic suggestions for Sarah to expect that she will continue to enjoy the ease and calm of taking time for herself; and for expectation that she will be able to create this peaceful restorative space for herself at home; and that she had done all the right things to support change and now she could just relax and repair; in keeping with, “what you focus on

you amplify in hypnosis” (Yapko, 2008). Hypnosis concluded with permissive disengagement with slow, paced count-back from 3 to 1 ...

The session concluded with her reporting a positive hypnotic experience and feeling hopeful.

## **Session 2**

Sarah cancelled her next appointment. A telephone follow-up was then made. Her presentation was flat and disappointed that she had gambled in the intervening time period. We agreed on substituting her face-to-face session with a telephone session later that day. In the meantime, Sarah agreed to go for a walk in the sunshine and we talked through the benefit of focused breathing for self-soothing her stress response and to re-engage her problem-solving capacity: in keeping with Pat Ogden’s (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006) “bottom up” approach to supporting clients in managing autonomic dysregulation. By starting with calming the body, sensorimotor psychotherapy directly treats the effects of trauma manifesting as physical symptoms, which in turn facilitates emotional and cognitive processing. This method is recommended as beneficial for working with dissociation, emotional reactivity or flat affect, frozen states or hyperarousal and other PTSD symptoms (refer Ogden & Minton, 2000).

Later that day, Sarah presented in a more positive emotional state and reported she had used safe place imagery and focused breathing to calm and soothe herself. We discussed the benefit of these positive coping strategies as helpful tools in managing the negative affect she had been feeling in the morning. I also “normalized” her lapse to gambling as a “slip-up,” rather than a major failure, in keeping with behaviour change theories that emphasize the importance of making a distinction between expected lapses and relapse. Marlatt and Gordon, (1985) distinguish the importance of learning from lapses, and incorporating that learning (identification of triggers and responses) into planning how to positively manage similar situations in the future and so prevent relapse. We consolidated this discussion with examples of people Sarah knew and their struggles to quit smoking, and how she observed them taking time to build their capacity to remain abstinent.

Sarah identified the trigger to gamble was her distress at her ongoing estrangement from her daughter when she had thought about Christmas. I encouraged her to re-frame her disappointment that her daughter had not responded to her attempts to reconnect, with imagery of a lighthouse sending out a signal to her daughter and that she knows where Sarah is, and that

Sarah is safe now. I talked her through relaxation breathing and eliciting her safe place imagery and her trust in her daughter as the good woman Sarah describes.

### Session 3

Sarah reported no further gambling and that, following her “down” day, she visited a friend and had a very positive day, and felt grounded again. Today she reported having a visit with neighbours, getting to know people and feeling positive about her new living circumstances. Review of her daily self-hypnosis revealed that she was doing well and feeling positive about the calming experience of colour breathing and her safe place.

To build on her positive coping skills, in hypnosis, I invited Sarah to try out other self-soothing activities (Linehan, 2003)<sup>3</sup> with suggestions prompting a mindful focus when eating, doing the dishes; enjoying the view of her developing garden; and reinforced this image as a metaphor for thriving. I encouraged giving over her full attention to a water feature in the garden and reinforced the rationale for soothing and calming the mind and body as both healing and building a buffer against stress. The session concluded with Sarah's report of anticipating a pleasant Christmas with her extended family.

### Session 4

Sarah reported coping well over Christmas, and routines which supported her being pain-free. Since then, she had again experienced urges to gamble, but much less frequently than in the past. In response, Sarah had been proactive in ramping up protective strategies; she described going into her local gambling venue and telling staff that she has self-excluded<sup>4</sup> and she wanted to be sure they would recognize her if she breached. I congratulated her courage and relapse prevention.

Sarah reported a surprise contact from her estranged daughter and a Christmas get-together. This good news was overshadowed by worry about her son who had not been in touch, which was out of character for him. She also identified that her stress was compounded by reduction in pain medication, resulting in poor sleep.

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<sup>3</sup> Marsha Linehan's dialectical behavior therapy (DBT) self-soothing recommendations. Refer *Skills Training Manual for Treating Borderline Personality Disorder*, Marsha M. Linehan, (1993).

<sup>4</sup> Self-exclusion is a contract taken out by a person who wishes to be banned from entering the gambling areas of a particular venue.



Given Sarah's attention to relapse prevention and her identification that her good news had been overshadowed by worry, pain and poor sleep, hypnosis focused on relapse prevention. To strengthen previous post-hypnotic suggestions of more rapid trance induction, this session's hypnotic suggestions included a presupposition, based on Sarah's past experience of hypnosis, that today she would quickly feel at ease and enjoy the calm of her safe place.

To consolidate psycho-education around stress and gambling as a negative outlet, Sarah was reminded of the "pressure cooker" metaphor used in an earlier session. The "pressure cooker" is used to discuss how a number of stressors build up like the pressure in an overloaded cooker, and that gambling, like the steam valve on the cooker, becomes the outlet for this pressure. The focus of therapy is to equip the client with a range of positive coping and stress management alternatives to gambling. Toward building Sarah's confidence and capacity in stress management, suggestions were included to encourage ego-strengthening, for example, reminding her how well she is already equipped for stress management. Examples of positive coping strategies and activities were reiterated from her self-reports over previous sessions. She was also reminded of how she had been proactive in relapse prevention, and that she can trust that she knows what she needs and what works. Extended this positive affirmation, and reinforcement of her self-efficacy, by restating her experience that her focus on relaxation, social connection, and being busy without stress, had resulted in periods of being pain-free.

To further strengthen her resolve to remain gambling free, "solution-focussed thinking" (de Shazer, 1985) was invited, to elicit her future vision of herself unrestricted by problems with gambling. This invitation was extended, while she was comfortable in her safe place. "In six months time, when you are feeling really confident that gambling is a thing of the past, how will you be ...? What will be happening in your life?" She reported aspiring to be sitting with all her family reunited under the tree that she envisages in her safe place imagery.

Sarah gave positive feedback about the peaceful joy of sitting with her family under her tree. This session was summarized as showing clear evidence that Sarah knows what supports her wellbeing. Further, Sarah was prompted to book-end her day with self-hypnosis and associate the respite of her safe place as rendering gambling redundant as stress management.

## Session 5

Sarah reported lunching near the local gambling venue and had no thoughts of gambling. Since then, however, she reported being triggered by a television program on pyramids<sup>5</sup> and had responded by turning it off immediately. Says she feels really strong and clear about managing urges.

She also reported feeling “like a huge load had been lifted” as she had seen her son, who had been unwell over Christmas. She feels hopeful for him as he is in a new positive and supportive relationship. Sarah described passing on her self-soothing tips to him.

Sarah continues self-hypnosis daily. She reports her attention is going to positive things: things she is looking forward to.

We undertook a review of how Sarah evaluated her progress toward the goals articulated in last session’s solution-focused approach. Sarah rated herself 6/10 where 10 is her top wellbeing rating, and the word “content” captures all her aspirations. She described herself as feeling “at home” in herself again and related to sitting in her sitting room and feeling content. Thinking ahead, Sarah aspires to be useful and helpful to others; she is thinking of volunteering to give back to the community, as she feels grateful for the support she has received while recovering.

Her choice of hypnosis focus for this session was to tune in to the pain in her body. Invited Sarah to imagine a pain thermometer, or measuring dial, on which she rated her pain at 3/10, stating that she had taken pain medication to support her in being able to attend her session today. While in trance, she was invited to give her full attention to the pain, where it was located, what it looked like in shape, colour, etc. While focusing on the pain image, she was asked to imagine breathing in her favourite, soothing coloured air, which she described as a “sky blue” colour. She was invited to imagine that soothing coloured air soaking through every cell of her mind and body; and in particular, to focus on breathing through the pain image and to notice when that image and intensity began to change. Sarah was able to relate to lower and lower pain readings on her “pain dial,” and a corresponding change in the density of the pain image. In debriefing this experience, she summarized it as a positive outcome, saying her pain was minimized, and stated that she was encouraged to work with this imagery at home especially before bed. Sarah was confident she could extend the session break to three weeks.

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<sup>5</sup> Pyramid imagery associated with a favourite “pokies” game played.

## **Session 6**

Focus of session was reconnection with her children on her birthday and acceptance that they care despite their very busy family lives. Sarah was content that her relationship with her elder daughter was healing even though she still felt some discomfort with her. Discussion explored the context of these statements and Sarah reported a number of serious family matters that were causing her daughter a deal of distress.

Focus of hypnosis was “safe place” and calming, reflecting on how her daughter shows Sarah care even while juggling serious worries in her own family. With the focus on reconnecting to her daughter, Sarah reported feeling very calm and peaceful and accepting that time is healing her and her relationship with her daughter.

## **Session 7**

Sarah reported urges to gamble had returned following the holiday period and contact with her family. It was agreed that she was feeling a range of both positive and negative emotions, after having various family visits over the holidays, and that now they were back to their busy lives she felt sad and lonely.

With relapse prevention in mind, we reviewed how triggers can be anything that brings back thoughts, feelings, and memories associated with her old pattern of gambling, eliciting urges or thoughts about gambling. Refer to Rickwood, Blaszczynski, Delfabbro, Dowling, and Heading (2010) for a comprehensive discussion of learning theory and triggers to gamble. We reviewed CBT strategies that Sarah had found helpful in the past and discussed more positive ways of coping with the feelings of sadness and loneliness that she was currently experiencing.

In hypnosis, Sarah was prompted that it was a normal part of recovery to re-experience urges to gamble in response to feelings of sadness and loss. She was also prompted to recall how well equipped she was now to cope with those feelings and manage her day in other positive life-enhancing ways. Sarah was prompted to recall that she could expect, and accept, that gambling thoughts will pop up from time to time, and that she can just ignore them like intrusive and unwanted advertising (an example we had discussed earlier in session).

Ego strengthening was encouraged with invitations to reflect on her stated core values and to see herself using wellbeing enhancing ways of self-soothing, which are true to those values. Prompted Sarah to re-experience her strength and the resolve she experienced when she instructed gambling venue staff about her self-exclusion.

Sarah was invited to imagine herself sitting beside the lake in her safe place imagery, and autumn leaves dropping on to the water, and whenever a thought /urge to gamble popped up just notice it and let it drop onto a leaf and float away. Defusion of the urge through this type of acceptance and commitment therapy (ACT) *mindfulness*-based technique aims to reduce the influence of unhelpful cognitive processes upon behaviour, and to gain psychological presence and flexibility (Harris, 2008), while calming and soothing (de Lisle, Dowling, & Allen, 2012).

### **Sessions 8, 9 and 10**

Sessions continued to reinforce positive coping strategies and to develop mindfulness thinking in session discussions, and then reinforce in hypnosis. Urges reported as less intrusive as Sarah's focus turned to social reconnection as finances began to recover and family events increased.

### **Session 9**

Sarah rated herself at 99.9% good. She still experienced occasional thoughts about gambling and she continued to adopt the mindful approach of imagining them drop on a leaf and float away. She says this continued to work for her.

### **Session 10**

A telephone session was booked, as Sarah was away, visiting a friend. She reported herself busy and still using her mindfulness routines for any thoughts about gambling. Discussed staying grounded and she reported feeling quite strong. Sarah advised she was awaiting a medical review pre-surgery.

## **OUTCOME**

At three months post her last gambling lapse, Sarah reported that she had remained gambling-free without stress, and that she had reconnected to family and friends, and reported improved quality of sleep.

## **CONCLUSIONS AND RETROSPECT**

In retrospect, I would be more directive earlier in shifting the focus from the past to the future, with the aim of accelerating gambling replacement change processes. For example, introduce hypnosis with a script theme along the lines of this example from Yapko (2008): "You have been so absorbed in feelings

of distress, it would be helpful to start to get absorbed in a different way of experiencing yourself ...” which is a more open invitation for Sarah to tune back into her own resources with less structured guidance from the therapist.

In the sessions reported, the focus on stabilizing from the chaos of gambling took precedence. Given Sarah’s positive response to minimal attention to pain management in hypnosis, if consultation had been possible with her specialist health professionals she may have benefited further from a larger repertoire of hypnotic suggestions, along the lines of “mental comfort and restfulness” (Kiernan, Dane, Philips, & Price, 1995) and “hypnotic analgesia” (Montgomery, Duhamel, & Redd, 2000), concepts that would further strengthen her recovery from past trauma and gambling urges while assisting pain management.

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# THE USE OF HYPNOSIS AS AN ADJUNCT TO COGNITIVE BEHAVIOURAL THERAPY IN THE TREATMENT OF PAIN, ANXIETY, AND SLEEPING DIFFICULTIES ASSOCIATED WITH MULTIPLE SCLEROSIS

Tilsa Slatter  
Psychologist, Melbourne

*This case study of Mrs S describes the use of hypnosis as an adjunct to cognitive-behavioural therapy in the treatment of chronic pain, anxiety, and sleeping difficulties associated with multiple sclerosis (MS). Therapy focused on increasing adaptive behaviour and improving emotional and cognitive responses to life changes, in particular, the deterioration of physical ability due to the onset of MS. The effectiveness of hypnosis and CBT in combination is demonstrated by the improvement in quality of sleep, a reduction of anxiety and depression, and positive behaviour changes. Chronic pain was decreased in the short term, but not in the long term. A retrospective evaluation of treatment is also included.*

Keywords: hypnosis, cognitive-behavioural therapy, multiple sclerosis, pain, anxiety.

## PRESENTING PROBLEM

Mrs S, a 72-year-old married woman, was referred for counselling by her GP who requested treatment for her anxiety and depression related to her recent physical decline associated with multiple sclerosis (MS). Mrs S was also experiencing chronic pain as a result of the MS, as well as difficulty sleeping, immobility, and declining independence. This had increasingly led to social isolation and a decline in emotional and psychological functioning. Mrs S had developed a pattern of negative thinking, and although her husband was coping well with the practical day-to-day tasks and caring duties, and was very

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Correspondence regarding this paper should be sent to Dr Tilsa Slatter at [tilsa@deakin.edu.au](mailto:tilsa@deakin.edu.au).



supportive of his wife, he found it difficult to cope with Mrs S's mental and behavioural disengagement.

### **Client's Presentation**

Due to her medical condition, Mrs S was immobile from the waist down, spending most of her time in a specially designed motorized chair, and suffered with a great deal of pain, particularly down her left side (arm and leg). She also experienced muscle spasms, which caused her hands and arms to shake. Mrs S was therefore unable to look after herself in any way, including eating, bathing, dressing, toileting, and even sleeping (where she required someone to roll her over during the night, preventing her from resting sufficiently). Nevertheless, Mrs S is intelligent and continued to be very cognitively aware, and expressed finding it extremely difficult to adjust to having others take care of her.

Following her physical deterioration, Mrs S became very negative about life, ceased engaging in her hobbies, partly due to physical limitations but largely due to her negative thoughts and mood, and became socially isolated. Mrs S did continue to see her children and grandchildren, but reported that this was difficult because she had to put on a facade and appear happy.

Mrs S's symptoms of anxiety (e.g., nervousness and worry) and depression (e.g., feelings of sadness and hopelessness, and loss of pleasure in activities) appeared to be directly linked with her declining medical condition and subsequent lack of independence. Mrs S was unable to take antidepressants due to unpleasant and unwanted side effects. Mrs S reported no suicidal ideation or suicidal intent or plan.

### **Relevant Past Psychological, Social, and Medical History**

Mrs S was born in South Africa and reported having a "normal" childhood and adolescence. After having two children while living in South Africa, Mrs S and her husband emigrated to Australia, where they had another four children in quick succession. Although Mrs S had no extended family in Australia, she had a close relationship with Mr S and adapted well to her new environment. Mrs S reported having no prior history of mental illness.

Mrs S was almost completely reliant on Mr S, who was her primary caregiver up until a year ago when Mrs S moved into a high care nursing home facility, which removed her last remaining aspects of independence. As her physical health began to decline, Mrs S began to isolate herself from friends and family, and stopped engaging in her hobbies, such as painting,

cooking, and reading. Nevertheless, Mr S would spend most of each day with Mrs S at the nursing home, and both Mrs S and Mr S did have the support of their children and grandchildren, who lived nearby and kept in touch regularly.

Mrs S's condition had impacted on her level of independence and mood in a number of ways. Chronic pain and difficulty sleeping were significantly contributing to Mrs S's low mood. Mrs S was also troubled by the muscle spasms in her arms and hands, which made it difficult for her to eat, write, paint, and perform other fine motor skills. Her lack of mobility meant that she was almost completely reliant on others for care.

Hammond (1990) emphasizes the importance of thorough medical and psychological evaluation of clients with chronic pain to become familiar with medical evaluation and treatment alternatives and how these may impact upon psychological treatment. A lengthy discussion with Mrs S's GP after the first session revealed that although medication could help to reduce pain and slow the decline in Mrs S's condition, her condition was not responsive to other treatments and symptoms would continue to worsen over time. Mrs S's GP was enthusiastic about any form of psychological treatment I could offer, thus the referral, and was also keen to try hypnosis. The GP stated that a reduction of pain would not mask symptoms or worsen her condition in any way. Any form of relief was considered beneficial.

### **Suitability for Hypnosis**

Hypnosis was deemed a suitable treatment method to use as an adjunct to CBT to increase the effectiveness of therapy aimed at pain reduction and improving sleep based on research illustrating the effectiveness of these techniques (described further below, e.g., Graci & Hardie, 2007; Jensen et al., 2011). Mrs S had no previous experience with hypnosis and reported having minimal knowledge of the theory or purpose of hypnosis. However, Mrs S did enjoy using relaxation tapes and music to induce relaxation. The theory and practice of hypnosis were discussed with Mrs S, and following this she was keen to incorporate it into her treatment. The use of hypnosis was discussed with Mrs S's doctor prior to use, to ensure that a reduction in pain would not mask worsening problems or symptoms. Mrs S's doctor was enthusiastic about trying all forms of therapy to improve Mrs S's wellbeing and comfort. Additionally, Mrs S indicated that she had no suicidal ideation, no intent or current plan of suicide. Although she was experiencing some symptoms of depression, these were not severe. There was no evidence of a personality disorder or psychosis, and Mrs S was not involved in any legal proceedings.

## **Informed Consent**

Informed consent was obtained in writing prior to conducting the initial hypnosis session in session 3. The hypnotic process was discussed and any questions from the client were addressed. The client was also asked for permission to record the hypnosis sessions, to which she agreed. The recorded session was transferred to CD and a copy was given to the client for continued use (self-hypnosis). The form used to obtain consent also enquired about the client's fears or phobias, allergies, and involvement in legal proceedings. Mrs S identified no fears/phobias, allergies, or involvement in legal proceedings.

## **THERAPY GOALS**

The purpose of therapy, in addition to developing a trusting professional relationship, was to reduce anxiety and depressive symptoms by encouraging positive behaviour and reducing negative cognitions. Moreover, an essential goal of therapy was to improve Mrs S's quality of sleep and help her to manage the chronic pain in her arm and leg.

Overall, the aim of therapy was to enhance day-to-day functioning, including thoughts, feelings, and behaviours, even while her condition continued to prevail. It was deemed important to improve her attitude to life and her future to enhance her overall wellbeing and engagement in life.

More specifically, a combination of CBT and hypnosis would be used for the following purposes:

1. Pain management: Reduce the level of pain and change the experience of pain to a more manageable sensation. Help Mrs S to utilize relaxation and other strategies to take control of pain and reduce the associated distress.
2. Improve sleep: Help Mrs S to fall asleep more quickly and maintain a more restful sleep throughout the night. Increase comfort and relaxation surrounding sleep.
3. Reduce anxiety: Strengthen sense of self and reduce nervousness and worry associated with lack of independence. Increase sense of enjoyment associated with hobbies.
4. Encourage positive behaviour to reduce thoughts and feelings associated with depression: Utilize behavioural therapy to set goals, encourage participation in activity, and overcome barriers.
5. Enhance wellbeing: Utilize cognitive therapy, in addition to hypnosis, to increase optimistic thinking and improve future outlook.

## **Treatment Approaches and Rationale**

Cognitive-behavioural therapy (CBT) with a large relaxation component was chosen as the primary therapy to reduce anxiety, increase adaptive behaviours, and reduce pain. Strong evidence for the effectiveness of CBT for the treatment of anxiety disorders and insomnia, particularly in the elderly, has been consistently documented (e.g., Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012).

Hypnosis was utilized as an adjunct to CBT in order to increase the efficiency of treatment. Jensen et al. (2011) reported that cognitive therapy in combination with hypnosis was more effective for both pain relief and decreasing catastrophizing cognitions in patients with multiple sclerosis, compared to either cognitive therapy or hypnosis alone. In addition to this, Graci and Hardie (2007) emphasize the importance of combining CBT and hypnotherapy as approaches for the successful treatment of sleeping difficulties.

Following discussion with Mrs S's general practitioner, I believed that the use of hypnosis would not be contraindicated, and, used in conjunction with CBT, could be effective for pain management, improving quality of sleep, and reducing anxiety.

## **OUTLINE OF SESSIONS AND PROGRESS**

### **Session 1**

The first session was used to gain an understanding of the client's personal, medical, and psychological history and her current physical and psychological problems and symptoms. The session also focused on building rapport and developing a trusting, therapeutic relationship with the client.

Mrs S's main complaints related to the pain she experienced almost continuously down her left arm and leg, her lack of quality sleep, and her worsening physical decline, all of which were contributing to her reduced involvement in hobbies and increasing social isolation. Additionally, Mrs S was also experiencing symptoms of anxiety and depression, largely a result of negative thinking.

The session concluded with an explanation of potentially beneficial therapeutic strategies (i.e., CBT, relaxation, hypnosis) and the provision of a simple controlled (diaphragmatic) breathing exercise aimed at reducing arousal and aiding sleep. Mrs S was also left with a homework task to write down all the things she enjoyed, or used to enjoy, doing.

## **Session 2**

Following a brief discussion of how Mrs S had been coping during the prior week, her responses to the homework task were discussed. Mrs S had indicated that she used to enjoy a number of things, such as painting and sewing. Barriers to engaging in these activities, and strategies to overcome barriers, were discussed, and small goals were set.

Psychoeducation was utilized to help Mrs S understand the process of the stress reaction during anxiety and how this may increase pain, and the importance of controlled breathing and relaxation to reduce the effects of this. Sleep hygiene was also discussed.

CBT was introduced, where I discussed the cycle of negative thinking and ABC thinking, to help Mrs S identify negative thought patterns and replace these with more optimistic ones. Cognitive distortions, such as catastrophizing in relation to pain, were also discussed. Various cognitive and behavioural strategies were used in each session throughout treatment.

## **Session 3**

The first use of hypnosis was in session 3. Prior to hypnosis the hypnotic process was again briefly described and Mrs S's consent was obtained in writing. Mrs S's experience of pain was then discussed in more detail. Hammond (1990) suggests that obtaining a clear description and history of the pain will help to gain insight into the client's experience and will provide clues that will be useful in tailoring hypnotic techniques. Specific questions related to the characteristics of Mrs S's pain experiences were asked, such as, level of pain intensity (out of 10), level of distress from pain, description of the pain, colour of pain, etc. Mrs S described the pain in her arms as "hot barbed wire," red in colour; while the pain in her leg was a dark blue, painful heaviness.

The induction method used was eye fixation and progressive relaxation was used for deepening. Intervention during hypnosis included ego-strengthening to increase self-efficacy regarding pain management and then included a visualization of the pain sensation, using the description obtained earlier from the client. It was then suggested to Mrs S to change the characteristics of the sensation, such as the colour, shape, and intensity, to create a more comfortable experience. The suggestion of a dial in the mind used to reduce the intensity of the pain was also made, and Mrs S could use this to reduce the pain and induce limb anaesthesia. Post-hypnotic suggestions were made regarding pre-sleep behaviours, such as putting on pyjamas, lying down, and putting head

on pillow, and these were suggested to be cues for relaxation and a sense of peacefulness. It was suggested that her mind and body would recognize these behaviours as cues for sleep and accept sleep as a time for healing. It was also suggested that she would be able to manage any pain that might arise at night. Mrs S reported that she felt very relaxed and comfortable during the session. A recording of the session was provided to Mrs S on a CD, and she was asked to listen to the CD each night prior to going to sleep. As suggested by Jensen et al. (2009) self-hypnosis training is an effective technique for the management of chronic pain in individuals with multiple sclerosis.

#### **Session 4**

Session 4 began with a discussion of Mrs S's progress and experiences in the past fortnight. She reported an increase in quality of sleep, and some reduction in pain. She had also been utilizing self-hypnosis each night to induce relaxation. Mrs S had brought some new paints and a canvas in the hope to begin painting again; however, she worried about the shaking of her hands and how this would affect her ability to paint.

This hypnosis session focused on pain reduction, in addition to reducing the muscle spasms and increasing confidence to achieve goals. Following guided imagery and the use of a large white cloud to release fears and anxieties, intervention included the use of a colour technique to induce relaxation in the muscles, particularly in the arms and hands, so that they are calm and steady. This feeling was then associated with a visualization of herself painting with steady hands and ideomotor cues, which had been set up prior to the hypnosis, were used to anchor these feelings. Post-hypnotic suggestions reinforced the experience of relaxation and steadiness of the hands, particularly during painting.

Mrs S reported that she very much enjoyed the guided imagery and was intensely absorbed by it. She expressed how relaxed it made her feel, and related it back to her paintings of landscapes.

#### **Session 5**

Mrs S appeared somewhat more positive in session 5. She had begun painting again, as her son had built and delivered her new easel, and she had undergone macular surgery so was again able to read and do crossword puzzles. She had also been home for a few hours on a number of occasions, which she had enjoyed immensely. Today's hypnosis session focused on healing and pain management.

Induction and deepening utilized controlled breathing and guided imagery. Intervention followed on from the guided imagery and it was suggested that Mrs S find a comfortable position to sit and rest in the forest and absorb its natural energy and healing abilities. More specific suggestions were then made for her to experience the flow of natural light throughout her body, containing natural healing bodies, repairing and rebuilding cells, muscle, and bone, and in particular, repairing the myelin sheath surrounding axons of the neurons in brain and spinal cord (associated with MS). It was suggested that these bodies were repairing pathways between the brain and spinal cord, allowing them to communicate more efficiently. This was also associated with pain reduction and increased energy. Post-hypnotic suggestions indicated that this healing would continue post-hypnosis and would not only give her energy during the day, but also a restful sleep at night where further healing would occur.

## **Session 6**

At the beginning of session 6, Mrs S proclaimed and demonstrated that she was starting to move her feet (slight up and down motions). She was happy about this, but was unsure of what it could be attributed to. She was extremely happy to report that she had continued to enjoy quality, restful sleep, and utilized self-hypnosis when the pain increased.

Hypnosis focused on reducing anxiety through guided imagery including the worry tree, as well as creating limb anaesthesia using progressive relaxation. Ego-strengthening was used throughout, and post-hypnotic suggestions for increased wellbeing, pain reduction, and motivation to achieve goals were included.

Mrs S remarked that she enjoyed the hypnosis sessions and experienced deep relaxation while in trance. She was particularly happy about overcoming barriers to change, and had noticed a significant improvement in mood.

Further sessions were conducted with the client on a less frequent basis, but these will not be discussed here.

## **OUTCOMES**

A variety of cognitive and behavioural strategies were utilized in conjunction with hypnosis to help Mrs S identify negative thought patterns and replace these with more optimistic thinking, and also to encourage more adaptive behaviour. As a result of these strategies, Mrs S began to make positive changes to her thinking and lifestyle. As she began to sleep better at night, Mrs S found

that she had more energy during the day. Mrs S began painting again, adapting to her shaky hands and obtaining an easel suitable for her chair, and she also began going for outings with Mr S, either in her motorized chair or in their new car specifically designed to fit her chair within. Following this, Mrs S started going home for periods of time during the day, and now spends every day at home, only returning to the nursing home to bathe and sleep. Mrs S reported low-levels of anxiety at last follow-up and she continues to enjoy restful sleep. The reduction in pain was temporary, however, and she continues to experience severe pain at certain times of the day. Mrs S continues to utilize the recordings of hypnosis sessions for self-hypnosis.

### **COMMENTS ON CONCLUSIONS AND RETROSPECT**

I believe that the success of Mrs S's therapy can be attributed to the use of both cognitive-behavioural therapy and hypnosis. The use of hypnosis enhanced the efficiency of the cognitive and behavioural strategies, and, simultaneously, helped Mrs S to experience the feeling of relaxation to enable her to utilize self-hypnosis on a regular basis. The hypnotic techniques used to aid with improving sleep appeared particularly successful, and Mrs S has continued to report experiencing undisturbed, restful sleep. However, although the hypnotic techniques utilized to reduce pain appeared to be successful in the short term, this did not continue in the long term. Mrs S reported that she preferred hypnosis when it involved more guided imagery (particularly of beaches, forests, and gardens), and therefore perhaps the more practical techniques utilized (such as the ideomotor cues, anchoring, and pain dials) were not as deeply accepted. In retrospect, it may have been more beneficial to utilize pain reduction techniques as part of the guided imagery, or utilize a variety of other pain reduction techniques, such as time distortion, pain amnesia, or metaphors.

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## A CASE FOR EGO-STRENGTHENING

George Gafner

Semi-retired licensed clinical social worker, Arizona, USA

*Maggie was a 37-year-old Mexican American woman who was seen in therapy over several months in 2004. A mortuary service worker in the first Persian Gulf War, she had been in therapy for depression on and off for years with a series of psychology interns. The first session, she stated she wanted “story therapy,” something she had heard about in the waiting room of the mental health clinic at the Veterans Affairs Medical Center in Tucson, Arizona. The author commenced hypnotherapy, she responded well to embedded suggestions within stories, and her constipation-predominant irritable bowel syndrome, our agreed-upon goal, improved. Early on, it became apparent that Maggie suffered chronic PTSD from her military duty; however, she resisted discussing her nightmares and repeatedly declined offers of exposure therapy. Her elderly mother attended all of her sessions, sitting quietly in the corner of the office. A breakthrough occurred with the help of her mother, but also with the assistance of the client’s priest and a neighbourhood folk healer.*

Key words: hypnotherapy, irritable bowel syndrome, PTSD, folk healing, curanderismo.

Cory Hammond (1990) likened the burdened psychotherapy client to the debilitated medical patient in need of major surgery. First, rest and nutrition are needed to strengthen the person for the rigours of the operating table. Hammond also believed that clients may not be willing to let go of a problem until they feel strong enough to do so. A therapist in the U.S. Veterans Affairs (VA) battles the “green poultrice”—not undeserved financial compensation for problems connected to the service—but a therapist also faces many personality disorders and high reactance, both indications for indirection, such as stories and anecdotes. However, I occasionally used directive suggestions, for example, “You can do it,” or “You can let go.” In the refugee clinic at the University of Arizona (Gafner & Benson, 2001), I employed indirection and directive

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Correspondence regarding this paper should be sent to George Gafner at [ggafner@yahoo.com](mailto:ggafner@yahoo.com).

techniques about equally with victims of torture from Central America and Africa. Harry Stanton's legacy is evident at a VA in Pennsylvania where Ron Pekala's and colleagues' (2004) study employed directive ego-strengthening suggestions in impacting relapse in substance abusers.

Then there was the subject of this case study, Maggie, wise beyond her years, irreverent, sarcastic, and one maddeningly challenging client. She was a 37-year-old Mexican-American woman I saw in 2004 at the Tucson, Arizona VA's mental health clinic. Fourteen years before she had been an Army mortuary worker in the first Persian Gulf War. She had been seen for depression by a series of psychology interns and had failed trials of SSRIs and other agents. She was followed in the GI clinic for constipation-predominant irritable bowel syndrome (IBS) that dated from the night in Kuwait when she cowered behind a berm as a SCUD missile flew over "and I puked in my gas mask" and "it literally scared the shit out of me." With her Aztec features she was as pretty as she was provocative. Reeking of marijuana smoke and defiant in her mirrored aviator's sunglasses, Maggie plopped down in the recliner, yanked up the footrest, and leaned back. "How can I help you?" I asked quietly, realizing a one-down, restraining posture was likely apt. She answered, "I want some of that 'story therapy' I heard about in the waiting room. Oh, and I don't like talking about myself, so save your breath." She saw me glancing at the shrivelled-up little elderly woman who had accompanied her and taken a seat in the corner of the room. "That's my mom. I didn't have any place to leave her today. She's pretty deaf and speaks hardly any English," she added. I greeted mom loudly in Spanish, she smiled wanly and replied, "Thank you for helping my Margarita."

I resisted the temptation to ask Maggie if she was high, knowing I could scare her off if I showed interest in substance use before we had a relationship. "She wants a story, so let's do it," I thought. I offered some suggestions for slowing down and relaxing and then launched into Pandora's Box. Remember that one? The story's meta-message is that there's hope even if you disclose your problem. In the story I interspersed suggestions directed at her IBS, like, "*exit* discussions were fruitful," or "transit time can speed up." She re-alerted slowly and it was evident she had experienced catalepsy and probably other hypnotic phenomena, like dissociation and time distortion, but sticking to a posture of restraint, I didn't reinforce her good response. "Was that hypnosis?" she asked. "Pretty close to it," I hedged. In 2006, the American Psychological Association came up with a much-criticized definition of hypnosis. I prefer

the APA's succinct and clear 1993 definition: "a procedure wherein changes in sensations, perceptions, thoughts, feelings, or behavior are suggested." When your client drifts off during progressive muscle relaxation or meditation—two of many techniques that don't carry the baggage of hypnosis—is that hypnosis? Probably not. What about when, during talk therapy, I tell a story and the client evinces markers of trance like Maggie? Long ago I tired of semantic jousting on this and now my rule of thumb is, "If you call it hypnosis, it's hypnosis."

I saw Maggie—always accompanied by her mother—about 15 times over five months. During that time, I often wondered if the therapy was for me or for her. After a few sessions I was certain I was dealing with chronic PTSD from the handling of corpses in Kuwait; however, as I tried to address her PTSD, Maggie, ever clever in her defensiveness, stonewalled me at every turn, either cancelling or just clamming up and asking for a story instead. Early on, I made her a CD in which IBS-specific suggestions were embedded in an ego-strengthening story, *Molasses Reef* (Gafner, 2004, 2013). She said she listened to it three times a week, and she did show moderate gains in constipation, our agreed-upon goal. I abandoned ego-strengthening stories for instigative stories in an attempt to perturb her into letting me begin exposure therapy. She did agree to two exploratory sessions of EMDR which generated no affect and gave her a headache. I pressed harder on the exposure. I tried alternating stories, story without an ending, and no stories. I sought consultation, which yielded nothing useful. Some days she showed up bedraggled and depressed, though not suicidal. I knew she had had a hospital admission for suicidal ideation some years ago and she agreed to let her cousin hold her handguns.

I learned she was an only child and that her father drank himself to death, dying when she was 16. She had had on-and-off boyfriends, mostly losers. I never smelled marijuana after the first time. She didn't drink, said she used marijuana only occasionally, and mostly managed stress by cuddling her cat. She endorsed insomnia and nightmares but declined to talk about her dreams, instead turning my hypnosis phrasing back on me, like, "George, you can control letting go, or simply let go of control." She angered and frustrated me no end. A psychiatrist got her to agree to PRN trazodone for sleep and she took it "now and then."

Her mother was now on dialysis. I had completed a course of radiation five years after a prostatectomy and still didn't feel full strength. I was tired, fed up, discouraged. I saw clients but I also had supervision, training and committees. One session, Maggie made a mocking remark. Perhaps it was one

narcissistic wound too many, and I blew up. I hastily dragged my chair over to her mom and said, “Look at this, your daughter has a chance to get better and she’s choosing suffering instead, like a martyr!” Maggie swore at me, yelling, shrieking, “Leave her out of this!” Mom said quietly, “She came back from there a different person ... she was cursed, you know.” Cursed? Did I hear her right? Then Maggie said under her breath, “And I was cursed again, over there, taking that crucifix out of the corpse.” Did I hear that right? They would later reveal hallmarks of a curse I had heard from other clients, like stones pelting the roof at night, dead chickens smeared on the front porch, and the like. And then, Maggie sobbed, wrenching sobs. We were done for the day. I told her, “I shouldn’t have said that, I apologize. I wasn’t in the service and I never had to handle dead bodies ... anyway, Maggie,” I continued maladroitly, “will you do it?” “Yes, goddamn you, I will,” she said softly. She promised to write everything down for me. I felt exhausted—but elated. Thinking back, I felt I could thank early ego-strengthening for anchoring therapy in a foundation that made change possible.

I’m not new to curses and *curanderismo* (folk healing). With one elderly couple I was seeing, a relative didn’t like the husband’s marrying a woman from across the Mexican border. He hired a *bruja*, or female witch, who paid neighbourhood children to do dirty deeds like leaving faeces on the step. A *curandero* (male healer) I had used before performed a cleansing ceremony in the home and the curse was broken. I remember the couple’s relating the “lifting of pressure” in the home and immediately after the ceremony they discovered a family Bible, lost 20 years before. I asked Maggie why someone would do this to her and she figured “someone didn’t think a Mexican girl should go in the Army.” Then, in Kuwait, she pulled a crucifix from the rectum of a mutilated soldier’s body and realized she had been cursed again. Once a week her mother sent her *cochitos*, Mexican molasses cookies in the shape of a pig, and she vomited them on the body. I worked with the priest from Maggie’s church who accompanied her to the home of a *curandera* (woman healer). The healer conducted a ceremony and gave her a task that involved praying at the Tiradito (little castaway) shrine in Tucson. Concurrently, in the office Maggie recorded her statement, listened to it first in the office, then repeatedly at home. On a 0 to 10 scale her distress went down from in the stratosphere to 3. Fear, helplessness and horror with attendant cognitions were processed, but also guilt and shame. Witnessing injustice done to another is also a distressing event for many veterans with PTSD, as it was for Maggie. She had to get on with her life as did I. She was now studying computer science

at the university and had a new boyfriend. Several weeks after the last session she left me a message saying her mother wanted to see me.

Her mother had removed herself from dialysis and was covered in uremic frost, a sort of green fuzz. She opened her eyes briefly and said, “Thank you for helping my Margarita.” I just smiled weakly, at a loss for words. When I left I didn’t see her daughter. A few years later I ran into Maggie at a street fair in the city. I greeted her enthusiastically, like a long-lost friend. Her mood was serious and she was polite but cold during this brief encounter. Perhaps I was a reminder of an unhappy chapter in her life. How often has that happened, where I attached inordinate meaning to a case I had invested in? The client moves on, but I remain stuck in time, the slow learner that I am.

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## USE OF CLINICAL HYPNOSIS AND EMDR IN KIDNAPPING AND RAPE: A CASE REPORT

Génesis M. Rocha and Arnaldo Téllez

*Universidad Autónoma de Nuevo León, Psychology School, Mexico*

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*This case study describes the use of clinical hypnosis and EMDR (eye movement desensitization and reprocessing) in a woman with post-traumatic stress disorder (PTSD) due to her kidnapping and rape, before and after which she also experienced emotional violence from her husband. The patient suffered from panic attacks, crying, and sadness, in a climate of constant social isolation. Treatment goals were to eliminate anxiety attacks and stress, and to strengthen self-esteem and resilience while encouraging an optimistic attitude. To measure these variables, five psychosocial scales and ratings of three emotional states (wellbeing, anxiety and tranquillity) were used throughout the treatment to assess the progress of therapy. EMDR was used in the first four sessions to treat PTSD symptoms, and hypnosis was employed to facilitate emotional abreaction and strengthen self-esteem during sessions 2 to 9. Findings showed a significant decrease in anxiety attacks and stress levels, along with improvements in general wellbeing, tranquillity, optimism, self-esteem and resilience. The combined use of hypnosis and EMDR was shown to be an effective therapeutic strategy to reduce PTSD related symptoms.*

Keywords: clinical hypnosis, EMDR, post-traumatic stress disorder, rape, kidnapping.

### INTRODUCTION

Among high-impact crimes in Mexico the most frequent is kidnapping, which refers to the illegal deprivation of a person's liberty in order to extort a payment (Reyes, 2013). Officially, there were 1307 kidnappings reported in the year 2012 (National Observatory Citizen [ONC], 2013); however, the real number is higher because many cases go unreported to the police. According to a government study, Mexico suffered an estimated 102,000 kidnappings in 2014 alone. Express kidnappings, where a smaller, affordable ransom is

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Correspondence regarding this paper should be sent to Génesis M. Rocha at [genesis.r@tecmilenio.mx](mailto:genesis.r@tecmilenio.mx) or Arnaldo Téllez at [atellez50@hotmail.com](mailto:atellez50@hotmail.com).

demanded rapidly, are the most frequent, comprising 59% of all kidnappings (National Institute of Statistics and Geography, 2015).

Jiménez (2002) states that: “Kidnapping is one of the illegal activities that affects our society presently the most, not only by the amount that are being perpetrated, but because how they are accomplished is increasingly violent.” Referring to the fact that concurrently kidnapping victims are beaten, mutilated and sexually abused.

After being raped and kidnapped some victims exhibit PTSD. The intensity or severity of this condition depends on various factors, which Williams and Poijula (2002) describe:

1. Factors prior to the event: The number and intensity of stressful events preceding the traumatic experience influence how the person will react to it. Examples of those events could be emotional or sexual child abuse or ineffective coping skills, amongst others.
2. Factors during the event: age and the event’s meaning to victim.
3. Factors after the event: this is whether social support was or was not received and/or being unable to find a meaning for the traumatic event.

Chacón (2006) describes the symptoms of PTSD as:

1. Re-experiencing:  
Flashbacks, feelings and sensations associated by the subject to the traumatic situation.  
Nightmares; the event or other images associated with it often recur in dreams.  
Disproportionate physical and emotional reactions to events associated with the traumatic situation.
2. Increased arousal:  
Difficulty sleeping.  
Hypervigilance.  
Trouble concentrating.  
Irritability, impulsivity and aggressiveness.
3. Avoidance behaviour and emotional blockage:  
Strong rejection of situations, places, thoughts, feelings or conversations about the traumatic event.  
Loss of interest.  
Emotional blocks.  
Social isolation.

These symptoms are widespread in the population affected by PTSD, but associated problems are commonly observed in clinical practice (Crowson,



Frueh, Beidel, & Turner, 1998; Frueh, Turner, Beidel, & Cahill, 2001).

PTSD involves multiple concurrent disorders, the most common are (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Zatzick et al., 1997):

- Panic attacks: present when exposed to situations related to the traumatic event. These include intense feelings of fear and anxiety accompanied by physical symptoms such as palpitations, sweating, nausea, and tremors.
- Depression: manifested as loss of interest, decreased self-esteem, and in the most serious cases as recurrent suicidal ideation.
- Anger and aggression: They are very common reactions amongst victims of trauma.
- Extreme behaviours of fear: avoiding everything related to the trauma.

PTSD was included in the chapter “Trauma and Stressor-Related Disorders” in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), and its diagnostic criteria include a history of exposure to a traumatic event followed by symptoms from each of four symptom clusters: intrusion (traumatic nightmares, dissociative reactions, flashbacks, and intense or prolonged distress); avoidance (avoiding thoughts, feelings, places or people related the traumatic event); negative alterations in cognitions and mood (dissociative amnesia, fear, anger, or guilt); and alterations in arousal and reactivity (hypervigilance, startle response, irritable behaviour, angry outbursts and sleep disturbance).

### **Treatment of Post-traumatic Stress:**

There are multiple psychological interventions for therapeutic work in kidnapping and rape, such as: psychoanalysis, pharmacotherapy, cognitive-behavioural therapy, Gestalt therapy, humanist techniques, eye movement desensitization and reprocessing (EMDR), and Ericksonian hypnosis techniques (De Shazer, 1995; Friedman, 2000; Harvey, Bryant, & Dang, 1998; Solomon & Shapiro, 2008).

Brief therapy focuses on potentiating the positive attitudes of the patient, expanding the ability to solve their problems by reviewing the changes, and attributing control to the patient. This prevents them from becoming dependent on therapy, since the interval between sessions is lengthened as the patient improves. Milton Erickson was a pioneer in brief and tailored therapy using hypnotic language for beneficial results, leading to a combination of hypnosis with other areas of psychology which is called clinical hypnosis or hypnotherapy (O’Hanlon & Martin, 1992; Téllez, 2007; Watkins & Watkins, 1997).

Hypnosis is widely considered to be a special state of consciousness, produced by a state of highly focused attention (Téllez, 2007). Some studies have demonstrated that hypnotherapy treatment is highly effective for the patient who has experienced a traumatic event (Cardeña, Maldonado, Van der Hart, & Spiegel, 2009). Hypnotherapy has effective techniques to eliminate the after-effects of kidnapping and rape, providing a safe environment for the treatment (Gil, 2007).

With this method it is possible to improve the quality of life for people who have suffered rape and kidnapping. De Shazer (1995) stated that the change is achieved most effectively and permanently when the therapist focuses on changing the unconscious patterns of the patient, which often include their values and frames of reference.

Another technique widely used for traumatic events is eye movement desensitization and reprocessing (EMDR; Edmond, Rubin, & Wambach, 1999). It is one of the psychotherapeutic approaches that emphasizes the importance of the brain's intrinsic system of processing information which activates symptoms considered a result of disturbing experiences (Solomon & Shapiro, 2008; Wilson, Silver, Covi, & Foster, 1996).

Shapiro (1995) proposes that the clinician “use hypnosis or guided imagery” to make the client feel more comfortable during the session of EMDR. There are several studies on the combination of EMDR and clinical hypnosis indicating that often the clinical effects of both are similar, besides being beneficial in a short term (Beere, Simon, & Welch, 2001; Bjick, 2001). Therefore it was decided to implement these techniques together in the following case to enhance the effectiveness that either clinical hypnosis or EMDR alone may provide.

## **METHOD**

The patient, a 39-year-old married mother of two children aged 16 and 17, with a certification as an executive assistant, reported frequent anxiety attacks after the kidnapping and rape by a group of criminals two years before the therapy. The patient met the DSM-5 diagnostic criteria of PTSD.

The therapeutic intervention was carried out across nine sessions, the first eight were weekly with the final, ninth, session two weeks later. The therapist who performed the intervention specializes in this approach.

The methodology unfolded across the sessions as follows (see Table 1). In the first four sessions a modified version of eye movement desensitization and reprocessing (EMDR) technique developed by Shapiro was applied:

1. An oral narrative of the critical incident or traumatic event was obtained along with the patient's self-rating of emotional distress, which was scored from 1 to 10, where 10 is the maximum intensity.
2. Subsequently, the patient was asked to write the narrative of the traumatic event, which was again scored from 1 to 10 on an emotional distress scale.
3. The patient narrated or read the traumatic event while moving eyes back and forth following an object which can be the therapist's finger or while being tapped on both sides of the head. This step was repeated several times until the patient reported no distress related to the targeted memory.
4. The negative thoughts that the patient had while the traumatic event occurred were identified and written down. These were then rated from 1 to 10 on an emotional distress scale.
5. The patient repeated or read their negative thoughts over and over again while they continued recollecting the event and moved their eyes back and forth following an object such as the therapist's finger, or while being tapped on both sides of the head.
6. The patient was asked to write a list of positive thoughts, which could make the patient feel very calm and self-confident.
7. The patient repeated or read over and over again the positive thoughts while recalling the event and while continuing to move their eyes rapidly from side to side following an object such as the therapist's finger or while being tapped on both sides of her head.

**Table 1:** Techniques used in each session

Session	Hypnosis techniques	
1	EMDR	— <sup>a</sup>
2	EMDR	Ego-strengthening (Torem, 1990)
3	EMDR	The prominent tree metaphor (Pelletier, 1979)
4	EMDR	—
5	—	Strengthening the Ego – Pekala (Pekala & Kumar, 1999).
6	—	Silent abreaction (Watkins, 1980)
7	—	“The empty chair technique” under hypnosis
8	—	An abstract technique for ego-strengthening (Gorman, 1974)
9	—	“The empty chair technique” under hypnosis

<sup>a</sup> Not applied

Before starting the first session the patient was asked to fill out the following psychosocial scales:

*The Duke-UNC-11 Functional Social Support Questionnaire* (Broadhead, Gehlbach, De Gruy, & Kaplan, 1988). The responses on this 11-item questionnaire are chosen from a 5-point Likert scale where 1 represents “as much as I would like” and 5 represents “much less than I would like.” The higher the total score is, the higher the level of social support. In this case, we used the Spanish version of Duke UNC-11; Cronbach’s  $\alpha = 0.92$  (Bellón, Delgado, Luna, & Lardelli, 1996).

*The Perceived Stress Scale* (Cohen, Kamarck, & Mermelstein, 1983). The original version of the PSS is a 14-item scale that measures the degree to which respondents appraise situations over the last month as stressful. We use the Spanish version of the PSS by Remor and Carrobbles (2001), which was culturally adapted for Mexico by González and Landero (2007); Cronbach’s  $\alpha = 0.83$ .

*The Rosenberg Self-Esteem Scale* (Rosenberg, 1965). This scale contains 10 items on self-respect and self-acceptance that are measured on a 4-point Likert scale, where 1 represents “totally disagree” and 4 represents “totally agree”. We use the valid RSES Spanish translation; Cronbach’s  $\alpha = 0.85$  (Martin-Albo, Núñez, Navarro, & Grijalvo, 2007).

*The Life Orientation Test – Revised version (LOT-R)*. This instrument is the most frequently used measure of dispositional optimism (Scheier, Carver, & Bridges, 1994). In this case report, we used the Spanish version of the LOT-R (Otero, Luengo, Romero, Gómez, & Castro, 1988). The LOT-R consists of 10 items with a 5-point Likert scale; 6 of these items measure dispositional optimism, and the other 4 are neutral. Cronbach’s  $\alpha = 0.79$ .

*Wagnild and Young’s Resilience Scale (RS)* measures the capacity to withstand life stressors, and be able to thrive by taking meaning from challenges; it consists of a 17-item “Personal Competence” subscale and an 8-item “Acceptance of Self and Life” subscale. Cronbach’s  $\alpha$  range from .72 – .94 (Abiola & Udofia, 2011).

## **Session 1**

When the session started an initial interview was conducted, from which the following information was collected:

In August 2010 three gunmen with high-powered rifles tried to kidnap her eldest son while he played street soccer with his friends. The boy ran

when he heard several gun shots, managed not to get injured and went into a neighbour's house, climbed to the roof and ran across several houses. Then he climbed down a tree and managed to escape. After that event the family moved home and went to live with the patient's mother in another town because they suspected people wanted to kidnap the boy, because his father was at that time a successful merchant.

She reported the event as follows: "I came back from shopping, headed home with my children and went to the kitchen to cook dinner. Then I heard somebody call out to my son to invite him to play soccer. A few minutes later, I heard screeching tires and a scream from my son, 'Dad! We just saw three boys that look like gang members.' But I didn't see my son and I thought that he must have run along with the other boys and hidden with the neighbours. Next I saw the gang members get in the car and leave. A few minutes later my son came and told me that they wanted him to get in the car. After that, we packed some stuff and immediately went to my mom's house. We didn't return to the house after that and I transferred him to another school."

In February 2012 at 10 pm when parking on the street outside her sister's home, a man appeared and prompted her to open the door. He asked for her purse and told her to move into the passenger seat. She responded by telling him to take the car and the purse but to let her get out of the car, but he refused. Another man climbed into the back seat, and she realized that another car was following them. Then they put her in the back seat and blindfolded her while the car was still moving. They stopped the car. One of the criminals raped her and she was locked in the boot so the vehicle could also be used to rob other people. This lasted eight hours, during which time the patient thought they would kill her, and she thought of her children. The car was stopped again. The criminals left, but not before telling her not to say anything because they knew where she lived. When she could not hear anything anymore, she kicked in the rear seat to be able to leave the vehicle and took a taxi back home.

She said that after this she had no one to vent to. Eventually the abductors were captured and she was present at a trial to identify one of the criminals, who was a minor, but her husband could not accompany her. She was unable to testify because she had her first anxiety attack. Following this, the patient had frequent panic attacks, the intensity of one being so great she had to be hospitalized. She took Tafil (alprazolam) to go to sleep because she was afraid to sleep, fearing she might suffer a heart attack while sleeping. The patient

cried almost every day and rarely left home. Her goal was to “stop thinking about all of that” and to “erase bad memories of her marriage.”

After describing the abduction the patient assessed her anxiety on a scale of 1 to 10, where 1 is the lowest and 10 the highest, placing it at 10. She was then asked to write the story of what happened and read it out loud, after which the intensity of her anxiety dropped to 6.

## **Session 2**

Although the patient said she still felt as she had in the first session, she realized that she had stopped crying and the feeling of losing her breath had been less frequent.

She was asked to read what happened out loud, and after reading it reported being at level 3 on the anxiety scale of 1 to 10.

The technique of EMDR was applied. We asked the patient to tell her traumatic story while experiencing lateral and upward eye movements, following the movement of a pen. After one trial the patient reported her anxiety at level 1. Immediately afterwards we asked her to describe the traumatic event again while we gave her alternating lateral taps in the temporal region of the head. She reported an anxiety level of 1 and also mentioned that the lump in her throat had disappeared. Finally, we wanted to strengthen the therapeutic accomplishment and she described the traumatic event again as she was given slaps on her thighs. She remained at level 1 on the scale of 1 to 10, and said she was feeling very calm.

Then we utilized a hypnotic technique for strengthening self-esteem developed by Torem (1990), and she reported feeling very calm. Using ratings of tranquillity on a 0 – 10 interval scale, with 0 representing “not at all tranquil” and 10 representing “most tranquil,” she reported 5.

## **Session 3**

The patient felt she had undergone a “mood improvement” as she previously was always moody and would respond rudely to any requests from family members. Her husband and children now felt they received a better response. She says it was because previously she had a lot of anger inside. She said, “I tried to endure it and I exploded, I don’t anymore.” The patient reported that that she had not had panic attacks that week, only small anxiety attacks which were present every day.

EMDR phase two began. This involved asking the patient to remember the negative thoughts that went through her mind during the different moments of the traumatic event. The thoughts reported were:

“Where are they taking me?”

“Maybe the gun will go off.”

“They’re going to torture me.”

“They’re going to rape me.”

“They are going to transmit a disease to me.”

“I’m not going to see my kids again.”

“How am I going to die?”

“I felt panic whenever the car stopped.”

“If they ask for ransom and my husband cannot pay the full amount they will kill me.”

The patient was asked to remember the traumatic event while repeating aloud the negative statements described above without any intervention, and the anxiety intensity went back to 5. When the therapist applied taps bilaterally on the patient’s head during the entire story retelling and the repetition of negative thoughts, the anxiety was maintained at level 5. The procedure was repeated and the anxiety intensity went down to level 3. The same procedure was repeated but with one more element added: The patient was asked to tap her thighs with her hands alternately and her anxiety decreased to level 2. In the fourth repeat it was held at level 2 and in the fifth it dropped to level 1.

After that we use the “prominent tree metaphor” hypnotic technique for strengthening self-esteem (Pelletier, 1979) and the patient said that she had felt sad because she had identified with the tree in the part that says: “See how tall the trunk is with a few twists and turns, the scars and rough edges that are the result of the tree’s struggle to survive against the wind, the hail, and the storms of life. The struggle to survive made it stronger.” The patient reported a 7 on a scale of 1 to 10 of tranquillity.

#### **Session 4**

The patient said, “I have not had panic attacks during the past week, only a very small one. Emotionally I felt very happy; I do not feel so angry. Since then, I don’t feel so pressured to do the house chores anymore. Also I sleep much better and I do not take the sleeping pills. I previously thought that if I fell asleep, my heart would stop. Before therapy I used to sleep for five hours, now I sleep for eight.” The patient said that she had reached 60% of general

wellbeing. Her husband who attended the session said, "I see her as being very different, very calm, and very quiet. I calculate an improvement of 50%."

In this session we had the third and final phase of EMDR. We asked the patient to make a list of thoughts that made her feel strong, confident, optimistic, and invulnerable. The patient constructed the following phrases:

"God is with me all the time."

"I'm going to see my children grow up."

"My husband is by my side."

"I'm going to see my children become professionals."

"I have my brothers with me."

"I have my parents."

"I'm going to do the projects that I have planned."

"I have good health."

"I will travel with my children."

"I will be happy with my family."

Then we asked the patient to recall the traumatic event while repeating aloud these positive and "empowering" sentences four times. The first trial was with eye movement and on a scale of 1 to 10 where 10 was the maximum level of tranquillity she reported 7.

During the second trial instead of eye movements we applied taps on the temporal region on each side of the head. The patient again rated tranquillity as 7. In the third trial the same procedure was repeated and she reported an 8 for tranquillity and on the fourth trial she reported a 10. Upon completion, the patient said she felt she was fine. When she was asked how long she had felt this way she said, "For the past several months I had a sense of a lack of purpose and meaning in my life, but now I feel so good".

## **Session 5**

The patient reported that "This week I have not had any panic attacks, only a negative thought [that she was going to get a heart attack]. That used to happen every day and would not let me sleep, but I slept just fine this time. In my daily life I am now more tolerant, I have not gone to the hospital for anxiety attacks, and I do not take tranquilizers [Xanax] because I no longer need them. What I cannot do yet is to watch the news on television because of everything that is happening lately. I begin to imagine what the victim felt, maybe it was not like that, but it's how I imagine it. It frustrates me and makes me feel bad." The patient reported that the relationship with her children and



husband was much better. She revealed that ten years ago her husband had an affair and that their eldest son was aware of this. The affair lasted four years. She accepted it meekly and never confronted her husband until she finally asked him to leave the house. Her husband eventually ended that extramarital relationship permanently.

In this session we applied Pekala and Kumar's (1999) technique of hypnotic ego-strengthening. Before we started she reported a 7 on a scale of tranquillity, with 10 being the maximum. After the technique she scored a 10 and said, "I felt completely happy. Yeah, I've visualized all the happy times doing what I love, I see myself on the beach with my kids and my husband, and at home with my family and my brothers. I am at peace, no insecurities, no fear, and no terror. I feel calm with a tranquillity level of 10. With the first tree session [hypnosis session] I felt sensitive. In the last session I felt good." The patient reported her level of general wellbeing as 75%.

After the session her eldest son, who initiated therapy in the aftermath of the attempted kidnapping, was asked how he perceived his mother, he replied: "My mom has changed and improved a lot. She's not angry or explosive anymore, now she smiles and is very happy."

## **Session 6**

The patient came to the meeting smiling and reported feeling more encouraged and very happy. She reported sleeping without waking up during the night. That week she had not a single panic attack. She said, "This week I felt better and I laughed more. Before therapy nothing made me laugh." The patient reported a 90% level of wellbeing, commenting: "Maybe I will never reach 100% and maybe there are things that I will never forget, but now I can have a good quality of life." On a scale of tranquillity from 1 to 10, where 10 is the maximum, she reported a 9.

In this session the silent abreaction technique (Watkins & Watkins, 1997) was used. She was asked to imagine if all the negative emotions were symbolized on a stone, what would that stone be like, and she said it would be a stone of more than one metre, rough, and dark. At end the session she again reported her relaxation level as 9. She had imagined that she broke the stone in half and she felt good doing that. After splitting the stone, she went into a waterfall of pure crystalline water and was cleansed inside and out. "The water was very comforting; I felt the water washed everything away, it felt great."

**Session 7**

The patient reported feeling very well, she felt a big change. She said that she felt a 90% improvement. However, she reported that her husband had caused her much psychological damage. She said that he puts his parents, his brothers, and his side of the family before her and their children. “During most of my pregnancy, he did not allow any housework breaks, the house had to be in perfect order. Before coming home, he would go first to his parents’ house. He also spoke to me so aggressively that I just remained quiet. In the past I often asked him for forgiveness without knowing why, because I thought that if I didn’t he would not speak to me or would leave me.”

At that moment she reported a level 8 on the emotional pain scale from 1 to 10, where 10 was the highest pain. After that we applied the “hypnotic empty chair,” which consists of the empty chair technique of Gestalt theory followed by a hypnotic induction. The hypnotic empty chair technique is a powerful method for helping patients become more aware and to express thoughts and feelings toward others which have been suppressed. In this technique we did not suggest the patient “see” a particular person on the chair. Instead of this we asked her unconscious mind to visualize a person to whom she needs to tell something important.

T: Who’s sitting in the chair?

P: My husband, who seems angry.

T: Say hello. Tell him, “How are you?”

P: I cannot confront him.

T: You’re not going to confront him, just say hello.

P: “How are you? I want to tell you that you caused a lot of damage to me and the boys. You would leave us alone for days. You didn’t know if we ate or not. I had to go and sell used clothing to be able to feed the kids. We went without breakfast, you didn’t know that. You spent your money on her, that’s why the business you had went bankrupt. You had me working while I was nine months pregnant with both children and then abandoned us. Before coming to our house you had to go to your parents first and you arrived late at night after I had worked all day. It hurt me to have to stop tending to my children to tend to you. You know that my child is how he is because of what he saw and the many things that you showed him, and he feels the same way I feel. Much of what my child is affected by is because of everything he witnessed. You placed your family first, then your brothers and then us. That’s why my children will not approach your family and they don’t even go into their houses. My children have the right to have two families, not just one.”

Then we asked her to imagine that he left his body (the dissociation), and during that moment she should imagine that she was her husband (introjection). But when we encourage “the husband” to speak, he (she) said, “I already told her what I had to say.”

### **Session 8**

The patient stated that she felt perfectly well without any anxiety attacks. During the week she went to a casino alone which was not the norm, as she used to go with her sister. She reported a score of 95% on the subjective wellbeing scale. Interviewed separately, her son reported that he perceived that his mother had improved very much because she doesn't get scared as she used to. She used to take fright every time she saw a car with men inside, thinking they were after her. Now she fears this to a lesser degree.

In this session we used the “magic carpet” technique, which suggests the patient, during hypnosis, imagine a magic carpet that can fly. We asked the patient to use the rug to take her up to the clouds and from the top she saw herself as a child. She was asked to come down to greet and talk to that girl; to strengthen the self-esteem of the girl by telling her how important she is, how much she is loved, how much she is worth; to make the girl feel protected and loved. After this she reported feeling very well and said she had a childhood full of love, freedom and happiness. She associated those emotions with the present, reporting feeling 10 on the tranquillity scale of 1 to 10. Later we applied the abstract technique for ego-strengthening (Gorman, 1974), and she reported feeling more relaxed, saying “I felt very calm, nothing crossed my mind and I stopped listening to your voice. There was a period where there was nothing. I am not sure what happened.” She again reported a tranquillity level of 10 on a scale of 1 to 10.

### **Session 9**

The patient reported that during the week she had two panic attacks which she saw as a result of a serious problem with her husband, but she was still sleeping well. She also reported that she was feeling a 4 on a scale of 1 to 10 of relaxation. The patient reported having a panic attack after going to the casino and another at home doing household chores. She assumed that it all began a week before when she was on vacation with her husband and kids. In the evening she went with her husband to a dance club, but she started to feel dizzy. So she went to the bathroom to vomit and after that her husband took her to the hotel. He told her he would go back to look for the kids, but later

she found out that he had returned to the club and he was talking to other women. That night she didn't allow him to sleep with her. She suppressed her anger and was miserable the rest of the time. She said she felt a very intense sensation of a lump in her throat; when asked how intense it was on a scale of 1 to 10, she responded 9.

We applied the hypnotic empty chair technique and she visualized her husband and began to express feelings of hostility and resentment toward him. After that the lump in the throat sensation disappeared. She was subsequently dissociated and we asked her to imagine herself being her husband, the husband was an important introject in the emotional life of the patient (Emerson, 2008). This helped her to express emotions and understand her husband's point of view. With this technique she felt that her husband felt lonely because she usually did not accompany him to social events and when she did she felt physically ill. She, acting as her "husband," apologized for what happened. At the end of the technique she reported a level 9 of tranquillity. Later a hypnotic technique for strengthening self-esteem was used. This involves a regression in age through various stages of her life until the time of birth and then a return to the present through the same stages adding a positive restructuring of each stage (Watkins & Watkins, 1997). The patient reported feeling 10 on the relaxation scale and mentioned at first she had to go through several negative moments of her life, but in the return to the present most of it became positive.

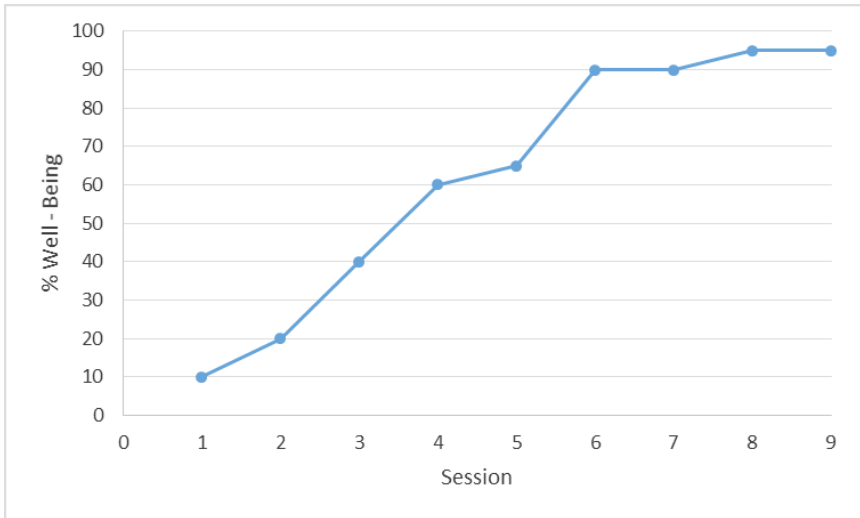
## EVALUATION OF THE EFFECTIVENESS OF TREATMENT

Throughout the treatment a series of changes were observed in the scales shown in Table 2.

**Table 2:** Percentage of change Pre- Treatment to Post-Treatment

Measure	Pre-treatment score	Post-treatment score	Percentage change
LOT-R. Dispositional Optimism Scale: Life Orientation	28	38	25%
Resilience	104	154	33%
Functional Social Support Questionnaire. Duke-UNC	36	44	18%
Perceived Stress Scale	37	28	-23%
Self-Esteem Scale	24	31	23%

Finally the progress achieved in each session is shown, evaluating treatment as represented by overall wellness (Figure 1).



**Figure 1:** Responses to the Question “Rate Your Overall Sense of Well-Being Using 0–100 Point Scales (0 = No sense of Well-Being and 100= Maximum of Wellbeing)”

The concept of wellbeing refers to optimal psychological functioning and experience (Ryan & Deci, 2001).

Over the course of treatment her panic attacks disappeared. Besides being able to sleep and rest without the need for medication, she stopped crying over the traumatic event and was more loving and understanding with her children. She also became more understanding with her husband. This was measured each session through a series of self-report scales.

## **DISCUSSION AND CONCLUSION**

Kidnapping and rape are amongst the most common crimes in Mexico (INEGI, 2015) and they can lead to PTSD that can have long-term negative health and social consequences for survivors if they do not receive appropriate psychological treatment. Therefore it is necessary to continue developing therapeutic strategies that can be useful to treat this anxiety disorder. This case study shows that the combined use of EMDR with clinical hypnosis was an effective strategy to reduce the symptoms of post-traumatic stress resulting from kidnapping and rape. EMDR was used in the first four sessions to reduce and eliminate the painful emotions of recalling the traumatic event

and facilitate cognitive restructuring. Clinical hypnosis was used to implement suggestions for strengthening self-esteem, optimism, and resilience to reduce perceived stress.

The combined use of clinical hypnosis and EMDR can be useful as a relatively fast and effective strategy to reduce the suffering of PTSD victims and help them reintegrate into a socially and economically productive life.

The most important advantages of the combined use of these two techniques is that in EMDR one formulates a target from an explicit memory in order to activate neural systems and the brain's innate capacity for healing to perform a restructuring of traumatic explicit memories at a conscious level, while hypnosis can work with implicit memory and catalyse the unconscious resources of the patient (Shapiro, 2001).

An important limitation of this case report was the lack of follow-up to determine the long-term effects of this therapeutic strategy. Although the clinical case report has a longstanding tradition in psychotherapy, some researchers have pointed out the lack of ability to generalize and difficulties to establish cause-effect relationship amongst its major limitations (Nissen & Wynn, 2014). Therefore we are planning to carry out in the future a randomized clinical trial to determine with greater certainty the real therapeutic power of the combination of these two techniques.

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