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## EDITORIAL

Welcome to this combined edition of Volumes 38 (2) and 39 (1) of the *Australian Journal of Clinical and Experimental Hypnosis*. As incoming editor I am delighted by the breadth and depth of the contributions that are presented here. The experimental study by Williams and colleagues presents an important contribution to research on the psychophysiology of hypnotic-analgesia mechanisms, clearly demonstrating their differentiation from focused attention within the brain. It is of great importance for clinicians treating pain to understand the distinction between hypnotic analgesia and cognitive behavioural methods of pain management, which both work but by different mechanisms, in order to tailor their treatment to the individual skills and capacities of their clients. For pain researchers the demonstration of an additional central mechanism of pain regulation opens up new research possibilities, while for hypnosis researchers this study adds to our understanding of the role of changing executive control in hypnosis in a way which supports one of the primary theories of hypnosis—the dissociated control model of Woody, Bowers and their associates. Writing from his practice in Harley Street David Kraft offers us the fourth in a series of papers on the place of hypnosis in psychiatry, focusing on agoraphobia and social phobia. Previous papers in this series were co-authored with his late father Dr Tom Kraft. From Australia we have contributions from highly experienced and much respected members of the clinical hypnosis community. Eugen Hlywa and Lynda Dolan share with us their experience of the role of spirituality in therapeutic practice. Karla Fenton asks us to consider the role of behavioural medicine as an alternative in treating the problem of constipation in the elderly and presents a practical script developed for this purpose.

Writing from a theoretical perspective, Natasha Loi and I consider the role of processes encountered in the study of absorption, fantasy proneness and hypnosis, in the responses of susceptible individuals to the experience of overwhelming negative affect that occurs in trauma. We argue for the centrality of (non-cognitive) affective regulation mechanisms in the trance condition and propose a novel experimental paradigm, the emotional Stroop, for researchers to explore trance-related changes in affective control. Case studies today are focusing more and more on providing a detailed account of clinical decision making in which theory informs practice and practice informs theory. This approach is clearly evident in the accounts, and particularly in the analysis of the choices made in designing hypnotic treatment interventions by

two contributions from an emerging generation of Australian practitioners. Elke Kellis provides a thoughtful account of the integration of hypnosis with cognitive-behavioural therapy in the treatment of a patient with depression, anxiety and self-concept problems. Susan Blunsden writes a detailed step-by-step analysis of the rationale and steps adopted in a brief narrative-based hypnotic intervention in the treatment of the skin disorder, lichen sclerosus of the vulva, with great sensitivity to the complex psychological meaning of the condition for her client.

The Excellence in Research for Australia (ERA) scheme of journal classification adopted by the Commonwealth government for assessing the merit of academic output seriously disadvantages specialist local journals. Currently *AJCEH* is rated at level C in this scheme, a situation that strongly discourages contributions from staff and students at Australian universities. We must work together to change this if the Australian hypnosis community is to truly embody the principles of the scientist practitioner model to be a community of practitioners and researchers each informing and enriching the other. This will involve directly lobbying the ERA in relation to re-evaluating the journal but it will also involve consistently attracting quality contributions of clinical and research-related papers from national and international contributors. My definition of quality is anything that seeks to make a difference for the better in the knowledge and practice of hypnosis. I ask all readers to consider what they may be able to do to join in that effort.

Since moving to an online format available not only to ASH members but as an accessible resource to practitioners and academics throughout the world, the *Australian Journal of Clinical and Experimental Hypnosis* has occupied an otherwise vacant niche which over time offers to vastly widen the scope of its readership and its contributor base. Collectively the contributors to this combined edition demonstrate the potential of *AJCEH* (we will need to disambiguate our acronym) to make an impact through the world wide web.

*Graham A. Jamieson*

## HYPNOTIC ANALGESIA AFFECTS THE PROCESSING OF PAINFUL STIMULI

J. D. Williams  
Coventry University

R. J. Croft  
University of Wollongong

J. Ferdinand  
University of Cambridge

J. H. Gruzelier  
Goldsmiths College

*This experiment explored the effects of hypnotic analgesia on painful stimuli in high and low susceptible participants (N = 33). Behavioural (target detection; RTs), subjective (pain ratings) and electrophysiological (SERP) responses of high and low susceptible participants were assessed during control, standard-hypnosis and hypnotic-analgesia conditions. The behavioural and subjective data showed that suggestion of hypnotic analgesia modulated the processing of painful stimuli, particularly in high susceptible participants. In contrast there were no significant changes in electrophysiological responses to these stimuli. Results in high susceptible participants demonstrate that hypnotic analgesia provides an important strategy for modulating experimentally induced pain. They also suggest that different brain mechanisms are involved in the processing of painful stimuli under hypnotic analgesia and attentional distraction instructions and support previous research findings that the differentiation of behavioural, subjective and electrophysiological responses may be a result of a dissociation between the processing of sensory information and the cognitive evaluation of that information.*

Hypnosis as a clinical intervention has increased in the treatment of acute and chronic pain. Reports of the use of hypnotic analgesia in medicine include; the reduction of chronic pain in cancer patients (Hilgard & LeBaron, 1984; Spiegel & Bloom, 1983) and procedures involving limb amputation, mastectomy, Caesarean section and appendectomy (Waxman, 1989). It has been used in the syringomyelia related pain (Jack, 1999) and to reduce pain and distress experienced during wound debridement (Patterson, Everett, Burns, & Marvin, 1992). It has also been shown to be effective in reducing acute experimentally induced pain (Friederich et al., 2001; Halliday & Mason, 1964; Hilgard & Hilgard, 1983; Miltner, Braun, & Revenstorf, 1992).

There is little dispute that hypnotic analgesia has a beneficial effect in pain treatment, but the underlying mechanisms remain a source of debate. Proponents of the socio-cognitive viewpoint suggest hypnotic analgesia involves conscious strategies to divert attention away from the pain, and that behaviour associated with hypnotic analgesia can be attributed to normal processes such as compliance and suggestibility (Barber, 1969; Wagstaff, 1986, 1998; Spanos, 1986, 1991). In contrast, the state theory viewpoint (Hilgard, 1986; Spiegel, 1994) has its origins in Hilgard's hierarchical model of cognitive control involving an executive controller that monitors and activates subsystems of control; the executive controller is bypassed and subsystems of control activated directly. Thus, pain perception is modulated without involvement of conscious executive function, a process known as dissociated control (Bowers, 1991; Hilgard & Hilgard, 1983; Miller & Bowers, 1993).

In line both with Hilgard's (1986) model of cognitive control and Gruzelier's (1998) model of frontolimbic inhibition, hypnotic analgesia has been viewed as an unconscious but active inhibitory process of sensory information (Crawford, Brown, & Moon, 1993; Crawford et al., 1996). See also Croft, Williams, Haenschel, and Gruzelier (2002). In support of this view, regional cerebral blood flow (rCBF) studies have reported neural activity in frontal and somatosensory cortices associated with hypnotic analgesia (Crawford, Gur, Skolnick, Gur, & Benson, 1993). Data from somatosensory event-related potential (ERP) studies also support this position: A significant decrease in P100 and P300 (Spiegel, Bierre, & Rootenberg 1989) and P200 and P300 amplitude (Crawford et al., 1996) was reported in high susceptibles during hypnotic analgesia. Similar evidence been reported by Arendt-Nielsen, Zacharie, and Bjerring (1990), Zacharie and Bjerring (1994) and Danziger et al. (1998). In contrast, neither Halliday and Mason (1964) nor Meier, Klucken, Soyka, and Bromm (1993) found evidence of any significant reductions in

pain-related ERPs.

One interpretation of ERP component modulation is that it is a result of changes in attention. Miltner, Johnson, Braun, and Larbig (1989) have demonstrated a clear relationship between attention and LEP amplitude, and higher pain ratings have been reported when participants attend to pain (Hutt, 1996; Janssen & Arntz, 1996). However in many of the above studies the participants' attention was diverted away from the pain. Arendt-Nielsen et al. (1990) instructed participants to "ignore everything except the pleasant and relaxed feelings," and when instructed to attend to a source of pain during hypnotic analgesia experimental instructions were different. It is possible then that a change in attention and variable experimental instructions can explain the modulation of late ERPs. Indeed when compared to a control task, only an attention distraction task and not hypnotic analgesia produced an amplitude reduction in late evoked potentials, suggesting separate brain mechanisms for hypnotic analgesia and attentional distraction during pain processing (Friederich et al., 2001).

The present study was an evaluation of hypnotic analgesia in conditions that had identical painful stimuli but where differences in attentional demands were kept to a minimum. The study was designed to have the same attentional focus during control, standard hypnosis and hypnotic-analgesia conditions. This allowed a comparison of subjective (pain ratings), behavioural (omission errors and RTs) and psychophysiological (ERP) data in high and low susceptible participants. It was hypothesized that hypnotic analgesia would result in lower pain report, higher omission errors (misses) and slower RTs in high participants. It was further hypothesized that if, as suggested by Friederich et al. (2001), hypnotic analgesia and attentional distraction involves separate cognitive processes then there would be no difference in the late ERP amplitudes of the two participant groups during the different ERP conditions.

## **METHOD**

### **Participants**

Thirty-three right-handed participants (17 male, 16 female) aged 17–37 (Mean = 22.03, *SD* = 3.4) were assessed using the Harvard Group Scale of Hypnotic Susceptibility, Form A (Shor & Orne, 1962). These participants were classified as high susceptibles (Harvard scores 8–12; *N* = 17) and low susceptibles (Harvard scores 0–4; *N* = 16). The study was approved by the Riverside Research Ethics Committee and informed consent was given by all participants.

## **Design**

A 2\*3 mixed design was used with hypnotizability (high and low) as the between subject variable, and condition (control, standard hypnosis and hypnotic analgesia) as the within subject variable.

## **Apparatus and Recording**

*Pain Stimulation* Pain related stimuli were administered to the index finger of the right hand using a Digitimer Constant Current Stimulator, model DS7A. The index finger was prepared by the removal of dead skin with an emery board and cleaned with an alcohol swab. Cathode and anode bands were placed on the proximal and middle phalanx respectively. The stimuli comprised single 1.6 millisecond duration square wave electrical pulses (rise/fall time of 20  $\mu$ sec), with a one second inter-stimulus interval. There were two types of pain stimuli: single pulse (Standard) and triple pulse (Target). Each condition comprised 550 randomly presented stimuli, 20% of which were target. To remove habituation effects the first 50 trials of each condition were precluded from analysis.

*EEG Recording* EEG was recorded from 9 tin surface electrodes (F3, Fz, F4, C3, Cz, C4, P3, Pz, P4) referenced to the left ear, and amplified online using a Neuroscan data acquisition system (Scan version 4.00 and SynAmps amplifiers). Ground was positioned midway between Fz and Fpz. EOG electrodes were positioned above and below the right eye, and lateral to both eyes. Impedances were kept below 20 kohms. Bandpass filters were set to 0.01 Hz and 100 Hz with a sampling rate of 500 samples/second. EEG data were visually inspected for artefact and then processed offline: A common average reference was calculated and high and low bandpass filters (24 Hz/octave ) were set at 30 Hz and 0.01 Hz respectively. Epochs (-100 ms pre-stimulus onset to 924 ms post stimulus) were extracted for analysis and baseline corrected. An artifact rejection algorithm was then used to remove any potentials outside the range  $-70\mu$ V to  $+70\mu$ V.

## **Procedure**

All participants were tested individually. During the first 10 to 15 minutes the experimenter developed a rapport with the participant in order to alleviate any worries or misconceptions about hypnosis. Sensory threshold

and pain tolerance levels were then assessed using an ascending method of limits. Participants were asked to rate the degree of their sensory pain on a standardized scale where 0 = *no pain*, 5 = *moderate pain* and 10 = *unbearable pain*.

The three conditions were presented in a random order (with hypnosis and non-hypnosis conditions counterbalanced across participants). Well-established induction procedures—that is, eye fixation, systematic muscle relaxation, counting down from 20 to 1 and a further “deepening” technique using guided imagery—were used *prior* to the hypnosis conditions. Identical instructions were given to the participants during all three conditions, requiring them to attend to their right index finger in order to minimize attention-related effects. They were required to press a response key with the thumb of their left hand if they detected a painful stimulus. Prior to the hypnotic-analgesia condition participants engaged in guided imagery involving them being on a warm sandy beach and that they had buried their right hand deep under the sand. They then received a suggestion that their hand would become numb and that they would lose sensation in their finger so they would be unable to detect the painful stimulus.

## RESULTS

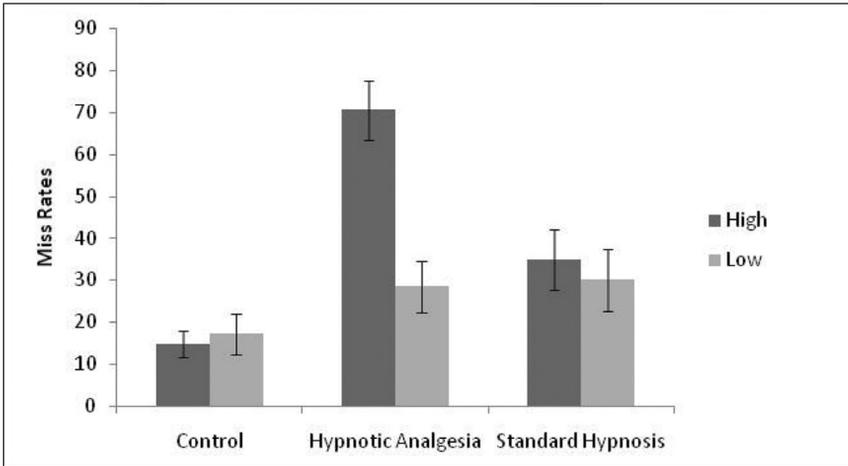
### Behavioural Data

*Stimulus Misses* To determine whether there were any significant differences between the miss rates of the painful stimuli a 2 (Group) x 3 (Condition) mixed ANOVA was performed on the data. The analysis showed a main condition effect,  $F(1.97, 61.07) = 32.88, p = 0.0001$ . Post hoc tests showed a higher percentage of misses in the hypnotic-analgesia condition compared to both the control,  $t(32) = 5.93, p = 0.0001$ , and the standard-hypnosis conditions,  $t(32) = 3.97, p = 0.0001$ . There was also a higher percentage of misses in the standard-hypnosis condition compared to the control condition,  $t(32) = 3.50, p = 0.001$ . A significant Group x Condition interaction was also observed,  $F(1.97, 61.07) = 16.56, p = 0.0001$ . This showed firstly that there was no significant difference during the control condition ( $p > 0.6$ ). Secondly, that both high and low susceptibles had a significantly more misses during hypnotic analgesia compared to control (high:  $t(16) = -8.37, p = 0.0001$ ; low:  $t(15) = -2.12, p = 0.05$ ), but misses were more than twice as great in high than low susceptibles during hypnotic analgesia,  $t(30.57) = 4.46, p = 0.0001$ . Thirdly, the difference between standard hypnosis and control was significant in both groups (high:  $t(16) = -3.11, p = 0.007$ ; low:  $t(15) = -2.44, p = 0.028$ )

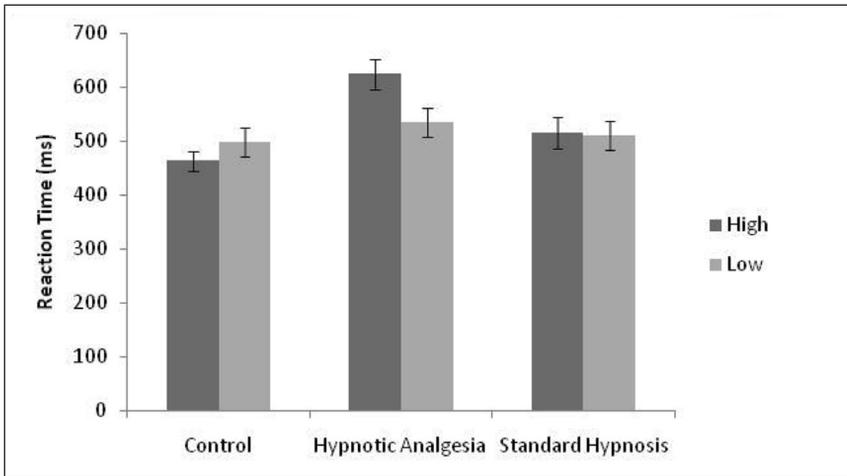
conditions. Fourthly, the effects of hypnotic analgesia over standard hypnosis was to double the number of misses in highs ( $t(16) = -5.39, p = 0.0001$ ) whereas it had no effect in lows who demonstrated a non-significant decrease ( $p > 0.6$ ). Means and standard errors are presented in Figure 1.

In summary, highs produced a twofold increase in misses during standard hypnosis with a further twofold increase during hypnotic analgesia. In contrast, low susceptibles produced a significant increase in misses during standard hypnosis but no increase was observed during hypnotic analgesia.

**Figure 1:** Miss Rates During Control, Hypnotic Analgesia and Standard Hypnosis Conditions



*Reaction Times* A 2 (Group) x 3 (Condition) ANOVA was performed on the RT data. A main Condition effect ( $F(1.88, 50.86) = 29.75, p = 0.0001$ ) and Condition x Group interaction ( $F(1.88, 50.86) = 10.23, p = 0.0001$ ) were significant. Post hoc tests showed the following: first, no significant differences during the control condition ( $p > 0.36$ ). Second, highs ( $t(15) = 2.83, p = 0.013$ ), but not lows ( $p > 0.42$ ) had slower RTs during standard hypnosis compared to control. Third, highs had even slower RTs during analgesia compared both to control ( $t(13) = 6.12, p = 0.0001$ ) and standard hypnosis ( $t(15) = 4.66, p = 0.0001$ ). RTs of lows were also slower during analgesia relative to control ( $t(15) = 2.86, p = 0.01$ ) and standard hypnosis ( $t(14) = 2.38, p = 0.03$ ) but to more modest levels compared to highs. Means and standard errors are presented in Figure 2. In summary, highs not only had significantly higher miss rates than lows during hypnotic analgesia, but when they were able to detect painful stimuli they had slower RTs.

**Figure 2:** Reaction Times During Control, Hypnotic Analgesia and Standard Hypnosis Conditions

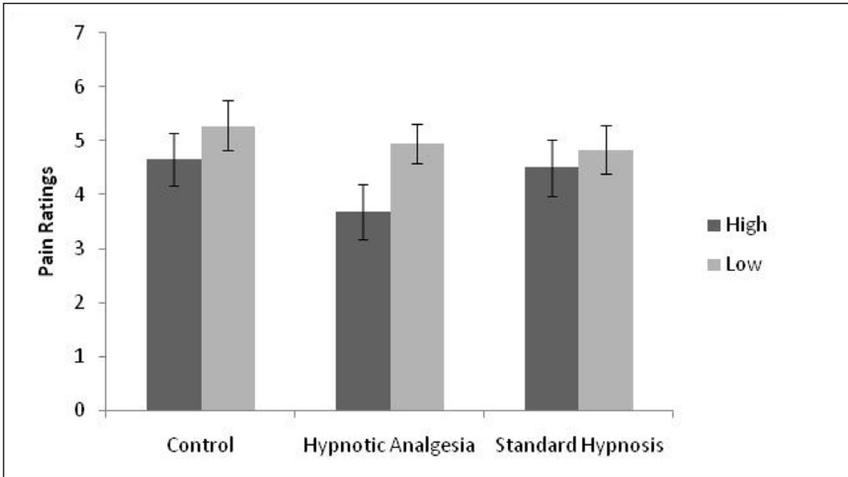
*Pain Ratings* A 2 (Group) x 3 (Condition) mixed ANOVA of pain ratings showed a main condition effect,  $F(1.90, 59.02) = 4.13, p = 0.02$ . Post hoc tests showed pain ratings in all participants were significantly lower during the hypnotic-analgesia condition compared to the control condition,  $t(32) = 2.84, p = 0.008$ . Figure 3 demonstrates that most of the variance in this effect was accounted for by the highs. No significant main group ( $F(1, 31) = 1.46, p > 0.05$ ) or interaction effects ( $F(1.9, 59.01) = 2.09, p > 0.05$ ) were observed but exploratory analysis showed no baseline difference ( $p > 0.36$ ). Moreover, highs but not lows ( $p > 0.3$ ) reported significantly lower pain levels during hypnotic analgesia relative to both the control ( $t(16) = 2.76, p = 0.01$ ) and standard-hypnosis conditions ( $t(16) = 2.57, p = 0.02$ ).

In summary, hypnotic analgesia resulted in lower detection rates, slower RTs and lower pain ratings to painful stimuli in highs compared to lows.

### EEG Data

Analysis of the average waveform in each condition demonstrated two major components post stimulus; 140–200 ms (P200) and 250ms to 450 ms (P300). A Condition (Baseline, Standard Hypnosis, Hypnotic Analgesia) x Stimulus (Target, Standard) x Electrode (Fz, Cz, Pz) x Group (High, Low) mixed factorial ANOVA was performed on the data for each of these two components.

**Figure 3:** Pain Ratings During Control, Hypnotic Analgesia and Standard Hypnosis Conditions



*P200* Analysis showed a significant stimulus effect  $F(1, 31) = 44.87, p = .0001, \epsilon = .59$ , there being significantly higher amplitude in the target condition (Mean = 4.71,  $SE = .69$ ) compared to the standard condition (Mean = 1.60,  $SE = .27$ ). There was also a significant electrode effect,  $F(1.48, 46) = 20.04, p = .0001, \epsilon = .39$ , with the amplitude at both at Fz (Mean = 4.4,  $SE = .8$ ) and Cz (Mean = 4.3,  $SE = .6$ ) significantly higher than Pz (Mean = 0.7,  $SE = .3$ ). The electrode x stimulus interaction was also significant  $F(1.35, 41.72) = 18.64, p = .0001, \epsilon = .38$ , there being significantly greater amplitude differences between the target and standard trials at Fz and Cz compared to Pz. Importantly, all other effects were found to be non-significant: main group effect  $F(1, 31) = .001, p = .97, \epsilon = .0001$ ; main condition effect  $F(1.92, 59.4) = .175, p = .83, \epsilon = .006$ ; condition x group interaction  $F(1.92, 59.4) = 1.13, p = .33, \epsilon = .03$ ; condition x electrode interaction  $F(2.67, 82.83) = .49, p = .66, \epsilon = .02$ ; condition x electrode x group interaction  $F(2.67, 82.83) = 1.80, p = .13, \epsilon = .05$ ; condition x electrode x stimulus interaction  $F(3.31, 102.41) = 1.95, p = .11, \epsilon = .06$ ; condition x electrode x stimulus x group interaction  $F(3.31, 102.41) = 1.61, p = .18, \epsilon = .05$ ; electrode x group interaction  $F(1.48, 46.02) = 2.18, p = .14, \epsilon = .07$ ; electrode x stimulus x group interaction  $F(1.35, 41.72) = 0.63, p = .48, \epsilon = .02$ .

*P300* Analysis showed a significant stimulus effect  $F(1, 31) = 76.70, p = .0001, \epsilon = .71$ , there being significantly higher amplitude in the target

condition (Mean = 7.41,  $SE = .75$ ) compared to the standard condition (Mean = 2.84,  $SE = .29$ ). There was also a significant electrode effect,  $F(1.72, 53.43) = 6.29, p = .005, \epsilon = .17$ , with the amplitude at both at Fz (Mean = 5.01,  $SE = .8$ ) and CZ (Mean = 6.3,  $SE = .65$ ) significantly higher than Pz (Mean = 4.04,  $SE = .5$ ). All other effects were found to be non significant: main group effect  $F(1, 31) = .008, p = .93, \epsilon = .0001$ ; main condition effect  $F(1.84, 58.4) = .12, p = .87, \epsilon = .004$ ; condition x group interaction  $F(1.88, 58.4) = 0.1, p = .89, \epsilon = .003$ ; condition x electrode interaction  $F(2.87, 8.89) = 1.17, p = .33, \epsilon = .04$ ; condition x electrode x group interaction  $F(2.87, 88.89) = .80, p = .49, \epsilon = .02$ ; condition x electrode x stimulus interaction  $F(2.65, 82.12) = .73, p = .52, \epsilon = .02$ ; condition x electrode x stimulus x group interaction  $F(2.65, 82.12) = .42, p = .71, \epsilon = .01$ ; electrode x stimulus interaction  $F(1.92, 59.57) = .19, p = .82, \epsilon = .006$ ; electrode x group interaction  $F(1.72, 53.43) = 2.84, p = .07, \epsilon = .08$ ; electrode x stimulus x group interaction  $F(1.92, 59.57) = 0.73, p = .47, \epsilon = .02$ .

## DISCUSSION

This study shows that hypnotic analgesia had a significant effect on participants' behavioural and subjective response to painful stimuli. Target misses in high participants during standard hypnosis produced a twofold increase compared to a control condition with a further two-fold increase with hypnotic analgesia. In contrast, while there was a significant increase in misses during standard-hypnosis in lows, no comparable increase was observed during hypnotic analgesia. High participants' reaction times for correctly identified target stimuli were significantly slower during the standard hypnosis condition compared to the control condition, and a further significant slowing occurred during hypnotic analgesia. In contrast, RTs of lows during standard hypnosis were not significantly different from the control condition but were slower during hypnotic analgesia, though to a more modest level compared to highs. Furthermore, high participants reported lower levels of pain during hypnotic analgesia relative to both the no-hypnosis baseline and standard-hypnosis condition. These data demonstrate that hypnotic analgesia is able to modulate the processing of painful stimuli, particularly in high participants, and supports previous research demonstrating the efficacy of hypnotic analgesia in reducing the feeling of painful stimuli (Friederich et al., 2001; Halliday & Mason, 1964; Hilgard & Hilgard, 1983; Miltner et al., 1992).

An examination of participants' SERP data showed that there were no significant changes in electrophysiological responses to painful stimuli. Analysis of the P200 and P300 components showed no amplitude difference between the control, standard-hypnosis and hypnotic-analgesia conditions. Moreover, there were no interactions with high and low susceptible participants. These results support previous research showing no amplitude differences between control and hypnotic-analgesia conditions (Friederich et al., 2001; Halliday & Mason, 1964; Meier et al., 1993; Miltner et al., 1992). These data do not however support other studies that showed a significant decrease in late ERP components during hypnotic analgesia (Arendt-Nielsen et al., 1990; Danziger et al., 1998; Zacharie & Bjerring, 1994). Friederich et al. (2001) note that a possible difference between their findings and those of Arendt-Nielsen et al., and Danziger et al., may have been due to the control condition always preceding the hypnotic analgesia order resulting in a habituation confound of the ERP amplitude. In the present study the control condition always preceded the two hypnosis conditions but the latter conditions were counterbalanced so the absence of any ERP amplitude reduction in the analgesia condition cannot be explained with reference to habituation. The present data suggest a dissociation between electrophysiological and subjective and behavioural measures of painful stimulation and support previous reports of this phenomenon (Meier et al., 1993). This is further demonstrated by an analysis of EEG oscillations that showed positive correlations between anterior gamma amplitude and the pain ratings prior to hypnosis were no longer maintained in high participants during hypnosis (Croft et al., 2002).

The present data then provide support to the findings by Friederich et al. (2001) and Miltner et al. (1989), who demonstrated a relationship between attention and SERP amplitude. It was noted above that changes in participants' attention and variable experimental instructions may explain the modulation of late ERPs in Arendt-Nielsen et al. (1990), so in this study an attempt to minimize attention-related effects participants were instructed to attend to the same stimulus in all conditions. Assuming these effects were minimal then the data show that when participants attended to painful stimuli, both high and lows decreased in their ability to detect target stimuli during both standard hypnosis and hypnotic analgesia, but had significantly slower reaction times to these stimuli when they were able to detect them. Moreover, highs reported lower levels of pain during hypnotic analgesia relative to both the control and standard-hypnosis conditions.

The current data suggest that during hypnotic analgesia different brain

mechanisms are involved in the processing of painful stimuli and support suggestions of Friederich et al. (2001) and Hilgard and Hilgard (1983) that the differentiation of subjective and ERP responses may be a result of a dissociation between the processing of sensory information and the cognitive evaluation of that information. That is, somatosensory and association cortices receive and process painful stimuli but this information is not transmitted to other neural areas involved in appropriate (cognitive and motor) pain-related behaviour. These data also provide evidence that this dissociation between sensory and cognitive processing is more manifest in high compared to low susceptible participants. Highs reported less pain and had an increase in miss rates during hypnotic analgesia whereas both high and low susceptibles had a slowing of reaction times during the analgesia condition (though the effects were much greater in highs).

The data for lows are also important as they demonstrate that factors other than hypnosis are able to affect the processing of painful stimuli in these participants. It has been suggested that relaxation is a major component of hypnotic analgesia (Evans & Paul, 1970), a view supported by EEG spectral analysis demonstrating that low susceptibles become more relaxed during the hypnotic procedure (Williams & Gruzelier, 2001). Although Miller, Barabasz, and Barabasz (1991) have proposed that relaxation is not necessary to induce hypnotic analgesia, this does not mean that it cannot play a significant role in some individuals and we suggest that the pattern of results in lows may be due to relaxation effects. Important individual differences in the ability to relax during hypnosis-based procedures have been demonstrated by the fact that while some studies have reported hypnotic suggestions to be more effective than relaxation per se (Stacher, Schuster, Bauer, Lahoda, & Schultze, 1975) others have found the two techniques to be equally effective (Houle, McGrath, Moran, & Garrett, 1988). This interpretation has important implications for the clinical use of hypnotic analgesia as it highlights the possibility that if the beliefs, expectations and attitudes of non-susceptible individuals can be modified and their susceptibility increased (cf. Spanos et al., 1983) then potentially it could be of benefit to a larger percentage of the population than is thought currently. Recognition of individual differences both in hypnotic susceptibility and ability to relax has important implications for the clinical use of hypnotic analgesia and demonstrates the potential benefits of hypnotic procedures in pain management.

A valid criticism of the present study is that attention may not have been controlled as intended. The authors acknowledge that there is an absence

of independent confirmatory evidence that attention was kept constant in the different conditions intended and any future study should incorporate a further pain irrelevant task such as that used by Friederich et al. (2001). It could also be argued the hypnotic-analgesia condition was more difficult for high participants (greater attentional demand) and resulted in compliance as suggestions were given both of analgesia and a resultant difficulty in detecting the painful stimuli. However, this viewpoint does not explain why lows also had slower reaction times during hypnotic analgesia and increased their omission rates during the standard-hypnosis condition. These findings were not expected and suggest that factors other than compliance were responsible for the effects in high participants. On the contrary we suggest that the pattern of results in high susceptibles provides important evidence in support of the dissociation of sensory and cognitive processes (Hilgard & Hilgard, 1983).

A further valid criticism of the study is that the painful stimuli (electric shocks) are polymodal (they activated both large and small peripheral fibres) and the validity of the observed effects may be dependent on this type of stimuli. That is, they could have affected central sensory processes independent of pain processes. It is important therefore that future studies should adopt more well-defined painful stimuli (e.g., laser stimulation cf. Friederich et al., 2001).

The present data suggest that hypnotic analgesia provides an important strategy for modulating experimentally induced pain. They also suggest that there is a dissociation between sensory and cognitive processes, especially in high participants and that these processes rely on different neural mechanisms.

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## **THE PLACE OF HYPNOSIS IN PSYCHIATRY, PART 4: ITS APPLICATION TO THE TREATMENT OF AGORAPHOBIA AND SOCIAL PHOBIA**

David Kraft

Private Practice, Harley Street, London

*This paper, the fourth in the present series, is based on a world-wide search of the literature, and focuses on the use of hypnosis in the treatment of social phobia and agoraphobia. Both disorders are complex and difficult to treat. Several explanations of the aetiology of social phobia and agoraphobia have been suggested over the years, but researchers are in agreement that, in both disorders, patients have frequently suffered inadequate parenting and experienced a huge amount of anxiety in early life. It is for this reason that therapists using psychodynamically orientated psychotherapy in treatment, must take great care to provide patients with the space to come to terms with these inner conflicts. Hypnosis is employed as an adjunct to therapy: It is used to help patients to reduce cognitive and physical symptoms of anxiety and provides them with more control in everyday situations. The author reviews a range of treatment procedures which have been shown to be highly effective in the treatment of both social phobia and agoraphobia. Some of these treatments are based on behavioural lines, but all of the approaches, to a greater or lesser extent, explore the psychodynamics responsible for the condition. Detailed accounts of the treatment procedures are given so that practitioners may incorporate these techniques in clinical practice. Implications of treatment are discussed.*

Phobias, according to the DSM IV classification (American Psychiatric Association, 1994), are contained within the category, “Anxiety Disorders.” In this journal, Kraft and Kraft (2006) gave an account of the use of hypnosis in the treatment of both anxiety disorders and sleeping disturbances. It is clear that, from the classification above, phobic anxiety comes under the remit of

anxiety disorders; however, due to the complex nature of both agoraphobia and social phobia, the author has decided to devote this paper to the subject. The following study looks at the way in which hypnosis has been employed as an adjunct to psychodynamic psychotherapy in the treatment of agoraphobia and social phobia. These disorders will be elaborated now and the role of hypnosis in their treatment considered.

## **AGORAPHOBIA**

Agoraphobia is a very complex condition and varies from person to person. The *Shorter Oxford Dictionary* (OUP, 1993) defines the term as “an irrational fear of open spaces”; however, the Greek word “agora” literally means “assembly” or “market place.” Individuals suffering from agoraphobia are anxious about a range of places or situations outside the comfort and safety of their home, although this can be extended to other places near or around the local area. These places are known as “comfort zones” (Chambless, 1982). Agoraphobics can indeed fear open spaces, but can also be afraid of being in a crowd, standing or walking across a bridge, travelling in a car, on a train or bus, being alone, standing in a field, meeting friends, climbing hills, going shopping, walking amongst tall buildings, and some fear different types of weather. The effects of agoraphobia vary considerably: some individuals are housebound while others are able to venture into the outside world, albeit with varying degrees of success (Buglass, Clarke, Henderson, Kreitman, & Presley, 1977; Chambless, 1982); further, each person can experience fluctuations within a week or month, and traumatic incidents in everyday life can often have a deleterious effect on wellbeing. In many instances, agoraphobic patients feel that they cannot escape a situation and most go at lengths to avoid difficult situations which might potentially set off a phobic response: Agoraphobia is often accompanied by panic attacks and these, according to DSM IV, can produce a range of symptoms. These include: palpitations and accelerated heart rate, hyperhidrosis, trembling or shaking, shortness of breath, choking sensations, chest pain, nausea, abdominal pain, dizziness or light-headedness, dissociation and/or feelings of depersonalization, feelings of losing control, fear of dying and hot flushes.

More often than not, individuals with agoraphobia stop working or begin to develop phobic attacks as a result of having stopped work (Ellis, 1980; Katerndahl & Realini, 1997); furthermore, their reduced mobility outside the house affects overall quality of life (Leon, Portera, & Weissman, 1995;

Milne, 1988). Others continue to work or expose themselves to their own personal feared situation or place, but continue to be anxious, and this is often associated with intermittent panic attacks. However, agoraphobia is selective and in some cases, for instance, on special occasions, individuals are able to cope with a feared situation with a companion or “safe partner.” However, these associated panic attacks can be so traumatic that many sufferers avoid any situation which might lead to a reaction and, as the condition worsens, more complex avoidance patterns begin to emerge. Some individuals who have been suffering from agoraphobia for a period of time complain that the mere anticipation of having a panic attack is enough for them to avoid, or be fearful of, a specific situation or place: Some authors refer to this as “the fear of fear” (Goldstein & Chambless, 1978; Kraft & Kraft, 2004).

Agoraphobia is very difficult to treat and its aetiology often centres around complex and irregular family dynamics: It is for this reason that treatment tends to be long-term (Milne, 1988). A number of case studies has shown that agoraphobia can be treated using behavioural procedures, and successful results have been reported using systematic desensitization (Kraft, 1967; Wolpe, 1958), group exposure (Teasdale, Walsh, Lancashire, & Matthews, 1977), flooding (Matthews et al., 1976), in vivo exposure (Emmelkamp, 1980), and hypnosis (Mellinger, 1992; Gruenewald, 1971). Agoraphobia has also been treated using antidepressants (Mavissakalian & Michelson, 1986), psychotherapy (e.g., Shilkret, 2002) and CBT (Beck & Emery, 1985). However, whether hypnosis is used as an adjunct to therapy or not, due to the complexity of this condition, it is extremely important for clinicians to provide clients with the opportunity to come to terms with the psychodynamics responsible for their condition. The following looks at how hypnosis can be employed to accelerate and enhance treatment in clinical practice.

An extensive search of the literature has uncovered seven studies which have used hypnosis in the treatment of agoraphobia: The first two studies (Gruenewald, 1971; Jackson & Elton, 1985) use a hypnoanalytic approach with age regression, the third and fourth studies (Hobbs, 1982; Schmidt, 1985) both use audiotapes, the fifth study (Mellinger, 1992) employs a hypnotically augmented multidimensional approach, while the sixth study (Roddick, 1992) uses a fantasy technique to encourage cognitive re-structuring. Finally, the seventh paper (Milne, 1988), is useful in that the therapist employs a number of approaches in treatment including group therapy, ego strengthening and the gradual introduction of hypnosis from a process similar to meditation. In all of these studies, with perhaps the exception of the final study (Roddick,

1992), the treatment hinges on an exploration of the family context in order to uncover the sources of the agoraphobia.

### **Hypnoanalysis and Age Regression**

Often in treatment, agoraphobic patients are highly resistant, and therapists need to make some important decisions about the treatment program and how to utilize these actions in order to effect change. In addition, the source of the phobia may lie in the distant past and focus on traumatic events in childhood involving one or both of the parents. When using age regression and/or hypnoanalysis in hypnosis, it is important to encourage the patient to explore safely their recollections of these traumatic events, but this must be done with care, and, at all times, exposure to these events should be combined with positive enhancement and ego strengthening. It is also recommended, when using age regression, to employ a dissociative technique during the process: This might include, for example, the patient watching a younger version of herself, watching a film or seeing a reflection. It is essential that the therapist should provide the patient with the opportunity to integrate the present with this past, traumatic experience and that the purpose of the regression should be to help her to learn from this event and to become stronger as a result.

Gruenewald (1971) described in detail the successful treatment of a 58-year-old woman who had had a 43-year history of agoraphobia with concomitant vertigo and anxiety attacks. She had an overwhelming fear of crossing the road, and she was petrified that she would fall over and hurt herself. In addition, she felt helpless, insignificant and small in comparison with tall buildings; these buildings seemed to close in on her and “crush her to death.” In the past, her over-protective husband would accompany her for short distances around the neighbourhood, and would fulfil daily tasks for her, thus self-perpetuating her condition; however, her husband’s failing health caused him to be less protective. As a result, she derived fewer secondary gains from her condition, and this, in turn, provided her with a rejuvenated motivation for therapy.

Born in Russia, the patient recounted early in treatment the fact that she had lost her only sister at the age of five, and as a result of her father’s underground activities had had to leave the country shortly after this event. The patient described her mother as “hostile towards men,” and she passed this hatred on to her daughter. She described the move to the U.S.A. as a frightening one: Both she and her mother, with some justification, felt that

they would be attacked or sexually assaulted by the soldiers on the train. But her main fear was one of abandonment: She feared that she would be left behind. This feeling was exaggerated when she arrived in the U.S.A. because she was retained on Ellis Island in order to recover from residual trachoma.

Later in treatment, the patient described her fear and trepidation when going to high school, and it was essentially at this time, aged 15, and at the time of menarche, that she developed agoraphobia and depression. She was unable to go to school, and were it not for her two brothers, who later took her to and from school, she would not have had a high school education at all. At the age of 20, the patient described having a complete breakdown and said that she had become “totally immobilized,” and consequently spent most of her time in bed with severe headaches. With her father’s help, aided by his optimism and humour, she was able to work locally; at 24, she married, and at 30 gave birth to a daughter. Twelve years later, after a phantom pregnancy which turned out to be a hydatidiform cyst, she suffered from a second depression which centred around the fact that she had a disappointing marriage and, consistently, sexual intercourse was a frustrating experience for her.

After several weeks of psychotherapy, a treatment strategy was formulated which would consist of three to six months of systematic desensitization, some hypnoanalysis, together with further psychodynamically orientated psychotherapy. It was clear that during the first hypnotherapy session, there was a huge amount of resistance to treatment: This manifested itself in the patient’s ambivalence towards the therapist. However, the therapist overcame this using an authoritative invitation to lie down and experience “a new kind of relaxation.” After the induction and deepener, she spontaneously abreacted and, after this subsided, she was encouraged to feel sensations of soothing and was given direct suggestions of reintegration. The therapist used the first hypnotherapy session to establish herself as a figure of authority and control, and she felt that this would encourage the patient to have a positive transference.

However, after several weeks it became clear that, every time the patient was asked to be active in the hypnosis, she resisted: She refused to give ideomotor signals, she was unable to simulate any sensory changes given by the therapist, and she refrained from carrying out the progressive muscle relaxation exercises at home. Later on in the treatment, the therapist employed scene visualization and sensory imagery and this started to reduce her anxiety; however, she began to develop a second psychosomatic symptom—sciatic pain. The therapist cleverly suggested that her unconscious mind “didn’t have

to acquire a secondary symptom” if she wanted to get rid of the old one, but, if she wanted, she could consult a medical doctor on the subject about her “symptom substitution.” This suggestion had the desired effect, as the mere prospect of having to pay extortionate private medical fees was enough to eliminate this secondary manifestation.

The psychodynamic psychotherapy at the beginning of each session was used to encourage the recall of stimuli in the hypnoanalysis. In the following weeks, the patient recalled three memories in her past which illustrated the roots of her agoraphobia. One recurring image was at the age of four or five. The patient described nearly drowning, and looking at nude men and women bathing in a lake; although the mother was there to revive the patient, she was absent in the fantasy image. This reinforced the therapist’s opinion that one of the sources of her problem was her fear of being abandoned; the therapist gave the patient space to come to terms with her infantile erotic fantasies, her fear of abandonment and death.

The second memory was when the patient was aged seven, and it was here that she recalled various children taunting a psychotic woman. After some time, she realized that the significance of this visualization was that she identified with this lady, and it was connected with her fear of failure. The third memory dated back to her ninth or tenth year. The memory consisted of her riding on her bike only to have her mother reprimand her when she got home. Her mother told her that there were many dangers outside: She realized at this point that she was made to feel that the outside world was a place that was associated with fear and trepidation. The patient also said that she enjoyed lying in the meadow, and the therapist utilized this memory to encourage feelings of strength and renewed hope. The age regression, in all cases, was used to set the patient on a new path, where she was in charge of her destiny. After these hypnotherapy sessions, the therapist then encouraged the patient to address this material and work through it, and she also set a time limit for the end of treatment. At the follow-up, a year later, she said that she was coping well, she had improved control of her anxiety and was coming to terms with her husband’s increasing lack of mobility.

Jackson and Elton (1985), treated four females all of whom met the criteria for agoraphobia. In two of the cases reported, hypnosis was used as an adjunct to treatment. In the first case, the authors described the treatment of a 41-year-old lady, Mrs B, who had had a long history of suffering from agoraphobia. When she was considered for treatment, she reported that she was unable to travel on public transport and could not cope with crowded places on her

own. At the time, she was still taking amitriptyline (75–100 mg daily), and clorazepate (15 mg at night), and this was gradually stopped before treatment began. Over the next six months, Mrs B went to the senior author (Jackson) for treatment, and she experienced significant gains in the initial stages using in vivo exposure therapy alone. However, these gains stopped in their tracks and the patient complained that she had experienced anticipatory anxiety. Further, she pointed out that, although she was able to travel on a train, she had had a number of panic attacks, especially when visiting her mother or when she was the only woman in the carriage.

Using hypnosis with age regression, Mrs B described a traumatic party scene at the age of eight in which her mother encouraged strange men to undress and fondle the petrified girl. At this point, Mrs B abreacted and screamed that she hated her mother. Her ambivalent feelings toward her mother engendered guilt because she was now old and frail, but the acknowledgement of this was extremely empowering for the patient. She also pointed out that she projected the molesters' faces onto the men on the train and felt that they were going to harm her or undress her in a similar way. The therapist made sure that, during the age regression, she was connected with the present, and that she should use this past event to make her stronger in the future. Following this important session, Mrs B was able to tell other people—including her friends and family—about this experience, and this had a huge relieving effect on her anxiety. As a result, Mrs B was able to travel freely on public transport. However, this caused further problems in the family context: It seemed that the husband had a vested interest in keeping Mrs B immobile and, now that she was able to travel more freely, he became increasingly more introspective, increased his alcohol intake and underplayed her treatment gains. In the psychotherapy, Mrs B revealed that she had not had sexual intercourse with her husband for some time, and that he was impotent. It was clear that her phobia camouflaged her husband's condition and the therapy focused on accepting her ambivalence and feelings of guilt. At the follow-up, the patient was completely asymptomatic.

The second patient described by these authors was a 42-year-old lady who feared leaving the house, shopping and using public transport. The patient had sessions once a week for 11 weeks. Early on in the treatment, the patient complained that she would be unable to practise the in vivo desensitization work because of her uncontrollable fear that she would be attacked by her ex-husband. This fear was eliminated in a single two-hour hypnosis session in which she was exposed to scenes in which she was being attacked by her

ex-husband. She then began to carry out various in vivo exercises on public transport.

After several weeks, the patient reported that, although her children upset her, she was unable to voice her opinions because of her uncontrollable fear of losing them, and this caused her to carry around with her a huge amount of repressed anger towards her children. Over a number of sessions, the patient was encouraged to express these feelings to her family. She also continued to practise her in vivo exposure tasks and made significant improvement.

### **Use of Audiotapes**

In some cases, particularly in the early stages of treatment, agoraphobic patients are unable to get out of the house and go for treatment. It is, therefore, helpful to provide telephonic sessions or to arrange home visits in order to help patients overcome the immense fear associated with leaving the “safe zone.”

Schmidt (1985) used a unique approach in the treatment of a 28-year-old female with agoraphobia. To begin with, she explained that she had developed agoraphobic symptoms after a prolonged trauma at work. In the first instance, she was unable to go shopping, and this caused a huge amount of anxiety; but this developed, and after a while she was unable to go further than her neighbour’s house across the street. The therapist arranged for a house call, at which the patient insisted that her neighbour be present at least somewhere in the house. The treatment strategy was designed to start with autogenic training (Luthe & Schultz, 2001), and then moving on to goal-centred hypnotherapy: This was combined with the use of specifically designed audiotapes. The rationale behind this was that the initial training in hypnosis would give the patient immediate success and feelings of empowerment, and that a carefully designed imagery program on audiotape, if practised regularly and consistently, would desensitize the patient to public places.

In the first session, after initial history taking, the therapist demonstrated the six steps of autogenic training as described by Schultz (Jencks, 1973; Luthe & Schultz, 2001): During this part of the therapy, the patient was encouraged to attain relaxation by imagining changes through progressive muscle relaxation, temperature, feelings of heaviness or lightness, and reducing heart and respiration rates. Following this, the therapist discussed with the patient the treatment program which consisted of (a) audiotapes, which helped her to experience different levels of relaxation, using all the sensory modalities, and (b) a graded imagery program. The first scenario in the graded imagery

program was to practise, in hypnosis, going on a trip with her husband near to the house, and gradually these distances were increased. As the therapy progressed, the patient negotiated with the therapist that one of the final goals would be to be able to go to the shopping mall.

It is important in treatment that the patient begins to exercise control not only in the consulting room but also in everyday situations. The therapist recognized this and, when the patient stressed the importance of moving slowly towards each goal, he responded appropriately and to the benefit of the patient. Each new scenario, which gradually moved closer and closer to the shopping mall, was incorporated into a new audiotape, and subsequently mailed to the patient; further, on completion of each task, the therapist arranged for a telephone session. These sessions were essential for the following reasons: They provided her with the support and encouragement that she needed, but they also gave her the opportunity to discuss her progress, and also to make any necessary changes to treatment strategy. She also felt that she had involvement in the process, and her somewhat obsessive nature and motivation were utilized by the therapist: Indeed, she consistently practised the autogenic training on a day-to-day basis and reported back a huge amount of material relating to her personal associations and thought intrusions each stage of the treatment. Her therapist also gave her direct suggestions to meet friends during the week, and these suggestions were accompanied by feelings of lightness. He pointed out that these lighter steps would build her self-confidence and provide her with a new sense of optimism. The treatment lasted six months and, in a letter to her therapist, she commented that her progress had been maintained.

Another approach which utilized the use of audiotapes is one by Hobbs (1982). She outlines a treatment program emphasizing the fact that the agoraphobic patients become introspective and self-analytical and that the therapist should interrupt this pattern of behaviour in order to effect change. In addition, agoraphobic patients are often overwhelmed by external and internal stimuli—for example, sound, heat and cold, light, climate, crowds—and this hyper-suggestibility to all the sensory modalities can be utilized by the therapist in the hypnosis in order to provide them with the opportunity to effect change in their own environments.

Hobbs emphasized that the first consultation is critically important for agoraphobic patients—and all patients for that matter. When a patient comes for the first session, (s)he has made a conscious decision to come to terms with the fact that (s)he has a problem that needs to be resolved; and, for some, the wait in the consulting room can be enough to provoke a panic attack of

some kind (Kraft, 2011). Hobbs points out that it is important not to keep the patient waiting for too long, and it is important to build good rapport—one that is based on trust and continued support—as quickly as possible.

Quite rightly, the author points out that the first two or three sessions vary from individual to individual, but suggests that all patients should be educated about the condition, and be provided with audiotapes and explanatory diagrams which explain the physiological changes which occur during panic attacks. Patients were also given questionnaires to complete in which they were asked to construct a hierarchy of difficult, potentially anxiety-provoking scenarios. Hobbs recorded the audiotapes in order for the patient to become used to her voice, and, although the tapes were educative, she included a large number of positive terms which, working as indirect suggestions, encouraged patients to become more confident. She also gave patients relaxation tapes to use at home. The first tapes used progressive muscle relaxation, and gradually hypnosis was introduced with guided imagery. As the treatment continued, Hobbs introduced patients to their hierarchy and worked through each scenario through the use of cue cards on which self-coping statements were written. As the patients became more desensitized to their own feared situations (Wolpe, 1958) they developed the ability to cope with their anxiety and eliminated the possibility of having a panic attack.

### **Multi-Dimensional Approach**

An interesting approach to the treatment of agoraphobia is one presented by Mellinger (1992). This report stresses the importance of the therapist being adaptable in his treatment approach; indeed, Mellinger had to change his strategy after the initial stages of treatment. The patient, Mrs G, suffered from agoraphobia with panic attacks, and had a number of associated phobias including a fear of flying, driving and shopping. In the first eight weeks of treatment, Mrs G was given the opportunity to talk about her situation and her fears. She was then briefed on cognitive restructuring techniques that would help her in the future, and on the basic principles of exposure therapy—that is to say, in vivo desensitization. She was also given a thorough explanation of her disorder and was taught progressive muscle relaxation. Further, she was given alprazolam which was gradually reduced to a maintenance dose of 1.5 mg three times a day.

In the next stage of treatment, Mrs G was prepared to begin her exposure therapy which consisted of gradually exposing herself to more difficult

anxiety-provoking situations. She planned to go to an all-night convenience store in order to buy some food; however, despite her preparation, applying both cognitive-behavioural strategies and using relaxation exercises prior to the expedition, she had a small panic attack in the shop. Mrs G reported that she had had a near escape in this situation, and as a result it was decided that they would use hypnosis and guided imagery in order to enhance her ability to cope in difficult situations before returning to the in vivo work. In this process, Mellinger also provided Mrs G with a powerful anchor which consisted of her touching her fingertips on her solar plexus, whispering the word “relax,” and this method provided her with a sense of calm and even respiration. Mellinger also encouraged her to visualize herself watching herself on a television screen where she was able to adjust the volume, brightness and focus controls (Clarke & Jackson, 1983). She was able to adjust the volume in order to reduce the intensity of affect and, when working through the scenario of going to the shops, she was able to cope using this strategy. Further, she was encouraged to practise auto-suggestion by herself at home. After six weeks of this work, she started the in vivo desensitization again, using anchoring whenever she became anxious, and she practised this four to six times a week. A further five weeks of this work meant that she was able to go shopping regularly without panic and reduce her alprazolam intake. Mellinger commented that the hypnotherapy acted as a “flexible vehicle for fortifying [her] coping skills” and helped her to be more equipped to tackle real life situations, even after an initial relapse.

### **Fantasy Technique**

Roddick (1992) briefly described a case of agoraphobia in which he employed a fantasy technique in hypnosis. The patient he described was a lady who was unable even to be driven by her husband for more than a mile from her home. She had a number of associated symptoms which included dry mouth and nausea and had had to give up a successful career because of her condition. Roddick must have had problems of resistance during the initial stages because he pointed out that it took four sessions for her to get used to his approach and to be able to relax in his presence. He pointed out that, once she had got used to her therapist, he was able to use hypnotherapy successfully in the consulting room, and she began to make more rapid progress.

After the induction and deepener, Roddick addressed her unconscious mind and focused on the following:

1. The importance of practising self-hypnosis and general relaxation,
2. Being able to sit and travel in a car, and
3. Being able to eat and drink.

The therapist then suggested that the three parts should be combined in order to come up with a strategy that would enable her to cope with her agoraphobia without any problems whatsoever: This was confirmed as being an acceptable approach by the patient by way of an ideomotor signal. The strategy consisted of a “secret place fantasy” in which the patient was encouraged to throw out all her negative feelings and aspects of her life. After only two sessions, she reported that she was able to travel 200 km away to visit her family and, after a further eight sessions, she was able to drive herself to the consulting room. At the time of writing the paper, Roddick said that she continued to make progress, and had secured a full time job in the local area.

### **Use of Group Therapy and Hypnosis**

Gordon Milne (1988) reported the treatment of three women with complex agoraphobia, the most successful of which is reported below. At the start of treatment, the patient was still able to drive her car but only when accompanied by her husband. Her panic attacks were severe: She suffered from hyperhidrosis, dizziness, weakness of the legs, tingling of the hands of the feet, and, more alarmingly, depersonalization. On journeys, when she lost sight of her “safe partner(s)” —namely, her husband or her sister—she would suffer from constant thought intrusions which centred around the following fears: (a) worrying about collapsing in public, (b) going mad or (c) dying.

During the initial case history taking, she pointed out that she suffered from periods of depersonalization at school at the age of 12, and that she experienced a great deal of frustration due to the fact that no one understood her condition. She managed to control her panic attacks and feelings of depersonalization with psychotropic medication, and these attacks lessened as she grew older; however, two sudden deaths of close members of her family had reactivated her condition.

The patient was delighted to find that there were other individuals who were suffering from the same condition, and she became a regular member of the support group at the community centre. She pointed out her life was made a misery because her husband couldn't understand why she was unable to socialize, and he consequently spent more time drinking with his colleagues after work, which in turn caused a number of arguments late at night.

Essentially, the first part of the treatment was to get the husband on board, and to brief him about the nature of agoraphobia and the treatment strategy. The therapist arranged a joint counselling session to this end.

The next stage of treatment focused on reducing the panic attacks without the use of medication: A treatment strategy was put in place so that she would gain more control of her panic attacks and gradually reduce her psychotropic medication. Hypnosis was introduced as an extension to meditation, and she was gradually able to respond adequately well to the therapist's suggestions. Later in the treatment, in the hypnosis, she was given ego strengthening to provide her with the ability to function outside the comfort of her home, and, using guided imagery, she began by sitting in the car on her own and worked towards driving to the supermarket. This process of systematic desensitization was slow. Whenever she became anxious, she raised her finger and was able to reduce her anxiety by taking five deep breaths. This exercise was taped and she practised this religiously at home twice a day.

As a result of her work in the consulting room, at home with her practice tapes, and with the continued support which she gained from being able to share and listen to other people's experiences in the support group, she made a significant recovery. Indeed, the support group was extremely helpful in this process: Not only were they able to support each other during group sessions, but they were also able to help by giving each other lifts to and from the therapy sessions. By the end of treatment, the patient was able to drive herself without support from anybody else, and was regularly going out on social events with her husband. At the follow-up, a year later, her improvement had been maintained.

## **SOCIAL PHOBIA**

According to DSM IV, Social Phobia is characterized by a noticeable fear response to social or performance situations, and this is connected with a fear of embarrassment, or being judged by other people. When social phobics experience a difficult social situation, they invariably become intolerably anxious, and this can lead to a panic attack. Often, they will go at lengths to avoid these threats and, in many cases, this can lead to a significant reduction in mobility and contact with other people. Avoidance in social phobia takes on many forms: Some patients will even avoid eating, drinking or talking in public because they fear that others will notice their behaviour or concomitant symptoms (Milne, 1988). Individuals with social phobia may suffer from

the following—shaking hands, palpitations, blushing, hyperhidrosis, muscle tension, stuttering, gastrointestinal discomfort, persistent feelings of wanting to urinate and nausea.

Like agoraphobia, social phobia is extremely difficult to treat. In many cases, the source of the phobia is inextricably interconnected with the quality of their attachment with their mother from birth until the age of five (Bowlby, 1999). This attachment is essential for individuals to develop. If adequate love, attunement and comfort are provided at this stage, infants are able to begin to explore the world around them and this, in turn, leads to individuation, separation, the ability later to engage in meaningful personal relationships and to pursue a professional career (Frankel & Macfie, 2010; Kohut, 1984; Winnicott, 1984). Inadequate attachment at this stage leads to a poor sense of identity and lack of both confidence and personal autonomy in adolescence and childhood (Winnicott, 1984): This can cause a constant fear of losing significant partners and friends. Some use self-sacrificing techniques in order to maintain relationships (McWilliams, 1994), while others are unable to assert themselves or display independence in their everyday lives.

The literature search revealed only a small number of case reports that used hypnosis to treat social phobia. The treatments of choice had tended to be psychotherapy (Leichsenring, Beutel, & Leibing, 2007), CBT (Taylor, 1996), pharmacotherapy (Versiani et al., 1992) or systematic desensitization (Marzillier, Lambert, & Kellert, 1976). However, there are two studies that used hypnosis in treatment: Lipsett (1998) who combined cognitive therapy with systematic desensitization (both in hypnosis and in vivo), and Frankel and Macfie (2010) who reported a case in which the therapist used insight-oriented psychodynamic psychotherapy and hypnosis. It was clear that, in both cases, to a greater or lesser extent, it was important that the hypnosis was combined with a thorough psychodynamic investigation of patients' dependency and separation, avoidance behaviour, feelings of guilt, and fears of rejection in both present-day relationships and as an infant.

Lipsett (1998) used a multi-modal approach in the treatment of a 26-year-old man with social phobia. In the first session, the patient, Eric, described how uncomfortable he felt in what he called "unstructured" social situations: He complained that he was unable to relate to people and, although he had some good friends, felt that he was handicapped in social situations, particularly with new people. Eric was asked for a goal to work towards, and he said that he wanted to be able to approach strangers with ease and to make new friends; the first goal, however, was to be able to walk into a hotel and

have a conversation with a stranger. Eric was then given direct suggestions of wellbeing and how the hypnosis would provide him with more control of his life, his control being enhanced with ideomotor signalling. In the second session, a cognitive approach was used in order to help Eric fulfil his potential with his communication skills. He was also taught self-hypnosis and was asked to practise this twice daily: It was explained to him that this would condition his sense of relaxation when it was required. He was also asked to read Matthews' (1990) *Making Friends*.

In the third session, these "unstructured" social situations were reframed so that Eric would be able to define the parameters of the interactions—for example, he would be able to engage in conversation, talking about the topic of his choice. During the hypnosis, and using the principles of systematic desensitization, Eric was then encouraged to buy a drink and to have a conversation with a stranger in a hotel. The therapist also gave Eric ego strengthening and asked him to imagine in detail a mental representation of a confident Eric engaging comfortably in social situations in the future. This was combined with self-image work (Langton & Langton, 1983), tracing back all the steps that helped him achieve this goal. Finally, as a homework task, Eric was asked to go into a hotel and to make conversation with a stranger, and that this should be done between now and the next session.

In the fourth and final session, Eric reported that he had had a successful conversation in a hotel and had been bought a drink. Eric did, however, point out that he dreaded walking in and that he felt chest pains. Lipsett asked Eric to move from chair to chair. First, he asked him to say what he saw when he wanted to be able to enter the hotel; secondly, in the next chair, he asked him what he heard when about to enter the hotel, and at this point he said that he heard his father's voice tell him that he "could not go in there." Using a somatic bridge, Lipsett instructed Eric to follow his paralysed feelings back in time: He identified that the source of his problem was at the age of three when he was terrified of his father's anger, and he said that he wanted to 'be safe'. The therapist then instructed the older, wiser Eric to comfort this little boy, telling him that he would "be safe." As a result, Eric said that he was able to enter a hotel with feelings of being in control and that he no longer froze or had the unpleasant chest pains.

The second study, provided by Frankel and Macfie (2010), consisted of a single case study of a lady in her twenties who, although described as having social and performance anxiety, displayed all the features of social phobia. She avoided confronting friends and family when she was angry; she experienced

accelerated heart rate and impaired attention; she had extreme difficulty in forming meaningful relationships with friends and potential romantic partners; and was obsessed with time management and meeting deadlines at work. The treatment consisted of 13 months of insight-orientated psychodynamic psychotherapy on a weekly basis, which amounted to 58 sessions in total, and this was combined with hypnosis.

In the psychotherapy, the therapist revealed that, as a result of inadequate attachment experiences as a child, the patient, Ms A, had struggled to develop into an independent and autonomous adult and was left feeling insecure and fearful of social situations. Her mother had developed cancer when Ms A was very young, and her fear of losing her mother was reactivated when the mother's cancer returned when Ms A was an adolescent. Importantly, the therapist provided the patient with a "safe space" and she was given support and encouragement in the consulting room: This secure environment made it possible for the patient to experiment with possible new interpersonal behaviours and explore the view of herself and others in her everyday life. The therapist provided an adequate attachment bond which, unlike her childhood experience, encouraged her to practise autonomous behaviours. The psychotherapy also focused on her avoidance of intimacy during adolescence and in adulthood; she explored the effect that her consistently unavailable mother had on her interdependence and began to shape a sense of identity.

Hypnosis was used in order specifically to focus on reducing anxiety in social situations. The therapist devoted several sessions to teaching Ms A self-hypnosis. During the hypnosis, the patient was encouraged to bring her mind to a "soothing and peaceful place," allowing the physiological manifestations of her anxiety—namely, the irritability, loss of concentration, accelerated heart rate, confusion and impaired attention—to disappear, and her mind to "refocus." Unfortunately, the patient used hypnosis inconsistently during the course of treatment; however, Ms A did use hypnotherapy successfully during difficult social situations, and she regarded it as an "on the spot intervention tool."

At the beginning of therapy, the mother's illness became rapidly worse and this had an effect on progress. The treatment significantly reduced her worries about time management but did not reduce the peak level of daily anxiety. The patient did, however, report that she had less rumination with regard to time management, while the daily self-reports indicated that there was a definite cognitive shift away from her anxious fears and worries. Ms A also

said that she had begun to place her own needs before other people's needs and felt that her behaviour was "less distressing": In the past, she felt unable to be forward with other people about her needs and preferences, but she was now able to communicate more successfully with others and to be consistently more "open." This resulted in a shift in her ability to trust others and, with the addition of hypnotic intervention, provided her with increased confidence in social situations.

## COMMENT

In the case studies reported in this paper, the main focus of the treatment was to establish the source of the phobia through the process of psychotherapy and, in both social phobia and agoraphobia cases, this source was associated with early trauma or inadequate parenting. It was also necessary to consider the role that marital and/or parental figures played in effectively maintaining or perpetuating the condition (Hand & Lamontague, 1976). The efficacy of in vivo exposure therapy has been established (e.g., Jansson & Ost, 1982), and it is recommended that clinicians incorporate in vivo desensitization into the treatment program using a hierarchy of anxiety-provoking situations—this work can be done between sessions.

The Milne study (1988) showed how helpful it was for patients to receive help from other people: Indeed, the patient in this study benefited significantly from the encouragement of her colleagues in the support group. Unfortunately, few support groups of this type exist; however, if group therapy is not available, it is important for patients to feel that they are not alone (Clarke & Jackson, 1983), and, as was the case in the Hobbs (1982) study, to be given education so that they can understand the physiological changes that take place during a panic attack.

Hypnosis is a powerful adjunct to therapy. The case studies presented here demonstrate that it has been highly effective in helping patients (a) to explore feared situations in a safe environment; (b) to reduce anxiety using desensitization; (c) to gain more control using anchoring, fantasy techniques and autogenic training; (d) to enhance coping strategies using ego strengthening and breathing techniques; and (e) to reduce affect using television screen imagery. Age regression (f) was also employed effectively to help a patient to address, and come to terms with, inner conflicts and traumatic events in early childhood. Finally, carefully designed audiotapes were employed to encourage two patients to practise self-hypnosis at home, and this had the effect of enhancing treatment outcome.

The use of hypnotherapy in clinical practice offers are more rapid and cost effective treatment for social phobia and agoraphobia, and it is recommended that it be used in conjunction with psychodynamic psychotherapy and/or in vivo exposure therapy.

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## **SPIRITUALITY, HYPNOSIS AND PSYCHOTHERAPY: A NEW PERSPECTIVE**

Eugen Hlywa and Lynda Dolan

*Clinical Psychologists in private practice, Sydney*

*The authors present a bio-psycho-social-spiritual paradigm for understanding the phenomenon of hypnosis in psychotherapy. Two case vignettes are described to illustrate the spiritual core of the psychotherapeutic process. The first author (E.H.) relates a clinical case of the hypnotherapeutic process where a patient with psychosomatic symptoms obtained insight and cure in spontaneous hypnotherapeutic abreaction. This case illustrates the very spiritual and human experience of guilt. The second author (L.D.) relates the case of a woman suffering from PTSD and depression who was able to negotiate several spiritual conflicts including grief, loss, guilt and hopelessness and transform her life by developing a sense of meaning, purpose and hope. The authors discuss the contribution of the great philosophers and thinkers and conclude by offering a new definition of hypnosis that embraces the essence of the spiritual dimension of human functioning.*

Experience in clinical practice suggests that the most frequent intrapsychic conflicts that are injurious to humans and resistant to psychotherapy on the conscious level lie within the spiritual domain. Human beings can transcend themselves fully when they embrace their beliefs, values, intellect and spirit. Spiritual integrity is eminently guarded by every human being and should be considered by every practitioner.

A bio-psycho-social-spiritual paradigm for understanding the phenomenon of hypnosis assumes a holistic approach. A holistic approach assumes integration of the intra- and interpersonal levels of functioning (Dolan, 2000). Holism is defined in the context of the present paper as the understanding of the human being in terms of an integrated whole whose properties cannot be reduced to those of smaller units (Smuts, 1926 in Dolan, 2000). Such an

approach embraces spirituality at the core of the psychotherapeutic process (Hlywa, 2006; Hlywa & Dolan, 2010). The hypno-analytic approach, which includes a positive psychotherapeutic relationship, paves the way to successful psychotherapy.

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

In the early 1950s a conscientious medical practitioner referred to me a 13-year-old boy suffering from rheumatoid arthritis for “hypnotic assistance in controlling severe pain.” Besides the pain, the patient was crippled and severely deformed. I felt great empathy for the victim of this vicious illness. According to long-established practice I never disregard the reason for referral. Otherwise one places oneself into direct conflict with the patient and with the referring practitioner/s. However, I appreciate a holistic approach believing that a complaint is usually a symptom of intra-personal conflict. Thus I fulfilled the request of the patient and the referring doctor with the expectation that an existentialist approach would in due course “unfold” and bring us to the genesis of the problem, which I conceive as spiritual.

I was aware that such a “symptom” must be treated with profound respect even after positive hypno-analytical procedures and removing a symptom too quickly should be avoided. Therefore, during the first session I limited procedures to induction and deepening of the trance.

As expected of a child of this age, he reached somnambulistic trance within several minutes, and I stood before a “call” to implement “some therapeutic procedure.” Being cautious, rather than impulsively committing a mistake, I suggested to the patient that “a rest creates natural healing condition” (Hlywa, 2008) and that he beneficially will enjoy the rest to the fullest extent. Upon awakening he looked at me, and shook his hands and moved his fingers, as if expecting to notice some change. The positive expectations of a patient play a tremendous role in the procedures and in the result of the hypnotherapeutic process.

Two days later I discussed with him the process of self-hypnosis and taught him how to use hypnotic analgesia, which he mastered within one hour. Hypnosis was introduced at this stage to create the deepest positive psychotherapeutic relationship in order to address the presenting problem. Self-hypnosis was specifically introduced because it places the onus on the patient to be responsible for his own self. This is aligned with the authors’ theory that all hypnosis emanates from deep within the person, and as such is

self-hypnosis and that one cannot impose anything onto another human being (Hlywa & Dolan, 2010).

During the third session he demonstrated how successfully he used this technique, but insisted that he would “very much like to see more of me,” a proposition which I welcomed, albeit with caution, suspecting that the insight of the patient involving intra-personal conflict is likely to come to the fore. I expected that a psychotherapeutic interpersonal relationship was ripe enough for the patient to reach for the unconscious material which caused him the rheumatoid arthritis and was suggestive of profound intra-psycho conflict. At the beginning of the 1950s I became interested in existential philosophy and its principles implicated in the psychotherapeutic process. Skovoroda (1973) was my primary influence. Through his voluminous writings he insisted that the core of the human being is not his somatic self but his spiritual self, the soul. He insisted that the body without the spiritual self is a “decaying corpse.” He elaborated that the spiritual (the invisible) has much more potential than anything in the realm of physical sciences. As an example he points out that lack of air (an invisible substance) would bring instant death. He points out that winds create waves thus moving the oceans, that small vibrations of the air can carry messages that make or break human beings. Here he means the power of words. Following Skovoroda’s writing I became acquainted with Emmanuel Kant’s (1958) *Critique of Pure Reason* which, like Skovoroda, points out the power of the human spirit and its ability to apprehend ontological truths. Skovoroda also points out that spirituality is the oldest method of healing.

Practically, I appreciate that as a clinical psychologist one has to elucidate the core of the problem, thus going into the anamnestic interview. However, in my experience, when therapists use questionnaires and tests to investigate the core of a problem, they fail, and fail because the core of the problem is often too painful and threatening for the patient to face. Thus I came to appreciate the adage, “if you ask less you will get more”—and you will get more with the assistance of profound psychotherapeutic relationship, the strongest form of which I believe is the hypnotic therapeutic relationship. In the present case the patient vehemently wanted to maintain the relationship, and as an experienced psychotherapist I requested a further protracted session. Expecting severe abreaction, I suggested to the patient that he discuss anything with me as long as he was in hypnotic trance, to which he agreed and readily placed himself into deep hypnotic trance. Due to the severity of the symptom, I expected that the intra-personal conflict may be too severe for him to face

in his conscious and unprepared state. Therefore I suggested that he would reveal things to me and himself while in hypnotic trance. He then started to tell me: “I don’t know whether it is the truth but I want to share it with you ...” He had abreacted to the core of the problem (guilt) which is obviously spiritual in nature—he felt *guilty* of contributing to the death of his brother. In abreaction, he covered his face with his hands and yelled while crying, “I did not kill him ... he, like I, had been swimming in the river ... he crossed the river several times ... he was in a pack of other children and I never suspected that he drowned ... after a while I decided to go home, calling him to come with me but [I thought] he probably went with other children on the bank of the river.” After this he howled and several times denied any guilt or any contribution to his brother’s death.

Not until that day had he, his parents, or his doctor mentioned his brother’s death to me. It was the sole abreaction that revealed to me that the cause of his rheumatoid arthritis was a “defence mechanism” to his guilt feeling of being a contributor to his brother’s death. Feeling guilt is conceived here as a spiritual response to doing something that is contrary to profound principles. Obviously one abreaction is insufficient to remove the feeling of guilt; one has to utilize several further abreactions and discontinue only when the guilt subsides (Watkins & Barabasz, 2008). The patient started to recover following the third session, in which he mastered self-hypnosis and the technique of controlling pain. Following several abreactions which removed or flattened the emotional state, the patient, in hypnosis, was subject to a dialogue in which he came to the conclusion that he had played no role in his brother’s drowning that could make him guilty. He fully recovered within a year. Follow-up several years later indicated that he was living a completely healthy life.

This case is very characteristic of the intra-personal conflict, *which is more than often a reason for crippling mental and emotional health, thus causing multitudes of psychosomatic, mental and emotional illnesses.*

### **Case of a Woman With Depressed Mood and PTSD (L.D.)**

A 36-year-old woman was referred by her doctor for psychotherapy to address symptoms of depressed mood. During the first session the patient, appearing rigid and tense, was unable to talk coherently. She was tearful at times and appeared hysterical, noting that she had “had a terrible childhood” and did not want to go into any of her past history as it was “too distressing and painful” for her. She also noted that she could not relax and any suggestions

on the conscious level to go into relaxation placed her more on edge. She had apparently refused anti-depressant medication as she wanted to be able to control her process herself. She expressed profound relief at being able to articulate her feelings of hopelessness and “wanting to die” and having such expressions acknowledged by myself without any interpretations or attempts to rescue her.

I noted that this patient was experiencing several symptoms of depressed mood, including feelings of hopelessness, helplessness, sleep difficulties, anhedonia and agitation. However, the nature of her depressed mood was clearly a reaction to distressing life events including several childhood traumas, her physical condition of advanced endometriosis and inability to conceive, as well as, more recently, work-related stress. Adopting a psychotherapeutic approach of acute listening to the patient, reassuring her, without interrogating or imposing any suggestions on her, enabled her to negotiate the session and agree to attend a follow-up session. Careful application of psychotherapeutic and hypnotic phenomena, including utilization of spontaneous hypnosis (Erickson, 1967), protracted hypnotic rest (Hlywa, 2008) and resonance (Rogers, 1951) with the patient facilitated the rapid establishment of a positive psychotherapeutic relationship. This involved establishing a level of trust where the patient was able to negotiate several inter- and intra-personal conflicts.

Over several months, the patient spontaneously abreacted various past and current traumas and stresses. These abreactions occurred both during and in between sessions and facilitated the patient to move forward in her life, with acceptance and hope in a meaningful future.<sup>1</sup> The spiritual issues negotiated during the sessions included those of guilt, loss, grief and hope at the levels of her inter- and intra-personal contexts, including her cognitive, emotional, behavioural, familial, social, occupational and existential areas of functioning. These included the following:

- She was able to negotiate issues of grief (i.e., the loss of her grandmother, loss of ability to conceive and the implications regarding her future goals and her marital and familial relationships). This led her to revisit and integrate traumatic issues relating to her cultural and family values from her childhood which she was unable to confront previously.
- She was able to embrace the spiritual dimension of functioning in her personality which included addressing her reasons for living, her goals

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<sup>1</sup>The use of repeated abreactions, as noted by Watkins and Barabasz (2008), was explained in the first case study of this paper

and hopes for the future; reformulating her life goals including career and relationships; as a result she replaced feelings of hopelessness with hope and faith (Marcel, 1973).

- The hypnoanalytic process enabled her to understand the symptoms of anxiety and depression which were expressions of the dissonance in her life.

As with the previous case presented by E.H., this case illustrates the very spiritual and human experiences which are at the core of the healing process.

## **THE SPIRITUAL DIMENSION OF HUMAN FUNCTIONING**

### **What is Spirit?**

The Bible refers to 'spirit' as the voice of God forever present in the consciousness of every human being (John 14:17, 14:26; John 16:13; 1 Corinthians 2:10; Romans 8:26; 2 Timothy 1:7; 2 Galatians 5:22,23; Matthew 12:13; Job 34:14,15; Solomon 15:11). These texts imply that the human being is endowed by the Creator with dynamics and the free will to gear his/her life.

*Webster's Dictionary* definition of the term spirit is:

The intelligent, immaterial, and immortal part of man; the soul, as distinguished from the body which it occupies; a person considered with respect to his mental or moral characteristics; the human soul after it has quitted the body; an apparition; a specter; a ghost; a supernatural being; angel, fairy, elf, sprite, demon, or the like; vivacity, animation, ardor, enthusiasm, courage, or the like; emotional state; mood; humor; the vital or the essential part of anything; inspiring or actuating principle; essence; real meaning; intent, as opposed to the letter or formal statement. (Thatcher, 1980, p. 808)

The *Oxford Dictionary* definition of the term spirit is:

The non-physical part of a person which is the seat of emotions and character; this regarded as surviving after the death of the body, often manifested as a ghost; a supernatural being; the prevailing or typical quality of mood ... a person's mood; courage, energy and determination; the real meaning of something as opposed to its strict verbal interpretation. (Soanes & Stevenson, 2009, p. 1391)

According to Hegel, the nature of Spirit may be understood by contrasting it with its opposite, namely Matter. He says that:

The essence of matter is gravity; the essence of Spirit is Freedom. Matter is outside itself, whereas Spirit has its centre in itself. Spirit is self-contained existence.

But what is Spirit? It is the one immutably homogenous infinite—pure Identity—which in its second phase separates from itself and makes this second aspect its own polar opposite, namely as existence for and in itself as contrasted with the universal. (Hegel, in Russell, 1971, p. 707)

It is ironic that the words “spirit” and “spiritual” have been completely ignored and often forbidden in the academic and scientific fields of psychophysiology and generally in the mechanistic model of health and medicine (Seaward, 2000). Seaward pointed to this irony and noted that “if something couldn’t be measured and validated scientifically, it didn’t exist, and human spirituality definitely fell into this category” (p. 242). He commented further on how, towards the end of his career, Selye’s perspective of stress grew when he spoke of spiritual issues, particularly meaning and purpose in one’s life (Selye, 1974, in Seaward, 2000) and yet his most important insights on stress were overshadowed by the mechanistic framework which so greatly influenced the start of his career. This is one example of many models of human functioning which have completely ignored the presence and influence of the spirit in human functioning. Even the World Health Organization (WHO) noted that “Health care should be in the hands of those who are fully aware of and sympathetic to the spiritual dimension” (World Health Organization, 1992, in Seaward, 2000, p. 244).

Spirituality of human beings has attracted the attention of philosophers and thinkers from ancient times. The universal nature and essence of human spirituality has been emphasized by shamans, sages, mystics, healers and wisdom keepers, and more recently quantum physicists have attempted to integrate science and spirit by studying the human energy field, while psychophysicologists have used their own language to attempt to understand the nature and essence of the integration of the human mind and body (Seaward, 2000). Even current “evidenced-based” treatment models such as “mindfulness and acceptance therapies” (Hayes, Follette, & Linehan, 2004), are attempting to incorporate spiritual elements in their treatment approaches. However, it is the contribution of the great philosophers of the past centuries as well as psychotherapy systems, including approaches of Jung, Frankl, Spiegel, Erikson, Rogers and others, that is the focus of the current paper due to their profound insights into the essence of spirituality.

## **THE CONTRIBUTION OF PHILOSOPHY TO THE SPIRITUAL DIMENSION**

Human spirituality has been embraced by the great philosophers and thinkers

investigating human nature and dynamics, some of whom will be mentioned below because of their profound influence in the endeavour of understanding the essence of human nature. These include Thales, Alcmeon of Croton, Plato, Aristotle, St Augustine, St Thomas Aquinas, Descartes and Kant. We have also included below the important contribution of Skovoroda, Ukrainian philosopher of the eighteenth century, due to his profound contribution to the understanding of the spiritual essence of the human being.

*Hryhorii Skovoroda* (1773) was born in 1725. He attended Kyiv-Mohyla Akademie and studied theology, philosophy and rhetoric. He mastered ancient languages and spoke Latin, Greek and Aramaic fluently, as well as several Western European languages. He became strongly interested in investigating the nature of the human being. Like Thales, more than 2000 years earlier, he likened the spirituality of the human being to that of a magnetic field. Like Socrates, Plato and Aristotle, he maintained that the core of the human being is the spirit. He left the soma of the human being to the medical profession and concentrated on the spirit, which he defined as something invisible but extremely powerful and dynamic for the human being. He did not criticize any other religion but proclaimed himself to be Christian and, contrary to other researchers of human nature, he maintained that every human being, as soon as they differentiate themselves from their mother, has ever present within themselves an inner voice which he calls, according to the Bible, the Holy Spirit. In his voluminous writings he highlights the spirit as the core and the dynamic power of the human being. He maintains, along with other philosophers, that happiness is easily obtained by a human being providing he is willing to open his heart to the voice of God and possesses the power of firm ontological faith. In the quest of understanding the human being, his epistemological approach does not prioritize a logical and intellectual capacity of the human being (because reason is liable to err). Therefore he granted openness to the Holy Spirit as the royal road to truth. He maintained that the invisible spirit does not change, does not err, and is positively verifiable by human experiences.

Skovoroda was a known intellectual in his time and was sought by the Russian throne as a philosopher to the Czarina, Elizabeth II and Katerina II. He was also in demand by the church hierarchy, who wanted him to be appointed a bishop of the Russian Orthodox Church (Ushkalov, 2004). The Holy Synod of the Russian Church was interested in Skovoroda's cooperation with the church, but he treasured freedom and in line with his existential principles he would not abdicate his independence regardless of the status of

positions offered to him (Ushkalov, 2004). He was offered many prestigious teaching positions but he rejected these too, preferring to maintain complete freedom to experience what he was advocating, namely, respect and freedom for every human being. Skovoroda died and was buried in his birthplace in 1794. On his tombstone is inscribed: “[The] world failed to capture me.” These words, being very characteristic of his life and teaching, were chosen by him.

Like most human beings, Skovoroda was motivated to achieve happiness and proclaimed that happiness is obtained by:

1. a person discovering human being within himself;
2. having strong faith and will;
3. obtaining freedom from “earthly dust,” meaning disregarding any of the laws, customs and other obligations which oppose and/or disregard the inner voice of the human being;
4. having high regard for human spiritual rather than somatic needs; and
5. placing spiritual values (the voice of Holy Spirit) in charge of one’s own pathway.

The philosopher *Thales of Miletus* (585 BC, in Hlywa, 2006) was probably the first to point out that the soul<sup>2</sup> has a motivating and moving force. He compared spirituality to the power of a magnet, indicating that the invisible *spirit* is the dynamic force in human beings.

*Alcmeon of Croton* (Hlywa, 2006) noticed that the human brain not only perceives senses of sight, hearing and smell, but also contains the process of thinking. And as the brain is an intellectual and moving centre of man, he called it soul, defining it as the main source of life. After all, man lives and moves only due to the presence of a soul in his body, and when the soul leaves the body, the latter dies.

*Socrates* (Hlywa, 2006) emphasized the priority of a soul over a body. He found that soul is “the essence” of man and as such it should be looked after and taken care of constantly. According to Socrates, it is only with the help of a soul that man can differentiate between good and evil, and only with one’s soul man chooses to be good. Therefore, soul is a vessel of human thinking and generosity.

*Plato* (1976, in Hlywa, 2006) elevated spirituality as the essence of human being. Searching for absolute knowledge, he found “soul” in the ideas or the forms which exist beyond changeable physical phenomena. Using Socrates’

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<sup>2</sup>The word “soul” has been simultaneously identified with the term “spirit” and used so until the present time.

teachings, he accepted the concept of the soul as a separate, immortal and more important essence than the body. According to Plato, the soul's activity is closely connected with willpower, thinking, pains, confidence, fear, hatred, love, and other psychic and intellectual processes. The soul is content only when the process is in unison with human nature, and discontented when the actions are anti-natural. The soul as core of the healing process is embraced by Plato, who wrote:

As you ought not to attempt to cure the eyes without the head, or the head without the body, then neither ought you attempt to cure the body without the soul ... for the part will never be well unless the whole is well. (Gatchel, 1993, in Dolan, 2000, p. 6)

Acknowledging the soul to be the dynamic force of human life and activities, Plato considered the soul to be indivisible. In addition to "rationality" he also acknowledged soul's "spirituality" and palatability, or three-directional functionality. Plato noted that the "spiritual" function also uses rationality, but it has a warlike, obstinate, demanding character and often serves as a "referee" between an appetite and rational functions. Plato remarked that conflict is based on rationality, emotiveness and strivings. He stated that the body is able to perceive only changeable non-reality and, possessing no life-giving qualities, it slows down spiritual progress.

Like Skovoroda, Plato considered the intellectual aspect of the soul to be of the greatest importance, though thinking is only one of the aspects of the soul's functions. Plato found rationality to be the human "essence"; man is as much human as he is rational. Though man has inferior aspects and wishes, he is able to choose and act in accordance with the highest human values. This is because, unlike the sense organs, it is the intellect (soul's function, defined by Skovoroda as "consideration") which synthesizes everything that is perceived, that serves as a source of information about the surroundings.

*Aristotle* (Hlywa, 2006), who greatly valued knowledge, cognition and truth, paid special attention to the human soul. He wrote that no matter how important knowledge is, understanding of the soul is much more precious. This is the essence of Skovoroda's understanding of human nature. Aristotle is known as a vitalist (a notion opposed to mechanistic views), as for him the soul was at the centre of life. According to Aristotle, the body is the vessel of all living. The soul presents the living with its core character. It has the potential and operatively executive function, without which there is neither mobility nor teleological process. Therefore, the soul and body are neither

contrasting nor dualistic substances. They are the aspects of one, indivisible life. The soul, as Aristotle states, governs the body, and when the soul is inactive the body governs the soul. Aristotle ascribed the soul's central location to the heart, on the basis that disease of the heart causes death, while psychological experiences, such as extreme joy or sorrow, may cause heart disease. He also states that the heart is man's first embryonic and functional organ.

*Saint Augustine* (Hlywa, 2006) considered the soul to be non-material, spiritual essence. As such, man is a combination of body and soul. The human soul is not material, but spiritual and immortal. According to St Augustine, both body and soul are the creation of God. The soul acts through body, which it revives and governs. The soul is its forming factor, which abandons the dying body, while remaining alive. Through its immortality the soul is able to experience eternity. The soul has three features—intellect (the ability to think), memory and will—among which the will is the most important, as only with its help, and if it coincides with God's will, can one choose good (Hlywa, 2006).

*Saint Thomas Aquinas* (Hlywa, 2006) pointed out that man has per se a rational soul. In his opinion, the man is not just a soul or a body, but an integral complex substance, which (while the soul is still within the body) performs all natural functions. The soul is not dependant on or "imprisoned" within the body: In unity with the body, it enriches and performs everything which is natural and good. The soul supplements and ennobles the body and enables it to achieve knowledge with the help of sense organs, forms and essence.

*Descartes* like his predecessors, in particular Thomas Aquinas, searched for a philosophical system which would satisfy the sceptic's demands. He came to the conclusion that every external thing perceived by human consciousness was subject to illusion and therefore to doubt. Notwithstanding this conclusion he believed that he must exist because he knew his own thoughts. His quote, "I think, therefore I am" (Descartes, 1968, p. 53) became widely known. Descartes concluded that man is a substance the essence or the nature of which is thinking, which is nonmaterial. Descartes believed that the existence of this I, the soul which I am, is known more certainly than that of the body, and therefore differs fundamentally from the body. Even if the body did not exist at all the reality of the soul would remain.

Descartes viewed the soul as a thinking, non-material substance, distinct from the body. For example, removing a part of the body will remove nothing from the soul—they can exist separately from each other, and as such they are subjected to different laws: While the soul is free, the body is subject to

the laws of nature. The soul is that which is capable of thinking. It has the characteristics of thoughts which are not extended in space. Therefore the power by which we reason/know is not part of the material (extended) world. This nonmaterial reality may be called the world of the “soul” or “spiritual.” Soul is that unity or wholeness which is capable of thoughts. Thinking incorporates doubt, imagination, will-power, feeling, rejection, memorization and sensitivity. Descartes differentiated cognitive processes such as understanding from will, to which he dedicated particular attention, on the basis that “will” stimulates action and accessibility of information for understanding. Descartes preached freedom of will and acknowledged that understanding was restricted by “will.” He argued that soul provides man with self-awareness and collaborates with willpower.

*Immanuel Kant* (1958) proposed *transcendental reflection* as a valid method in search of the essence of the human being which he found to be spiritual. He claimed that man’s psyche (soul) cannot be studied with the application of experimental or research methods on the basis that soul depends not on the condition of space, but only of time. He glorified the human mind for the reason that only with its help can man learn concepts and categories, and to understand the emotional experiences which he obtains with the help of his sense organs. Kant called this process of reflection on the categories found in the mind “apperception.” Thus, man perceives phenomena only in a way that is offered to him by his psyche, because the psyche chooses and interprets the experienced. Kant classified the mental abilities as: cognitive (mental, rational, value), emotional and desiring. He favoured the method of subjectivism, emphasizing the significance of psychic phenomena and phenomenalism.

Kant’s philosophy may be summed up by his arguments, where he propagates the moral foundation of the theological epiphanies, which is based on a priori (pure or transcendental) knowledge, as opposed to a posteriori knowledge obtained via the sense organs and will. Consequently, the importance of thinking is decreased for the benefit of faith. This notion is often emphasized by Skovoroda (1973), stating that thinking is capable of being wrong, while the voice of God, which is within man, is always right (Hlywa, 2006).

Criticizing the arguments of natural theology that seek to prove the existence of God from the natural world, Kant considers them to be insufficient. He considers that the *ontological* argument is required to serve as “proof of all-sufficient primordial being,” as such arguments point out something resolute, which cannot be derived from the concept of being, which is “all-mighty, wise

... in the world as well as most perfect, characteristic for all-sufficient being” (Kant, 1958, p. 296).

Kant (1958, p. 298) states:

physico-theological proof of existence of an original or supreme being rests upon the cosmological proof, and the cosmological upon the ontological ... the ontological proof from pure concepts of reason is the only possible one.

Kant (1958, p. 330) makes the following conclusion: “For although we have to surrender the language of *knowledge*, we still have sufficient ground to employ, in the presence of the most exacting reason, the quite legitimate language of a firm *faith*.” He noted further that:

Whenever I hear that a writer of real ability has demonstrated a way to the freedom of the human will, the hope of a future life, and the existence of God, I am eager to read the book, for I expect him by his talents to increase my insight into these matters. Already, before having opened it, I am perfectly certain that he has not justified any one of his specific claims not because I believe that I am in possession of conclusive proofs of these propositions, but because the transcendental critique, which has disclosed to me all the resources of our pure reason, has completely convinced me that, as reason is incompetent to arrive at affirmative assertions in this field, it is equally unable, indeed even less able, to establish any negative conclusion in regard to these questions. For from what source will the freethinker derive his professed knowledge that there is, for example, no supreme being? (Kant, 1958, p. 330)

The philosopher claimed that all assumptions must undergo thorough examination, based on reliable sources. At the same time, purely on moral grounds, he accepted the truth of traditional theological statements and beliefs which contain rational psychological ideas, for example: *soul as immortal substance*, and *God as necessary perfect being*. These ideas are incapable of being empirically tested, but are the rational requirements of practical (especially moral) action. According to Kant, these beliefs *are not a form of external knowledge but arise from transcendental reflection on the action of the mind*. The moral value of action is measured by man’s intentions. The subjective (rational) principle of morality is the “categorical imperative,” described by Kant as: “Act only on that maxim through which you can at the same time will that it should become a universal law” (1958, p. 329). This rational foundation of morality is found within the world of the intellect and does not depend on outer material factors.

## **Contribution of Modern Systems of Psychotherapy to Spirituality**

Since psychology has been divided from philosophy, the spirituality of human beings continues to be of interest to researchers and clinicians. A review of psychotherapy systems including Spiegel and Spiegel (2004), Erikson (1967), Frankl (1967), Rogers (1951), van Kaam (1975), Jung (1971) and Adler (1969) makes one appreciate that the person's right to decide and be responsible for themselves cannot be challenged because the therapeutic process will then become a battle of ideas.

*Carl Jung* (1933/2001) defends spirituality as a vital part of the human being and maintains that spirituality can make or break us. He stated that most of the people who came to him for psychological assistance from all over the globe had been suffering because they had a severe disconnection with their religions and spiritual core. Jung stated that every crisis is a spiritual crisis. He noted that spiritual conflict can be both positive and negative and that spiritual development requires cultivation throughout life.

*Adriaan van Kaam* (founder of the Institute of Formative Spirituality at Dequesne University) emphasized how the soul is shaped and how faith is lived out in daily life (Muto & Martin, 2009). In his book *In Search of Spiritual Identity* (1975), van Kaam discusses the voice within man that inspires his essence to combine in love and faith with God, Christ, and simultaneously draws man into the process of self-discovery (Hlywa, 2006).

Although current evidenced-based research and practice describe phenomena of hypnosis (which every practitioner should be aware of and be able to utilize in their clinical work), we believe current research and practice should definitely consider the incorporation of the spiritual dimension of the human essence.

## **HYPNOSIS, SPIRITUALITY AND THE PSYCHOTHERAPEUTIC RELATIONSHIP**

A positive psychotherapeutic relationship which is usually achieved over many sessions on the conscious level is often achieved within a very short space of time in the hypnotic relationship. That this presumes a spiritual dimension of experience is evident in the work of many therapists, a fine example being *Ainslie Meares* (1967), the former president of the International Society of Clinical and Experimental Hypnosis. He refers to the ideal interpersonal psychotherapeutic relationship when the patient and doctor come so close

together that there is no “space between.” He states:

hypnosis is a work of art achieved only by detailed attention to the space between. The art of hypnosis is a dynamic art; it is ever-changing. Meaning is conveyed by more than mere words, a form of communication. Like the lover we use it to tell the patient all those things which are so simple and so basic to our humanity that they are quite beyond expression by the cold logic of words. (Meares, 1967, p. 156)

## **NEW DEFINITION OF HYPNOSIS**

We define hypnosis herewith as the *inherent, enhanced potentiality of human beings, which spontaneously appears in human life and which is also tapped by certain procedures known as hypnotic induction.* Such a definition of the phenomenon of hypnosis became apparent to us, as more accurately descriptive of naturally occurring hypnosis, as a result of decade’s long observation and utilization in psychotherapeutic practice.

In our recent article (Hlywa & Dolan, 2010) we expressed our concerns that the APA’s definition of “hypnosis” (Division 30, American Psychological Association, 2005) excludes the spiritual dimension. We believe that hypnosis cannot be defined in the absence of spirituality, which is made explicit in our definition of hypnosis as the enhanced potentiality or life force inherent within the human being which appears spontaneously at birth (Hlywa & Dolan, 2010).

## **CONCLUDING REMARKS**

A review of some of the great philosophers and thinkers highlights the *spiritual* struggle of the individual which cannot be ignored during the psychotherapy process. Human beings can transcend themselves when they embrace fully their beliefs, values, intellect and spirit. If any of these ingredients are neglected or lacking, the human being is likely to suffer from intra-psyche conflict. The hypnotherapeutic relationship creates optimal conditions in which the person can reach deeply within themselves, draw closer to God and arrive at a “right” decision. The person’s right to decide and be responsible for themselves cannot be challenged because the therapeutic process will then become a battle of ideas.

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## CONSTIPATION TREATED BY CBT AND HYPNOSIS

Karla Fenton

*Medical Practitioner, Tasmania*

Used as a medical tool, hypnosis is very successful in bringing about physical changes in bodily functions. With the brain not being hard-wired but capable of rewiring itself and suggestions made in an altered state able to change functioning as well as behaviour, I have just used these valuable tools to cure a case of chronic constipation which had troubled the patient all her life. She had been led to believe that she had a “lazy” bowel and that there was little that could be done about it except to cope with it.

Hypnosis has been used as a therapeutic tool to treat many physical conditions from which human beings suffer as well as the psychological ones. I have had success with skin conditions which are allergic, traumatic or psychosomatic, hay fever, allergies and asthma, along with gastrointestinal tract maladies, cardiovascular system problems, sexual dysfunctions and many other disorders. Hypnosis is an adjunct to normal medical practice and facilitates a quicker and lasting effect on the therapies. If medical intervention does not cure the patient it is always worth using hypnosis, as its effects can still add a great deal to the comfort and mental state of the patient.

Constipation is a common condition but one that is seldom discussed with the doctor outside of the hospital in-patient situation or the nursing home. In such facilities it is a daily subject for enquiry. Part of the care plan is to enquire about the bowel function of each patient and to deal with the situation as is required. In the outside world, many people buy over-the-counter bowel medicines to soften the stools and to induce peristalsis. This “do it yourself” attitude does not get down to the cause of the problem and is just a habit-forming routine that does not help the bowel at all. Prolonged use of medication disrupts tissue exchange, especially the metabolism of potassium, essential to each cell.

## **HISTORY**

I was attending a workshop on resuscitation and the young doctor who was teaching the group made the comment that he had just come from the ward where he had been called on to disimpact an elderly person's bowel. This is not a pleasant procedure for either the doctor or the patient.

This alerted me to the fact that such an occurrence would not only be unpleasant physically, but an enormous psychological trauma for the subject of such a procedure. Looking into the future I had visions of being in such a position myself with the onset of old age and thought long and deeply about it.

My understanding of the ability of the brain to rewire itself and interest in bringing about change in the function of the bowel so that it would benefit the person and bring about a cure challenged me, and I decided to use hypnosis to bring about a change in a longstanding case of chronic constipation.

So I prepared a tape outlining the normal function of the bowel and suggesting the steps to take to bring about the desired changes.

After daily and sometimes twice daily use of the tape for three weeks, the patient reported progress and her obdurate bowel had begun to respond satisfactorily to the training. Now months later there are no problems with the normal functioning of her bowel. The passage of well formed and soft stools has eased a burden that she had tried to cope with for her whole life by using the various medications offered over the counter at the pharmacy.

If during treatment, changed diet, dehydration or lack of exercise cause difficulties with the evacuation of the bowel, it is recommended that the patient take a sachet of Movicol and the bowel will begin responding again. I also recommend that they play the tape again should this happen.

As you can imagine, this patient is now eager to try any other applications of CBT together with hypnotherapy to address other physical conditions. Details of the original treatment follow.

Ask the patient to lie on the couch or sit in a comfortable chair, whichever they prefer.

Using any method you prefer to induce trance state—for example, breathing techniques, progressive relaxation, eye fixation—I then proceed with the following suggestions. (If the patient wants to do the therapy herself/himself, then I use the first person which I record on a tape or voice recorder.)

## SCRIPT

*You are lying with your eyes closed, feeling quite calm and very relaxed. Your limbs feel pleasantly heavy, you are breathing slowly and regularly and with each breath you sink deeper and deeper into a more and more relaxed and comfortable state. You continue to go deeper and deeper, more and more relaxed.*

*As I talk to you, your subconscious mind records everything I say and you will carry out my instructions carefully.*

*Constipation has been a problem for you for most of your life and the use of laxatives has become a habit which you wish to break free from.*

*You truly want to take natural control of your bowels and your bowel habits and have the normal function of a well-performing bowel.*

*It is possible for you to regulate your bowel function so that the bowel will perform naturally and normally every day.*

*Concentrating all your attention on your bowel we will trace its course from where it begins at the lower end of the stomach and progresses through to the end of the gastrointestinal tract. After swallowing food it enters the stomach and progresses into the duodenum through the duodenal cap. It then passes along the jejunum, the ileum and then into the caecum. From here it ascends the ascending colon, goes along the transverse colon and down the descending colon to the sigmoid colon, rectum and then through the anal canal and out through the anus. Digestive processes extract the nourishment you need from the food and the waste products and toxins are left to be pushed to their final destination outside your body.*

*Your mind is now penetrating deeper and deeper into your body ... Your mind is reaching into the middle of your body ... Your mind is beginning to establish control over all of your intestines ... you can now feel these intestines from the bottom of your stomach to the point where they leave your body ... You can feel their warmth ... you can feel their strength ... and you can feel the cleansing power they have for all your body. So the intestines are your body's cleanser and will keep you well and strong ... They are able to cleanse your body every day.*

*They will take all the waste and toxins out of your body as they are strong ... and the desire to expel all the waste will be irresistible.*

*So every morning when you go to the bathroom, the bowel will start to contract so that it will deliver the waste products to the rectum from whence it will be expelled.*

*Having suffered for so long from constipation and having been a slave to laxatives, you have decided to break out of this cycle forever and take natural control of your bowels and your bowel habits. This means that you will establish a natural regularity every day or every other day and not need to stimulate your bowel by artificial means.*

*Now concentrate deeper and deeper into your body, concentrate on your bowel running from your stomach to your anus, so that your mind takes control over all of your intestines and becomes aware*

*that those intestines become warm and strong and have the power to cleanse your body of all the waste and toxic material in your bowel.*

*The intestines are your body's cleanser, they are your body's purifier ... they get rid of all the waste from your bowel and keep your body well and strong and their purpose is to cleanse your body every day. They take out of your body all the waste material and toxic material and cause all the waste and toxic material to be expelled from your body every day. You are aware that this is the function of your intestines and you know that they can do this because they are strong and will respond to your commands to carry out their function, every day.*

*Every day you will feel the need to go to the toilet so that your bowels will cleanse themselves. The contractions of the bowel will make you aware of the need to go to the toilet and empty your bowel. So every day your bowel will automatically begin to contract and push the waste material out of your body.*

*You will find that it is a comfortable and easy process with no straining and no pain and no damage to surrounding tissues.*

*So without any force you will have a daily evacuation of your bowel and you will discover that it is easy, with no straining and no discomfort. You can rest assured that this will happen and trust your bowel to automatically cleanse itself and make you feel clean and healthy and strong.*

*You are now feeling very well and confident and when you wish you can return to your normal alert state, refreshed, renewed, calm and relaxed. You are very confident that you can be the winner in this situation and it will bring you great satisfaction that you have been able to succeed.*

## THE ROLE OF ABSORPTION, FANTASY PRONENESS AND HYPNOSIS IN RESPONSE TO TRAUMA

Natasha M. Loi and Graham A. Jamieson  
University of New England

*Detachment and compartmentalization are frequently reported features of psychological reactions to trauma. We propose that these responses are the result of changes in two distinct but reciprocally active neuronal systems of self-regulatory control. The former is linked to affective and experiential self-regulation and the latter to cognitive and behavioural self-regulation. Detachment and compartmentalization are neither intrinsically negative nor positive. Each is a process which carries with it a discrete set of potentials for self-regulation which in turn closes off access to an alternative set of conscious cognitive self-regulatory strategies. Compartmentalization results from the disengagement of networks of volitional control. Detachment may be invoked by absorption in inner-generated experiences, a process equivalent to hypnosis, through which individuals may learn to regain control of the shifts between the two modes of self-regulation as contexts and circumstances require.*

This paper explores the potential role of individual differences in the personality traits absorption, fantasy proneness and hypnotic susceptibility in the response to trauma and the potential importance of this process for both researchers and clinicians. Each is closely related to self-generated “inner” experience and thereby, it is argued, to important potential pathways for regulating awareness of stressful and painful situations.

We aim to use these individual differences to build a model of at least some trauma responses. While we will not be presenting results from new experimental research, we will be examining the literature in order to gain a clearer understanding of some of the major psychological components of traumatic stress. Our examination of the relevant literature will also guide us in our attempt to best determine how our model can be tested experimentally.

Ultimately, the aim of building a model of the differences in trauma responding is to tailor individual treatment programs to individual responses. However, this paper does not attempt to describe a treatment program or to cover all aspects of responses to trauma. What we hope to describe is a way of thinking about these issues that is both new and beneficial.

There is no simple definition of a traumatic incident. Traumatic incidents run the gamut of experiences from natural disasters through to deliberate human acts of immense cruelty. The experience of trauma is not an uncommon one, as van der Kolk and McFarlane (1996, p. 3) state: "Experiencing trauma is an essential part of being human." However, defining what trauma is can be a complex undertaking. Trauma has been defined as something "outside the range of usual human experience" according to the *Diagnostic and Statistical Manual of Mental Disorders*, third edition (DSM-III-R; American Psychiatric Association, 1987, p. 250). However, this definition came under some scrutiny for the implication that experiencing trauma was in some way abnormal. As Herman (1997, p. 33) was to state many years later, "Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life."

Spiegel (1997, p. 494), for instance, describes trauma as a "sudden discontinuity in physical experience that elicits similar discontinuities in mental experience." The most recent edition of the DSM, the DSM-IV-TR (American Psychiatric Association, 2000) provides a broad, but relatively all-encompassing definition which no longer makes reference to traumatic situations as uncommon. Rather, it describes a traumatic stressor as one:

involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat or injury experienced by a family member or other close associate. (p. 463)

The DSM-IV-TR (2000, pp. 463–464) also presents a long list of experiences that may be perceived as traumatic ranging from experiences that may be considered at the extreme end of the trauma spectrum (e.g., being taken hostage, incarceration in a concentration camp) to more everyday experiences that could happen to anyone anywhere (e.g., natural disasters, automobile accidents, being diagnosed with a life-threatening illness). This list is far from exhaustive, however, as there are potentially many other situations which may be perceived as traumatic.

A great deal of research has been conducted on reactions to various traumatic incidents. For example, research has examined earthquakes (e.g., Cardeña & Spiegel, 1993), a firestorm (Koopman, Classen, & Spiegel, 1994), rape (e.g., Griffin, Resick, & Mechanic, 1997) and motor vehicle accidents (e.g., Harvey & Bryant, 1999). The individuals who had experienced these traumas responded with numerous negative reactions including anxiety, depression, acute stress, or posttraumatic stress disorder (PTSD). Many studies have reported that those exposed to traumatic events often experience dissociation, both at the time of the incident (peritraumatic dissociation) and at a later time (Nijenhuis, van der Hart, & Steele, 2010). It appears that dissociation is either an effect or a coping mechanism by which many confronted with trauma respond to what Brown (2004, p. 797) refers to as “overwhelming negative affect.”

Research has also investigated the possibility that the capacity for dissociation may result in vulnerabilities to certain psychopathological reactions (Merckelbach & Muris, 2001). While it has been found that dissociation is not an abnormal response to a traumatic situation (e.g., Brown, 2004), this response may become maladaptive if it persists in new contexts. For instance, Nixon, Bryant, Moulds, Felmingham, and Mastrodomenico (2005) claim that for those exposed to trauma, dissociation may be a useful response that can assist in limiting distress. However, this is in the *short-term*. They claim that the continued use of a dissociative mechanism may interfere with trauma recovery. Littleton, Horsley, John, and Nelson (2007) found similar results when individuals rely on any kind of avoidance strategy for too long a period of time. Again, these strategies are helpful and adaptive in the short term but problematic in the long term. The long-term use of a dissociative mechanism or other avoidance strategy may be a central feature of the development of PTSD. PTSD is characterized by persistent avoidance of any reminder of the trauma, emotional numbing (i.e., dampened affect and detachment) and trouble concentrating (Foa & Riggs, 1995).

## **TRAUMA AND DISSOCIATION**

The concept of dissociation, and its relationship to trauma, has a long history. In the nineteenth century, Jean-Martin Charcot, the French neurologist, was in residence at the famous Salpêtrière Hospital in Paris where he worked with patients experiencing hysteria. Charcot was the first to determine that a relationship existed between hysteria and dissociation, although he did not

coin the phrase and only approached the study of this phenomenon from a purely neurological viewpoint (Scaer, 2001). The concept of dissociation itself was first introduced by Pierre Janet (1907, as cited in Roelofs et al., 2002), a student of Charcot. Janet introduced the concept of autohypnosis which he considered to be “an adaptive reaction to overwhelming stress” and thus a dissociative response (Roelofs et al., 2002, p. 390). In subsequent studies on hysteria, Janet was convinced that hysteria itself was the result of traumatic experiences and, as such, could be studied and treated through the use of hypnosis (Butler, Duran, Jasiukaitis, Koopman, & Spiegel, 1996). This was a progression in thinking from that of Charcot who believed that hysteria was a hereditary and degenerative process (Scaer, 2001). According to Janet, dissociation only occurred in individuals exposed to traumatic situations and thus experiencing hysteria (van der Hart & Horst, 1989). Since then, others have taken the view that some forms of dissociation occur within the ordinary range of experience and are not necessarily confined to pathological circumstances (Giesbrecht, Lynn, Lilienfeld, & Merckelbach, 2008).

## **THE CONCEPT OF DISSOCIATION**

As there is no agreed-upon definition of what constitutes dissociation (Cardeña, 1994), many different researchers have taken the concept and divined many different ways to describe it. The DSM-IV-TR (American Psychiatric Association, 2000, p. 519) defines dissociation as a “disruption in the usually integrated functions of consciousness, memory, identity, or perception.” On the other hand, Marmar, Weiss, Metzler, and Delucchi (1996, p. 94) define dissociation solely in terms of the compartmentalization “of experience in which elements of a traumatic experience are stored in memory as isolated fragments rather than as an integrated whole.”

In their 2005 review, Holmes et al. compared three theorists’ conceptualizations of dissociation in order to find points of convergence in their different viewpoints. First, Cardeña (1994) identified three categories of dissociation which Holmes et al. (2005, p. 4) described as: (a) the lack of integration between mental systems, (b) an “alteration in consciousness involving a disconnection from self or the world,” and (c) a defensive strategy. The first category encompasses disorders such as dissociative amnesia or dissociative identity disorder (DID). Category two intrinsically covers just two concepts: depersonalization (the feeling that one is removed or detached from one’s feelings, thoughts or emotions; Cardeña, 1994) and derealization

(experiencing the world as unreal or feeling that there is no substance to it; Cardeña, 1994). Such a feeling may arise in situations such as in the aftermath of natural disasters where such traumatic incidents “profoundly alter the individual’s sense of personal and environmental continuity and challenge the usual integrative processes of identity and conscious experience” (Cardeña & Spiegel, 1993, p.477). Cardeña and Spiegel (1993) present just such evidence in their study of the reactions to the San Francisco Bay Area earthquake of 1989.

Second, Putnam (1997, as cited in Holmes et al., 2005, p. 5) distinguished between two categories. The first is referred to as “dissociative-process symptoms” and encompasses the concepts depersonalization and derealization. The second category is one Putnam also referred to as compartmentalization and can describe the process that occurs in DID. That is, a lack of integration that echoes Cardeña’s (1994) category one dissociation.

Finally, Brown (2002) distinguished between two categories of dissociation: Type 1 (inclusive of conditions such as the conversion disorders, dissociative amnesia, dissociative fugue and DID) and Type 2 dissociation (which comprises depersonalization and derealization).

As may be observed from the preceding review, there are many similarities between the three different perspectives. Holmes et al. (2005) concluded that these points of similarity converge on two distinct categories of dissociation that they call detachment and compartmentalization.

Detachment may be defined in terms of an “altered state of consciousness characterized by a sense of separation (or ‘detachment’) from certain aspects of everyday experience, be it their body ... sense of self (as in depersonalization), or the external world (as in derealization)” (Holmes et al., 2005, p. 5). It may be observed that this definition encompasses Cardeña’s (1994) category 2 dissociation, Putnam’s (1997) “dissociative-process symptoms” and Brown’s (2002) Type 2 dissociation. There has been a great deal of research conducted on the experience of detachment on individuals after traumatic experiences. For instance, Noyes and Kletti (1977) interviewed 101 survivors of life-threatening danger (e.g., motor vehicle accidents, falls, serious illnesses, etc.) and found that 34% felt detached from their bodies and 30% experienced derealization during the actual life-threatening event. These figures increase substantially when only looking at those individuals who believed that they were going to die as a result of the trauma (61% and 49%, respectively;  $n = 59$ ). Cardeña and Spiegel (1993) found that for the week following the San Francisco Bay Area earthquake, the individuals they interviewed reported more experiences of depersonalization (e.g., self-detaching from the body,

seeing events at a distance) and derealization (e.g., having a lack of interest in activities, feeling that one's surroundings are unreal).

Compartmentalization, on the other hand, encompasses Cardena's (1994) category 1 dissociation, Putnam's (1997) use of the term and Brown's (2002) Type 1 dissociation. Compartmentalization may be defined in terms of an inability to "deliberately control processes or actions that would normally be amenable to such control" and which "incorporates conditions characterized by an inability to bring normally accessible information into conscious awareness" (Holmes et al., 2005, p. 6) and is exemplified in the disorders previously mentioned by Brown (2002). Thus, it is a lack of volition. Holmes et al. (2005) speak of the relationship between "traumatic amnesia" (i.e., an inability to retrieve a required memory) and compartmentalization. Their claim is that details and memories of the traumatic event never reach consciousness and are therefore "compartmentalized" or isolated away from conscious thought. In addition, Holmes et al. (2005) claim that compartmentalization may best be exemplified in the symptoms of conversion disorder.

Conversion disorder is a condition whereby individuals display neurological symptoms even when no neurological explanation can be found. When an individual is exposed to a traumatic or stressful situation, the physical symptoms that arise in response to this event allow the individual to effectively repress the memory of the actual event and instead focus on their symptomatology. So as Brown (2004) states, the individual is able to express distress without focusing on the actual cause of that distress. Roelofs et al. (2002, p. 390), taking their cue from the work of Kihlstrom (1992), describe conversion as a "dissociation of lower level implicit information processes from higher level explicit information processes." Kihlstrom, Barnhardt, and Tataryn (1992) provide an example involving visual processing in a person with conversion blindness. Conversion blindness occurs when an individual reports a lack of visual awareness in the absence of an organic cause. A particular curiosity of this condition is that people are unlikely to run into furniture or other people or to trip over obstacles in front of them. Kihlstrom et al. (1992) explain the reason for this phenomenon is that while individuals claim honestly that they cannot see (i.e., they have a failure in explicit visual processing), the stimuli around them are still being processed, albeit at a lower, implicit level. This is the reason why they do not collide with the items or people around them: The stimuli still have an influence on their behaviour.

Also of interest, Roelofs et al. (2002) found evidence to support the claim that those with conversion disorder show higher levels of hypnotic susceptibility

compared with those diagnosed with another disorder (e.g., affective disorder). Thus, they believe that information is dissociated from consciousness after a traumatic event and the individual “self-hypnotizes” in order to separate themselves from the impact of the situation. This idea is in line with Janet’s original thoughts on autohypnosis in response to overwhelming stress. Thus conversion disorder may be regarded as a defence mechanism.

Research has also found that there is a close association between absorption and widely used measures of dissociation (e.g., Hutchinson-Phillips, Gow, & Jamieson, 2007), and between absorption and fantasy proneness (e.g., Braffman & Kirsch, 1999; Lynn & Rhue, 1988; Merckelbach, Muris, & Rassin, 1999). It was Hilgard (1970) who, in her study on imaginative involvement, determined that individuals were prone to become deeply involved in a wide variety of experiences or imaginative activities. This discovery gives credence to the close links that exist between absorption and fantasy proneness. Hilgard (1970) also found that those who experienced greater numbers of imaginary involvements were more hypnotically suggestible. Thus, it is this “imaginative involvement” that helps to facilitate absorption (Lynn & Rhue, 1988; Tellegen & Atkinson, 1974).

Lynn and Rhue (1986, 1988) are two researchers who have conducted numerous studies in this field and continually found evidence to support the contention that fantasy proneness and absorption are strongly related. In fact, Lynn and Rhue (1988) have concluded that the two constructs are in fact indistinguishable. Further evidence for this close association may be given in the form of the instruments used to measure the two constructs. For example, Merckelbach et al. (1999) found that the Tellegen Absorption Scale (TAS; Tellegen & Atkinson, 1974), the primary measure of absorption, and the Creative Experiences Questionnaire (CEQ; Merckelbach, Horselenberg, & Muris, 2001), a measure of fantasy proneness, correlated at  $r = .76$ . Lynn and Rhue (1988) have also found, on more than one occasion, high correlations ( $>.70$ ) between the measures of absorption and fantasy proneness (see Lynn & Rhue, 1986, 1988). With such a close association existing between these two constructs, it has been suggested that a more apt name for this particular characteristic should be “fantasy-absorption” (Hough, 2006).

## **ABSORPTION**

Absorption may be defined as the ability to become engrossed in an experience to the exclusion of other distracting concerns and is a relatively common

characteristic in the population. Much of the original research on this construct is attributable to Tellegen and Atkinson (1974, p. 268) who defined absorption as “a disposition for having episodes of ‘total’ attention that fully engages one’s representational (i.e., perceptual, enactive, imaginative and ideational) resources” and which results “in a heightened sense of the reality of the attentional object, imperviousness to distracting events, and an altered sense of reality in general, including an empathically altered sense of self.” While absorption often relates to quite ordinary experiences (e.g., watching an engrossing film in a cinema and being quite unaware of your surroundings or actions), some researchers have drawn parallels between the components of hypnosis (dissociation, absorption and suggestibility) and experiences related to trauma. For example, Spiegel (1997) examined these three components and their relation to PTSD. He claimed that absorption, in particular, may be considered as similar in experience to the intrusive re-experiencing that some individuals undergo after a traumatic event. An example of such a traumatic re-living is the experience of flashbacks.

Tellegen (1981) extended the definition of absorption by introducing the concept of two distinct modes of attentional deployment that he regarded as of central importance to the construct: the instrumental and the experiential mental sets. The instrumental mental set may be defined as a “state of readiness to engage in active, realistic, voluntary, and relatively effortful planning, decision making, and goal-directed behavior” (Tellegen, 1981, p. 222). The experiential mental set, on the other hand, is a “state of receptivity or openness to experiencing in the sense of readiness to undergo whatever experiential events, sensory or imaginal, that may occur, with a tendency to dwell on ... the experiences themselves and the objects they represent” and thus there is a sense of “effortlessness” and “involuntariness” (Tellegen, 1981, p. 222). Tellegen concluded that those high in absorption are more inclined, when circumstances permit, to set aside an instrumental set and to adopt an experiential set, whereas those low in the trait are predisposed to continue to hold an instrumental set. Thus, in the face of traumatic experiences, individuals high in the trait are more likely to be able to use this ability to “escape” their current aversive reality. The individual is able to use this as a coping mechanism to remove themselves from an experience that would otherwise be unbearable.

## **FANTASY PRONENESS**

The related personality trait of fantasy proneness is a relatively recent “discovery” in the psychological literature. This discovery was explicated in light of

Josephine Hilgard's work in the related field of imaginative involvement which was a huge leap forward in the area of hypnosis research. What Hilgard (1970) discovered after interviewing both high and low hypnotizable individuals was that some individuals were capable of becoming so involved in an activity (e.g., reading or music) that they were indifferent to distracting stimuli. They were able to block it out and become totally absorbed in whatever they were actively pursuing. Hilgard thus determined that imaginative involvement was a necessary component of hypnotic susceptibility.

Following Hilgard's (1970) pioneering work on imaginative involvement in highly hypnotizable individuals, Wilson and Barber (1983) conducted an initial study which involved interviewing 27 women who they had rated as highly hypnotizable and comparing them with 25 low-to-medium hypnotizable women. The results of this research indicated to Wilson and Barber (1981, 1983) that a subset of the population (approximately 4% of North Americans) fantasize throughout large portions of their waking life and vividly experience their imaginings as though they are "as real as real" (Wilson & Barber, 1983, p. 340). While this research had its limitations (i.e., all the participants were female and the majority were university educated), the implications were still noteworthy.

Wilson and Barber (1983) also found that those individuals high in fantasy proneness could use their ability to become absorbed in fantasy as a coping device. These individuals can use their imaginings as a means to escape a difficult or stressful situation, or as Wilson and Barber (1983, p. 353) state: "...they never need to ... feel miserable, or feel stuck in an unbearable life situation because they can always escape into fantasy." They also state that this reaction or ability is automatic; it occurs spontaneously in response to their thoughts and feelings at the time (Wilson & Barber, 1983). This escape from the reality of a painful or stressful event is echoed in studies on dissociation (e.g., Cardeña, 1994; Koopman, Classen, Cardeña, & Spiegel, 1995; Marmar et al., 1996; Nixon et al., 2005).

Lynn and Rhue and colleagues (e.g., Lynn & Rhue, 1986, 1988; Lynn, Rhue, & Green, 1988; Rhue & Lynn, 1987, 1989) have spent many years examining the relationship between fantasy proneness and the related constructs of hypnotizability, absorption, imaginative ability and waking suggestion. They have continually discovered that fantasizers are distinguishable from non-fantasizers on measures of fantasy, imagination, creativity and hypnotizability. Their research has also determined that there may in fact be developmental antecedents for the fantasy prone personality. Rhue and Lynn (1987) found

that fantasy prone individuals tended to come from two different backgrounds. The first group had a history of extensive involvement in fantasy dating back to childhood. They were encouraged in many activities such as the reinforcement of imaginary play. In addition, they were read to by significant adults (e.g., parents or grandparents) who reinforced their fantasies (Lynn & Rhue, 1988). The second group, though, experienced punishment and/or physical abuse or isolation in their childhood and used their fantasy ability to escape from their aversive environment. Thus fantasy served a defensive function that may be regarded as an adaptive response (Lynn & Rhue, 1988).

## **ABSORPTION AND PSYCHOSOMATIC SELF-REGULATION**

While it has been suggested that hypnotic suggestibility is a risk factor for dissociative psychopathology (e.g., Nixon et al., 2005), absorption and hypnotic suggestibility can also be adaptive and both have been found to be related to psychosomatic self-regulation. For example, Ott, Sammer, and Vaitl (2002; Vaitl et al., 2005) conducted research on baroreflex sensitivity in response to rhythmic tilting. The baroreflex is a mechanism employed by the body to maintain blood pressure. It works by way of a negative feedback loop that reduces elevated blood pressure and increases blood pressure that has fallen too low. Ott et al. (2002) found that baroreflex sensitivity is significantly correlated with absorption. The higher the individual was in trait absorption, the greater was baroreflex sensitivity.

Further relevant evidence of the role of inner experience in psychosomatic self-regulation is found in Qualls and Sheehan (1981), who conducted research on the effect of inner and outer directed attention on electromyograph (EMG) biofeedback in high and low absorption participants. EMG biofeedback has been used to promote relaxation by drawing attention (by way of light or sound) to muscles that have become contracted through stress. Through continuous monitoring of their muscle activity, individuals become more aware of their tension and through biofeedback training learn to control their anxiety when they feel it building in their everyday lives. Interestingly, Qualls and Sheehan found that biofeedback interfered with high absorption participants' ability to relax, but assisted those low in absorption. It was determined that high absorption participants already had the requisite skills necessary to become relaxed and so did not need external assistance. These skills included the ability to divert attention from the environment onto

inner-generated experiences and imaginings. As those low in absorption did not have these skills, biofeedback actually encouraged them to redirect their thoughts and to concentrate on relaxing. As Qualls and Sheehan (p. 205) state: “It is thus hypothesized that the biofeedback condition places an external attentional demand on low-absorption subjects that enhances their capacity to focus on the task at hand.” Thus, this supports the notion that those high in absorption are more capable of these forms of somatic self-regulation than those low in absorption as a result of their ability to “focus inwardly” in response to the problems plaguing them.

An example of the role high hypnotic suggestibility has in psychosomatic self-regulation comes from Santarcangelo and Sebastiani (2004), who found that this trait offered protection against cardiovascular threat. In this study, the researchers found that highs were able to better maintain an adaptive cardiovascular response (i.e., flow-mediated dilation [FMD] of peripheral arteries) when confronted with a moderately aversive stimulus compared with those low in hypnotic suggestibility (Sebastiani, Simoni, Gemignani, Ghelarducci, & Santarcangelo, 2003). FMD is reduced during mental stress and is an important risk factor for cardiovascular disease (Santarcangelo & Sebastiani, 2004). Their research found that hypnosis buffers the stress-induced reduction of FMD in highs and provides a kind of protective barrier against stress at the vascular level (Jambrik, Sebastiani, Picano, Ghelarducci, & Santarcangelo, 2005; Santarcangelo & Sebastiani, 2004).

## **HYPNOSIS AND ANALGESIA**

One of the principal clinical uses of hypnosis has been for analgesia, the relief of pain. The sensation of pain may be regarded as multidimensional (Rainville, Carrier, Hofbauer, Bushnell, & Duncan, 1999). Pain may be described in terms of its quality (i.e., the characteristics that distinguishes it from other sensory experiences), intensity (i.e., the strength of the sensation) and spatio-temporal characteristics (i.e., where and when it occurs; Rainville et al., 1999). Pain has been defined as “an unpleasant sensory and emotional experience associated with *actual* or *potential* [italics added] tissue damage, or described in terms of such damage” (Mersky & Bogduk, 1994, as cited in Rainville, 2002, p. 195). Thus pain may or may not involve actual physical stimuli.

There has been extensive research conducted employing combined behavioural, self-report and neuroimaging paradigms to investigate the role of hypnosis in attenuating the sensation of pain (e.g., Faymonville et al., 2000;

Faymonville et al., 2003; Rainville, 2002; Rainville et al., 1999). These studies utilized actual physical stimuli to induce pain (e.g., immersion of a participant's hand in hot water) and found that the anterior cingulate cortex (ACC) is one of the key brain regions activated in the experience of pain. The ACC has been found to be involved in the regulation of autonomic (sympathetic) activity (Luu & Posner, 2003). A study by Rainville, Duncan, Price, Carrier, and Bushnell (1997) found that pain affect (i.e., the painfulness and perceived unpleasantness of pain), as distinct from the sensory experience of pain, was encoded in the dorsal region of the ACC. When hypnotic suggestion was employed to reduce or alter the experience of pain, they found that participants rated the pain as less unpleasant even though it was still as intense. Of importance, they also discovered that activity in the same region of the ACC actually *decreased* (Rainville et al., 1997).

Marie Faymonville is an anaesthetist who has successfully employed hypnotic analgesia in her clinical practice since the early 1990s. She employs a surgical technique known as hypnosedation which uses a combination of hypnosis, local anaesthesia and a mild sedative instead of a general anaesthesia (Song, 2006). Since creating this technique, it has been used on more than 5,000 people. Faymonville does not induce analgesia directly by referring to a suggestion to reduce pain; rather, patients are instructed to think of pleasant experiences in which they then become immersed. She has continued this approach in her experimental work (e.g., Faymonville et al., 2000) to great effect. For instance, Faymonville et al. (2000) conducted a study to examine the brain areas that may be modulated by hypnosis in response to a painful stimulus (a heat probe applied to the right hand). They found that hypnosis (induced by instructing participants to think of something pleasant from their past experiences) decreased pain sensation and the perceived unpleasantness of the painful stimulus. Both perception of pain and the reduction of painful affect in the hypnotic state were found to correlate with activity in the ACC (as determined by positron emission tomography [PET]).

Interestingly, research has not limited itself to examining the experience of physical trauma. Rather, there has been some research which has examined the experience of social or emotional pain and found that the brain regions implicated are those active in the affective component of physical pain. Vastag (2003) found that social rejection generated activity in the ACC and so may be regarded as equivalent to actual physical pain. Eisenberger and Lieberman (2004) also discovered that the ACC was involved in the affective components of both physical and social pain and that increased levels of activity in the ACC

coincide with increased levels of reported pain unpleasantness.

Brown (2004) considers “overwhelming negative affect” as the fundamental psychological component of trauma. Negative affect is undoubtedly a painful emotion and, as has been demonstrated, is represented by activation in the same neural networks as physical pain. Thus psychological mechanisms which have been successful in the regulation of physical pain (e.g., hypnotic analgesia) are very likely to be implicated in the modulation of affective responses to trauma. Hypnotic suggestibility (and/or related traits such as absorption and fantasy proneness) in combination with the mechanism underlying hypnotic analgesia is therefore likely to be successful in the regulation of negative affect.

## **EMOTIONAL NUMBING**

Hypnotic suggestion has also been used to produce emotional numbing which is closely related to the concept of analgesia (e.g., Foa, Zinbarg, & Rothbaum, 1992). Emotional numbing may be defined as “the lack of emotional responsiveness to stimuli that would normally elicit emotional reactions” and is particularly characteristic of PTSD (Bryant & Kourch, 2001, p. 220).

One of the most influential researchers in the field of trauma, dissociative processes and PTSD is the Australian, Richard Bryant. Bryant and colleagues have conducted a number of studies investigating hypnotically induced emotional numbing. In an initial pilot study, Bryant and Kourch (2001) analysed hypnotic suggestion in the suppression of emotional responses in high and low hypnotizable participants. The researchers presented individuals with a series of slides of neutral and disfigured faces and found that individuals who received an emotional numbing suggestion (i.e., they would be “unable to feel any emotions” and feel “emotionally numb” and “cut off from any emotional responses”; Bryant & Kourch, 2001, p. 222) were less distressed and displayed less responsiveness (as measured by self-report and their facial expressions) than those who did not receive such a suggestion, and this pattern was stronger for high than low hypnotizable individuals. Thus the emotional numbing suggestion was able to significantly suppress emotional responding in high hypnotizable participants.

In a second study, Bryant and Mallard (2002) examined the reactions of “real” hypnotized and “simulating” un hypnotized participants who were also given a hypnotic induction and presented with ten neutral and aversive images from the International Affective Picture System (IAPS; Lang, Bradley, & Cuthbert, 2005). Half the participants were also administered an emotional numbing suggestion.

The results of this study found that those who received the suggestion (both reals and simulators) experienced less distress and emotional responsivity to the aversive imagery (as measured by self-report and facial EMG corrugator muscle activity) compared with those who received no such suggestion.

Bryant (2005) conducted a similar study in which high and low hypnotizable participants were administered a hypnotic induction and half were also given an emotional numbing suggestion. He then presented participants with a series of neutral and aversive images. Participants rated, on a 100-point scale, how they felt while looking at these images. Following this, participants were shown a series of neutral words and asked to rate their valence on a 100-point scale. Prior to the presentation of each word, though, participants were shown a subliminal neutral or aversive image. The results confirmed and validated those of Bryant and colleagues' previous studies (Bryant & Kourch, 2001; Bryant & Mallard, 2002). High hypnotizable participants who received the numbing suggestion rated the words preceding the aversive images more positively than other highs who did not receive the suggestion as well as low hypnotizable participants who did or did not receive the suggestion.

A final study into the effects of emotional numbing to be investigated is that by Bryant and Kapur (2006). In this study, Bryant and Kapur examined the role of hypnotizability and hypnosis in suggested emotional numbing. The researchers hypothesized that hypnosis is related to stronger responding to suggestion and thus high hypnotizable participants in a hypnosis condition would display less emotional responding than highs in a wake condition (i.e., no hypnotic induction). Again, participants were shown a series of neutral and aversive images and their facial EMG was recorded in addition to them rating how they felt while looking at the images. The results found that highs who received an emotional numbing suggestion were less responsive to the aversive stimuli in both the hypnosis and wake conditions. Bryant and Kapur thus claim that it is hypnotic susceptibility that is important in successfully responding to an emotional numbing suggestion.

Hypnotizability is significantly related to both absorption and fantasy proneness (Roche & McConkey, 1990; Wilson & Barber, 1981, 1983), thus high-hypnotizables are also reliably high in absorption levels. Bryant and colleagues demonstrate that those high in hypnotic susceptibility are also more responsive to emotional numbing suggestions—a response which functionally parallels the peritraumatic response of detachment. These findings lead us to suggest that high absorption and fantasy proneness may also play a generative role in at least some dissociative responses to trauma.

## **SELF-REGULATION AND DISSOCIATIVE RESPONSES**

Individuals who are high in the ability to dissociate are able to detach from exposure to negative stimuli more effectively than those low in the ability (e.g., Nixon et al., 2005). Recent research has found that the parasympathetic (i.e., calming) component of heart rate variability (HRV) can be modulated in a state of disengagement from external reality. For instance, Diamond, Davis, and Howe (2008) investigated whether HRV could serve as an instrument of self-rated hypnotic depth (SRHD). Hypnotic depth is inferred from an individual's subjective and behavioural responses to hypnosis (Pekala et al., 2009). So for example, the individual may be asked to rate in a questionnaire how hypnotized they felt they became. Diamond et al. (2008) found that SRHD was correlated with the high frequency (HF) component of HRV, the component associated with parasympathetic nervous system activity. Thus the more deeply participants were hypnotized (or perceived they were hypnotized) the more relaxed they felt and this was demonstrated physiologically.

Noyes and Kletti (1977, p. 375) claim that it is possible to identify depersonalization (one form of detachment) as a state of "heightened arousal on the one hand and attenuation of potentially disorganizing emotion on the other." Sierra and Berrios (1998), in their study of depersonalization, concluded that the ACC is inhibited and thus painful affect is not felt. They refer to this as an "indifference to pain" (Sierra & Berrios, 1998, p. 898) which is closely linked to the previous discussion on hypnotic analgesia.

Holmes et al. (2005, p.12), in their discussion on the phenomenon of compartmentalization describe it as a "deficit in functioning alongside evidence demonstrating the preservation of the apparently disturbed function." The disruption in the sense of volition (i.e., the lack of willpower or control) that characterizes the somatization disorders (Brown, 2002) is itself a form of compartmentalization. In hypnosis (which serves as a model for somatization disorder symptoms), the sense of non-volition emerges as a consequence of a breakdown in the integration of monitoring and control aspects of supervisory attentional system (SAS) monitoring (Egner, Jamieson, & Gruzelier, 2005). Conscious volition and self-awareness are closely tied to the functional integration of the SAS and hypnotic induction in high susceptibles can result in a weakening of its operation (Brown, 2004; Jamieson & Sheehan, 2004). Under normal circumstances, individuals are able to manage most instances of "negative affect via self-regulatory processing and goal-oriented action" (Brown, 2004, p. 806). But as the negative affect associated with traumatic

episodes may be regarded as “overwhelming,” self-regulation becomes a much more difficult proposition (Brown, 2004). Thus, as trait measures of dissociation have been found to correlate with fantasy proneness, hypnotizability and absorption, it is likely that those individuals high in these latter traits will find it easier to become detached from their experience of traumatic events or negative affect relative to those low in these traits. *Therefore we propose that those individuals who are high in the traits of hypnotizability, absorption, or fantasy proneness are likely to engage these skills to become detached from their experience of traumatic events whereas those low in these traits will need to employ other response options.*

There are a number of different reactions that individuals may experience in response to acute trauma. Detachment and compartmentalization are reactions which, if overgeneralized, ultimately become maladaptive (Butler et al., 1996). It is clear that detachment may play an adaptive as well as a maladaptive role. Hypnosis-like interventions may be better placed than cognitive-behavioural techniques (alone) to harness the adaptive and to ameliorate the maladaptive potential of these responses in those who are prone to exhibit them. A similar conclusion is reached by Butler et al. (1996, p. 53), who state: “As a therapeutic tool, hypnosis may be used to regulate the intensity and immediacy of painful affect while processing traumatic experiences.”

## **HOW TO STUDY THE EFFECTS OF TRAUMA ON COGNITIVE AND AFFECTIVE SELF-REGULATION**

Detachment, hypnotic analgesia and emotional numbing all involve a muting of emotional responsivity to aversive stimuli. We propose that trance or absorption in inner-generated experiences is a discrete pathway of response to traumatic events. Recent brain imaging studies show that the emotional Stroop task provides an important new method by which we can investigate the neuroscience of affective self-regulation which underlies this effect.

The emotional Stroop is used to study the effects of emotional conflict on response selection. In an initial version of this task, participants are required to name the colour of a word when it is either emotionally neutral (e.g., apple) or emotionally salient (e.g., death) and what has been discovered is that response times (RTs) for the colour naming of emotionally salient words is slower than for emotionally neutral words (Etkin, Egner, Peraza, Kandel, & Hirsch, 2006). The emotional Stroop thus “assesses the ability of emotional stimuli ... to withdraw attention from the main task” which is the naming of the colour (Etkin et al., 2006, p. 1). Etkin et al. (pp. 1–2), however, aimed to create an

emotional Stroop task that directly assessed emotional conflict which arose from “incompatibility between the task-relevant and task-irrelevant emotional dimensions of a stimulus” and which “represents an appropriate emotional analog to the color-word Stroop task.” They claim that the original emotional Stroop did not directly assess the interference of emotional processing and cognitive processing because there is no link between the word and the colour of the ink so there is inadequate relevance. This is unlike the traditional Stroop in which the colour of the ink interferes with the reading of the word (e.g., the word “green” in red ink).

Etkin et al. (2006) created a modified version of the emotional Stroop task in which facial expressions were presented with the words “happy” or “sad” written across them. This new paradigm more closely parallels the traditional Stroop: It creates a conflict between emotional and cognitive processing as the main task is to identify the facial expression while ignoring the word.

Successful performance on the emotional Stroop involves the ability to control the effects of emotional arousal. That is, the ability to focus on the task-relevant dimension of the presented stimulus. The mechanism for this control was investigated by Etkin et al. (2006) in a functional magnetic resonance imaging (fMRI) study. They discovered that emotional conflict evoked activity in the amygdala. Conflict resolution, however, evoked activity within the rostral ACC (rACC). When participants were presented with an incongruent image (e.g., a happy facial expression with the word “fear” printed on it), the conflict-induced activation of the amygdala was inhibited by the rACC. Thus Etkin et al. concluded that the role of the rACC was the mediation of emotional conflict through the suppression of amygdalae activity.

Sheehan, Donovan, and MacLeod (1988) tested whether those highly susceptible to hypnotic suggestion, compared with those low in susceptibility, would show less interference under hypnosis than in a waking condition. To their surprise, they found that the Stroop interference effect (SIE) was worse (i.e., RTs were slower) for highs under hypnosis compared to when they were awake. One hypothesis proposed for this unexpected result was that, under hypnosis, there was a weakening of the SAS which meant that participants were less able to control the tendency to read the word (see Jamieson & Sheehan, 2004). However, when an “attentional focusing instruction” was administered under hypnosis, highs were then able to reduce the SIE unlike in the hypnosis alone condition. Raz and his colleagues (Raz, Kirsch, Pollard, & Nitin-Kaner, 2006; Raz, Shapiro, Fan, & Posner, 2002) extended Sheehan et al.’s (1988) research. They too found that hypnosis and suggestion together

could reduce the SIE in highs but not lows (Raz et al., 2002), but they also discovered that suggestion alone could reduce the effect in highs *without* a hypnotic induction (Raz et al., 2006).

In this context, the traditional Stroop task may be considered to measure the effect of Holmes et al. (2005) type compartmentalization. Compartmentalization is characterized by the failure to control processes and actions normally under volitional command. Support for this contention comes from studies which have found that even under hypnotic induction, highly suggestible individuals will perform poorly (i.e., display increased errors) on the Stroop task (Jamieson & Sheehan, 2004) as the hypnotic context seems to attenuate attentional control. The emotional Stroop, by contrast, may then be considered as a measure of affective control. We propose that the later version of the emotional Stroop is particularly well suited to test our account of the role of the state and trait processes involved with inner-generated experiences in determining the psychological responses elicited by traumatic events and their subsequent effects on affective self-regulation.

## **CLINICAL IMPLICATIONS**

The model developed here proposes that when confronted by trauma, those high in hypnotizability and/or absorption and/or fantasy proneness will have difficulty in volitionally disengaging from what they are seeing. This follows from what Jamieson and Sheehan (2004) refer to as a breakdown in SAS control. Action that is under SAS control is perceived as voluntary, but other actions are experienced as automatic and lacking self-control. However, as has been demonstrated in previous research, the deliberate use of appropriate suggestion may be an important factor in self-regulation for those higher on the traits of hypnotizability, absorption or fantasy proneness.

Individuals who have prior experience of trauma are more susceptible to uncontrolled negative reactions than those who have no prior exposure. Those high in hypnotizability and/or absorption and/or fantasy proneness have the ability to detach themselves from the situation and focus on inner-generated experiences that may help them to modulate these painful experiences (Wilson & Barber, 1983) and thus cope with otherwise overwhelming negative affect (Brown, 2004). On the other hand, those low in these traits are far less likely to utilize such mechanisms as they lack the ability to focus inwardly (they may, however, be able to utilize other self-regulatory strategies successfully). If this thinking is indeed correct, then highs who have experienced trauma should be

able to utilize specific suggestions to regulate their affective responses leading to better performance on the emotional Stroop (as they will be less disrupted by the effects of emotional arousal evoked by negative images) and experience a greater sense of authorship and control over their subjective state.

Those with prior experience of a traumatic incident will be particularly vulnerable to strong negative reactions. It is expected then, that high hypnotizability and/or absorption and/or fantasy proneness will directly influence the availability of detachment and compartmentalization as coping responses. It is likely that the ability to modulate further processing of relevant aspects of a scene (or in the case of a traumatic incident, painful aspects) is central to how those high in hypnotizability and/or absorption and/or fantasy proneness are able to suppress (detach or compartmentalize) their emotional (and cognitive-behavioural) reactions. Those low in these traits are less able to disengage from the irrelevant or painful aspects of a scene by this route and will be better served by conventional cognitive-behavioural therapeutic interventions.

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## CLINICAL HYPNOSIS AND COGNITIVE–BEHAVIOUR THERAPY IN THE TREATMENT OF A YOUNG WOMAN WITH ANXIETY, DEPRESSION, AND SELF-ESTEEM ISSUES

Elke Kellis

Registered Psychologist, Melbourne

*The following case study advocates for the important role clinical hypnosis can play in the enhancement of cognitive–behavioural treatment (CBT) of anxiety, depression and self-esteem issues through deepening and consolidating cognitive–behavioural aspects of treatment. It is argued that clinical hypnosis can incorporate many cognitive–behavioural themes such as flexibility in thinking styles, and the fact that our cognitions do not define us. It is further stipulated that an important aspect of successful treatment of depression and anxiety includes ego strengthening and the development of a stronger sense of self which again can be greatly enhanced through the use of clinical hypnosis. While hypnosis may not be indicated immediately at the start of treatment, it may become increasingly more appropriate and useful as therapy progresses.*

### **Presenting Problem and Initial Assessment**

A young woman, Anthea, presented for psychotherapeutic treatment following the break-up of an intimate relationship. Anthea had been referred by her family doctor, who had known her all of her life, through the Better Access to Mental Health scheme. Following the break-up of her relationship shortly after her engagement, Anthea had suffered a nervous breakdown. Her family doctor determined that Anthea was suffering from extreme anxiety and depression due to the immense pressure she was placing on herself to be married as well as the family and cultural pressure she perceived herself to be under. In his referral documentation, her doctor highlighted that Anthea had suffered significant levels of anxiety for most of her teenage and adult life.

He also reported that she was suffering from perfectionism and unrealistic expectation of herself and significant others. He had recommended long-term therapy for her and had told her that he anticipated that she would need to attend counselling for at least a year, well beyond the period covered by the Medicare scheme.

Outcome measures administered during her first treatment session included the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995)—Short Version (DASS21) as well as the Beck Depression Inventory (BDI-II) (Beck, Steer, & Brown, 1996 ) and Beck Anxiety Scale (BAI) (Beck, 1993). Combined with clinical interview, these indicated a moderate to severe level of depression and some anxiety (see Table 1). These results were discussed in terms of grief rather than clinical depression due to the recency of Anthea's relationship break-up. Anthea discussed her therapeutic goals for treatment in her first session and explained that she wanted to gain control over her anxiety and reduce the importance she was placing on the expectations of others so that she would no longer damage her relationship with undue pressures based on unrealistic expectations. She also stated that she wanted to learn how to care less about other people's opinions of her and gain a greater sense of self.

## **History**

Anthea presented as a well-groomed, well-dressed 27-year-old woman. She was of Greek Orthodox background, and although she described herself as "not religious" she reported growing up in a strict and religious household with one older sibling. She reported that she had always been self-conscious and often felt that she was different and did not quite fit in. She said she had a good relationship with her parents, particularly her mother. She confided in her mother but would also often yell at her and take out her frustration on her. She reported that she also had a good relationship with her older brother, who was married and no longer living at home. Anthea did not particularly enjoy her work but it paid well, allowing her to save for her future while still living at home with her parents.

For the past three years Anthea had been in a relationship with a young man from a different cultural background. While the relationship went well in the first year, it was plagued by arguments, mostly over getting married and having a family which she felt was expected of her by her friends and family but also by herself and her own standards. These arguments were also over how he dressed and behaved around family and friends, how he performed at

his job and how ambitious he was, when their parents would meet and when they would get married.

Anthea reported that they would often yell at each other and fight quite badly. She said that her partner proposed but later stated that this was under duress as their many fights had raised doubts about the relationship in his mind. Anthea reported that he had loved her but was unable to handle the stress their relationship placed on him and therefore needed to break up to gain some perspective on what he wanted for the future. This devastated Anthea, who was well aware of her anxiety, and led to the emotional breakdown which prompted the referral by her family doctor.

**Table 1:** Outcome Measure Scores at Initial Assessment and Medicare Review Sessions

Formal psychological assessment administered	Session 1	Session 2	Session 3
DASS 21 Depression Anxiety Stress Scale	D = 22 (severe)	D = 12 (mild)	D = 34 (extremely severe)
	A = 8 (mild)	A = 2 (normal)	A = 20 (extremely severe)
	S = 24 (moderate)	S = 6 (normal)	S = 12 (moderate)
BDI-II	23 (moderate depression)	17 (mild depression)	33 (severe depression)
BAI	15 (low anxiety)	7 (low anxiety)	23 (moderate anxiety)

## The Role of Hypnosis in Treatment

Anthea had heard a lot about hypnosis from a family friend who had quit smoking through the help of hypnosis. She had later learned that hypnosis can also assist with anxiety. Anthea requested the use of hypnosis in her first session. A thorough discussion followed, which focused on educating Anthea about hypnosis and how it may be used to assist her in managing her presenting issues as well as the guidelines and requirements for eligibility of access to Medicare. Her request at the start of treatment indicated that she was looking for a “quick fix” and someone to “fix it for her.” This discussion

allowed for the prioritization of therapeutic goals and highlighted to Anthea that it was important for her to take an active role in treatment and learn new life skills. It also allowed for a discussion of what hypnosis is and is not, bringing responsibility back to her as active participant in learning to manage her mood more effectively. It was agreed to focus on practical strategies for immediate symptoms relief in the first instance, and later to use hypnosis to consolidate and deepen these therapeutic gains.

The use of hypnosis as an adjunct to CBT has been well documented (Nolan, 2008; Schoenberger, 2000; Yapko, 2003). Particularly, in the treatment of anxiety, it has been suggested that hypnosis enhances the cognitive components used to manage anxiety and stress (Kahn, 2010, p. 83). Historically, this has not always been the case in the treatment of depression. Burrows (1980) argued that “there are many important controversial issues involving the use of hypnosis in affective illness” (p. 149). He argued that “most experienced clinicians teach that severe depressive illness is a definite contra-indication to hypnosis” (p. 167). Porter (1990), when discussing the use of clinical hypnosis in the treatment of test anxiety and enhanced performance during study, also argued that caution needs to be exercised when depression is mixed with anxiety. Burrows (1995) discusses “the great overlap of anxiety with depressive disorders” (p. 48). The cautions and concerns were raised in response to the belief that hypnosis would strip the depressed patient of their defences and increase the risk of suicidal tendencies.

More recently, however, there has been a growing body of research (see list of studies cited by Alladin, 2010) providing “empirical validation for integrating hypnosis with CBT in the management of depression” (Alladin, 2010, p. 73). Yapko (2001, 2003) has argued that hypnosis is a highly effective adjunct to CBT for depression. His response to cautions and concerns regarding the use of hypnosis with depression is that one “can do hypnosis with any category of disorder, but each category requires its own specialized approach” (Yapko, 2003, p. 177). In other words, it is important how hypnosis is used with certain disorders but this does not mean the use of hypnosis is contra-indicated.

In the case of Anthea, and more generally in the case of anxiety and depression, hypnosis in conjunction with CBT can be useful in deepening and enhancing particular cognitive interventions such as cognitive restructuring, increasing confidence, coping better with life’s challenges, shifting focus from failures to successes, enhancing a sense of control, improving relaxation, and increasing frustration tolerance (Alladin, 2010; Kahn, 2010; Yapko, 2001, 2003).

## **Treatment Outline**

Following thorough assessment including relevant family history, treatment within a cognitive-behavioural framework commenced and focused on working through Anthea's mix of emotions (which included guilt, anger, grief, sadness, confusion, overwhelm, and anxiety about the future) as well as on building coping strategies designed to encourage healthy behaviours to assist in reconnecting with others. Cognitive strategies of the treatment regime focused on improving the quality of Anthea's thoughts and thinking processes. Treatment also focused on building Anthea's sense of self and healthy self-esteem to allow her to learn to be her own person, with focus on her own values and beliefs rather than perceived pressure from others. This included exploration of her values, beliefs, opinions and priorities, her view of herself, forgiveness of herself for past anxiety which caused her partner stress and despair, as well as embracing her own humanity.

Hypnosis was considered as an adjunct to therapy once Anthea had mastered practical strategies for symptoms relief and her outcome measure scores indicated that her level of depression had reduced to a mild level. At this point, hypnosis was discussed as a means of consolidating and deepening her learning thus far outside of the Better Access to Mental Health scheme.

## **Assessment of Suitability of the Patient for Hypnosis**

Since hypnosis had been flagged and discussed as an adjunct to therapy in the first session, the practitioner was mindful to take careful note of Anthea's level of suggestibility and hypnotizability throughout treatment sessions. As it became more appropriate to consider using hypnosis, the suitability of the patient for hypnosis was further assessed by inviting Anthea to vividly imagine certain situations. McCarthy (2009) uses the teapot test to determine a subject's potential for suggestion and hypnotizability. McCarthy here invites a subject to imagine making a pot of tea using different sensory descriptions and details such as the sound of the kettle boiling, the scent of a slice of lemon, or the swirling of tea leaves in the pot as it is stirred. The degree to which a patient is able to imagine making the tea and the level of sensory detail experienced determines the level of suggestibility potential. For example, a patient who can vividly "see" the colours of items mentioned is likely to have good ability to visualize and is likely to respond well to visual suggestions in hypnosis. Since olfactory details are often experienced by fewer clients, those who report having smelled the tea and lemon as though they were actually

in the kitchen are considered highly hypnotizable. A client does therefore not pass or fail the teapot test, but rather the teapot test provides valuable information regarding the client's capacity to respond to suggestions. During treatment sessions leading up to the hypnosis session, Anthea was invited to participate in the teapot test and her suitability for hypnotic intervention was determined based on her ability to imagine these different scenarios and the degree of detail and sensory input she was able to generate. Anthea was found to be a suitable subject for hypnosis.

### **Application of Hypnosis to the Particular Condition and the Rationale for Choosing this Approach**

It has previously been argued that hypnosis enhances treatment for anxiety within a cognitive-behaviour therapy framework (Kahn, 2010; Nolan, 2008; Yapko, 2003). Once Anthea had learnt practical strategies for symptom relief and her level of depression was within a mild range, hypnosis was indicated. Yapko (2001) argued the benefits of integrating hypnosis and cognitive-behaviour therapy. It has been found that hypnosis can be a particularly useful adjunct to CBT strategies (Alladin, 2010; Kahn, 2010; Yapko, 2001). The application of hypnosis can be particularly useful in the deepening of the patient's understanding of cognitive-behavioural principles such as the fact that our cognitions do not define us, the importance of flexibility in our thinking styles, as well as the fact that each experience has value in our learning (Alladin, 2010; Kahn, 2010; Yapko, 2001). Consequently, a hypnotic intervention was designed using aspects of a variety of different published scripts, incorporating these cognitive-behavioural principles as well as ego-enhancement and ego-strengthening suggestions with special attention given to resolving feelings of guilt (Barnett, 1990; Stanton, 1990; Watkins, 1990; Wilson & Barber, 1990; Yapko, 2001). The final script included suggestions to shift focus from past to future, from failures to successes, highlighting the process of learning and growth to build Anthea's confidence in herself and the process of therapy. It was suggested that she could change through learning new skills, thus building confidence in a new and different future and in mastery over her anxiety. These suggestions were also designed to combat her feelings of guilt over past episodes of anxiety and distress she had caused her partner and parents through reminding her that she was now learning new skills to manage her anxiety more effectively.

## **Details of Hypnotic Techniques and Interventions Used**

Prior to the hypnosis session, special attention was given to preparing the patient for the session through educating her about the process, and seeking informed consent as well as to determining Anthea's level of motivation. Both preparation of the patient and a significant level of motivation and positive belief in the treatment have been found to be important aspects of hypnosis treatment (Crasilneck, 1980; McConkey, 1995; Yapko, 2003).

Erickson, as quoted by Rossi et al. (1998), highlighted the importance of accepting and utilizing the patient's point of view. The important role ego-strengthening can play in treatment was described by Linden (1995) as follows: "Strengthening ego functioning means reinforcing their healthy efforts, evaluating the risks if changing behavior and rehearsal of new behaviors." (p. 170). The focus here is on the emotions of guilt, overwhelm, disappointment, loss, anger, depression and redefinition of self when describing common psychological reactions. These elements were incorporated in the hypnosis script alongside the elements previously listed above. Suggestions included a focus on forgiveness for past distress Anthea had caused her loved ones and a new confidence in herself and her ability to manage her anxiety more effectively in the future.

A single hypnosis session, outside of and in addition to her allocated Medicare sessions, was conducted with Anthea at the time of session number 8. The induction process included progressive muscle relaxation as well as breathing techniques, as these have been found to greatly assist in the management of anxiety. The main basis of the hypnosis script was taken from Yapko (2001) but elements of other scripts (Barnett, 1990; Stanton, 1990; Watkins, 1990; Wilson & Barber, 1990) were woven through to incorporate other important treatment aspects. Anthea was provided with an audio recording of the hypnosis session with the invitation to listen to the recording on a regular basis over the next two weeks.

## **Goals of Therapeutic Intervention and Management**

The goal of therapy and, in particular, of the hypnosis intervention was to develop and strengthen Anthea's flexibility of thinking style and thinking processes, to improve the quality of her thinking, to address and resolve her emotions of guilt and anger, to develop her ability to soothe and manage her anxiety without putting pressure on others to reassure her, and to develop and strengthen her sense of self.

## **Outcome**

Anthea responded well, both to therapy within the cognitive-behavioural framework and to hypnosis as an adjunct to therapy. Following the hypnosis session, Anthea reported that she had previously not been able to relax as deeply as she was able to during hypnosis. While Anthea did not attribute any significant shift in her feelings or thoughts to the hypnosis session, she presented as progressively more calm, comfortable within herself and positive about the future, particularly in the sessions following the hypnosis session. For example, her rate of speech and level of agitation, energy, and fidgeting were markedly reduced after the hypnosis session. Anthea reported that she had used the audio recording of her hypnosis session only on two occasions outside of therapy, but found the recording a useful tool. Anthea did experience a further episode of intense anxiety related to interactions with her partner (at the time of her session 12 review, as indicated by the spiking in her outcome measures at this time; see Table 1) but was able to recover from these more quickly with the tools she had learnt. Over the course of the next couple of sessions, she reported a more positive outlook toward the future, greater confidence in her ability to manage intense anxiety, and had reconnected with her family and friends as well as her previous partner, with whom she had re-entered a relationship. Once Anthea had re-entered her relationship with her partner, she dropped out of treatment after session 14 and, to date, has not re-engaged in treatment despite follow-up.

## **Discussion and Conclusion**

This case demonstrates how, at the appropriate time within the treatment process, hypnosis can enhance and deepen a client's understanding of cognitive-behavioural principles by emphasizing strategies to reframe cognitive distortions, increasing frustration tolerance and a better understanding of the learning process, and building confidence and a greater sense of control as well as positive expectations for the future. This case has also shown that an important aspect of successful treatment of depression and anxiety may need to include ego strengthening and the development of a stronger sense of self, which again can be greatly assisted through the use of clinical hypnosis. For treatment to be successful, Anthea needed to forgive herself for past anxious outbursts and the stress and destruction her anxiety had caused her loved ones. She needed to feel confident that she could change and learn more effective ways to manage her anxiety in the future. She also needed to reconnect

with her own views and priorities rather than feel subjected to social and cultural pressures. The hypnosis session presented an opportunity to deepen and enhance CBT concepts presented to Anthea in therapy which resulted in observable shifts in her level of nervous energy and sense of calm.

Hypnosis in conjunction with CBT may not be indicated immediately at the onset of treatment, as was the case here, since in thorough discussion with the client it was mutually agreed to focus initially on the development of practical skills to provide immediate symptom relief and the psycho-educational components of CBT. The use of hypnosis may, however, become increasingly useful and appropriate as symptoms subside and therapeutic goals shift as treatment progresses. Hypnosis provided a wonderful vehicle for enhancing the cognitive-behavioural treatment of anxiety and depression provided in this case through a weaving together of different CBT concepts with ego-strengthening components such as forgiveness, building confidence, and reconnection with self in the one hypnosis session. This resulted in an observable shift in the client's level of relaxation, comfort in her own skin, and greater calm and confidence in her ability to change through direct experience. Anthea was able to recover quickly and with increased confidence in her ability to cope even when her anxiety spiked.

This case illustrates that hypnosis can provide a useful way of combining different CBT concepts and deliver these in a concentrated fashion that the client can easily review outside of the therapy session and that can have visible and immediate results. In Anthea's case, hypnosis allowed her to feel a level of relaxation she had not experienced before and did not believe was possible for her. This experiences allowed her to gain greater confidence and hope in a future where she could apply the skills she had learnt effectively and make positive changes in the way she managed her mood. Hypnosis, here, provided direct experience of the CBT concepts taught in action and added a new dimension to treatment.

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## **BRIEF PSYCHOTHERAPY UTILIZING HYPNOSIS TO REDUCE NEGATIVE EMOTIONS TRIGGERING A STRESS RESPONSE, EXACERBATING A CHRONIC SKIN COMPLAINT—LICHEN SCLEROSUS OF THE VULVA**

Susan Blunsden  
Psychologist, Sydney

*A recent diagnosis, being a second chronic illness, of a skin condition on the genitals of a 40-year-old woman, triggered a stress response of heightened emotions including: anxiety, grief, guilt and anger. Her goal was specifically to treat the anger. The process of brief psychotherapy using the language of narrative therapy was the framework for treatment. Content of therapy specifically utilized self-hypnosis and the indirect hypnotic approach of metaphor. This allowed us to refer to sexual intimacy in a symbolic way. Therapeutic outcome was positive at six months' follow-up.*

### **BACKGROUND**

Sally was a 40-year-old mother. She had married later in life and lived with her husband and her two children, a 15-year-old daughter and a two-year-old son. Sally and Barry had recently married. He was the father of two-year-old Timmy. Twenty-five years ago, while still at high school, Sally contracted another chronic disease, hepatitis C, which had only been diagnosed eight years ago.

Sally and her family had Christmas commitments and she wanted to contain her current levels of distress over the next few weeks. She thought she needed to be “psychoanalyzed” because she thought she was definitely doing something wrong with how she lived her life and did not want to develop a third associated chronic disease in the future. This was an intolerable thought, producing intense negative emotions.

## **CASE FORMULATION**

Hypnosis can be used successfully to treat the related stress but not always the organic cause of skin diseases (Brown & Fromm, 1987). Skin diseases are complex with many interrelated causes. Some causes are unknown, as in this case, but can include psychological factors—the combination of negative emotional responses and the autonomic nervous system. For example, redness, swelling, sweating and the sebaceous glands, functioning together, can be a clear factor in the aetiology of some skin complaints like neurodermatitis. Yet they are unknown in others, such as lichen sclerosis.

Successful use of conversational therapies including psychotherapy and hypnosis when treating skin diseases requires purposefully identifying and utilizing the client's goals. Sally's goal was to reduce her feelings of "anger" and "meanness." When the symptom has a limited defensive function, outcomes are much more favourable. (Wolberg, 1948, p.1).

Sally's negative emotions of "anger" and "meanness" are conceptualized here as expressions of a defensive function. She had currently adopted these negative emotions to try to gain control of her fears and keep functioning as a parent and spouse. In her developmental history Sally spoke about identifying with the "mean girl" who bullied her in high school. It appeared she had adopted the defensive function of identifying with the aggressor (see "Personal History" for more detail).

The concept of emanation was important when formulating treatment in this case (Hlywa, 1998). Emanation refers to the emphasis and priority given to suggestions using the client's own words, consistent with their values and beliefs (Hlywa, 2009/2010, 2010). For Sally, that was to express less anger and meanness to those closest to her. Her therapy could not just be conducted as "an exercise in order to satisfy perimeters of some theories" (Hlywa & Dolan, 2008, p. 6).

## **REFERRAL INFORMATION**

Sally had recently been diagnosed with lichen sclerosis (LS), which she found very difficult, following prolonged symptoms. LS is a skin condition but not an infection and cannot be passed on to anyone else. It may involve any part of the skin, but in this case it was found on the genital area. This disturbed Sally—she felt "guilty and evil." It is not an internal disease and never extends into the vagina. It can occur at any age. Most cases are found in adult women. Causes are unknown. The tendency could be inherited because this disease

may reoccur in families (NSW Department of Health, 2008).

The typical appearance is of whitened skin around the vulva, perineum and anus. There may be lesions that look like blisters and bruises. It is not uncommon for the skin to split open easily. There can be soreness and pain with intercourse. LS may cause scarring resulting in loss of labia minora (inner lips of the vagina) and reduction in size of the vaginal opening.

People who suffer from LS can face an increased risk of cancer of the vulva. They may also suffer from “autoimmune” diseases like systemic lupus erythematosus and thyroid disease (NSW Department of Health, 2008). These associations are not common, but still Sally needed to discuss her fear of contracting a third chronic illness with her medical practitioner. Sally was very upset about the possibility of the future development of these symptoms or associated diseases. Educational information about LS intensified her anxiety. Sally feared the worst.

LS is treated with cortisone cream. Treatment is continuous. Intercourse is possible again once LS is being treated. (NSW Department of Health, 2008). The prognosis for most patients with LS is very good. It nearly always responds quickly to treatment and if this were continued, with time Sally was assured by her GP she would need less medication to remain symptom free. From the perspective of using hypnosis, this was a strong positive suggestion from which to begin treatment.

## **PRESENTING SYMPTOMS**

The physical symptoms Sally experienced were itch and atrophy or early aging of the genitals. Cortisone cream was helping with the itch. No underlying cause was identified. The LS had made her feel very fragile and disturbed because she had a chronic disease, which she said she “will have to learn to deal with.” This was on top of a previous diagnosis of hepatitis C, also a chronic disease. She had coped quite well with the hepatitis C up until this point. She now reported feeling overwhelmed, isolated and was having difficulty managing.

Sally’s general practitioner was supportive. Sally found this GP after a number of difficult consultations with other doctors. She kept seeking new opinions until she gained definitive answers. She did not need to discuss medical issues around her disease management. Sally recognized her need for ongoing counselling and emotional support. Sally was highly motivated by her current situation and the need for symptom-free functioning was a powerful

incentive in itself. Her anger or “meanness to those closest” was a safer coping mechanism than expressing the grief created by the current diagnosis.

In early consultations Sally reflected on her life (see “Personal History”). She feared her LS was a punishment for the life she lived prior to her marriage. She referred to herself as a “wild child,” when settling down in a committed relationship with a male was not important. Sally was afraid of the negative emotions present, which were overwhelming. Her underlying guilt and sadness could lead to despair and feeling trapped by her illness. It was important to Sally that she could externalize her anger in therapy and for the therapist to respect this coping mechanism (Hlywa, 2004). This was the only safe place where she could display her anger.

Gibney (2003, p. 142) reports Bieber’s opinion that “there are many cases in which transference develops quickly and confrontingly ... in the first forty-five minutes” of therapy. This was evident in this case. Experiencing the energy of the anger between us was where the transference and counter-transference quickly developed. There was no need to react to this but simply for the therapist to be aware and informed. This anger gave her energy to keep functioning as mother and partner. Leaving out the anger would leave Sally feeling misunderstood. The depth and resonance of therapy would lack intensity and completeness. Sally especially expressed how she “wanted to be less mean and more positive and loving to those closest” to her (symptom-free functioning), as they were so supportive of her (powerful incentive). Treasuring her family was important. There was no suicidal ideation, present or past. Sally informed me she had never been to a counsellor or psychologist before.

Sally and Barry’s relationship was reported to be good. They had recently married. She reported that her husband was supportive about all her health issues. He was not afraid of these affecting their sexual relationship. Sally admitted she had fears about this. At present, Sally reported that her anger and meanness were preventing her from being more loving toward her husband. Sally did not want to talk about LS in detail or answer intimate questions about how LS was affecting her. Questioning felt like an interrogation and inadvertently mimicked the recent ordeal experienced, during the process of reaching this diagnosis.

### **Psychometric Testing**

We completed genograms for family of origin and family of creation, talking about relationship dynamics while proceeding to draw diagrams. Results on

the Depression Anxiety and Stress Scale (DASS) showed moderate levels of depression and stress. Anxiety levels were medium to low. These results came from the referring GP.

The Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI) were completed. Sally's scores showed mild levels of anxiety and depression. Her sleep and appetite were good. Sally's negative thoughts about herself were expressed as self-blame and shame.

## **PERSONAL HISTORY**

Sally grew up in an intact family, with an older sister and younger brother. She referred to herself as the "wild child." Her sister rang me and made the referral and appointment time. Sally saw her older sister as the "good girl" and herself as the "bad girl" in the family. Sally's 15-year-old daughter was also good like her older sister.

Sally became a single parent when her daughter was born. She learnt how to provide for herself and her daughter as that partner was not capable of supporting himself.

Sally, who was a qualified high school English teacher, was passionate about poetry. She had been a casual teacher before her son was born. Sally's primary occupation now was "family caregiver." Currently she was tutoring and babysitting in the evenings because she wanted to be there for her son during the day. By working part-time, Sally wanted to reduce any stress that would exacerbate her symptoms.

Sally talked about being bullied when she was in high school because of noticeable facial hair on her upper lip that developed during puberty. To cope she became the bully's or "mean girl's best friend." As a result, Sally said she spent her adolescence being "angry and mean." During the last few years, she had saved and had paid for laser hair removal, as treatment to rectify that problem permanently.

Sally was happy with her appearance. She was pretty, well groomed, looked healthy and 10 years younger than her chronological age. She explained how she was very health conscious with her diet, exercise and meditation. This was because she wanted to manage her hepatitis C, "the best she could." She had always kept up with the latest research, asked her GP for advice and had joined a support group for those diagnosed with hepatitis C.

Sally explained how her family had always been supportive of her. She wanted to appreciate her "daughter's strength and parents' support instead of

being angry and mean about it.” She had observed her father as a stoic man when facing crises in his life. They shared this trait. She described her mother as being very private, like Sally had become due to her diagnoses. Sally, in hindsight, was sure her mother also had LS. To date, neither had disclosed this to the other. It was something to consider. That openness was not the way her family operated. Now she could appreciate more fully why this may have been so.

Due to Christmas celebrations and the long summer school holidays starting, time was at a premium for Sally and her family at present.

## **TREATMENT APPROACH**

The initial session was on a Friday and Sally asked to see me on Monday, Wednesday and Friday of the next week, just before Christmas and holiday commitments. Psychoeducation about the possible therapies that could be provided was presented and discussed. Financial viability and restraints around time were negotiated.

Knowing a therapeutic effect can be increased and that therapy duration can be reduced using hypnosis, it was considered appropriate (Baker & Nash, 2008; Barber, 2008). Sally was a highly motivated client, which is an important factor when considering how hypnosis can enhance the inherent capabilities and potential of an individual (Spiegel & Spiegel, 1978).

Sally’s priority was to communicate better with her loved ones. Her goal was to “get rid of the mean communication and anger” she expressed toward her closest supporters, especially her daughter and husband. She was wondering how her chronic diseases and aggression to those closest to her related to how she had internalized past bullying and earlier dangerous, intimate relationships during adolescence. She wanted to “find her real self.”

Sally disclosed a series of abusive and reckless relationships in adolescence and early adulthood. The hepatitis C was contracted as a result of the activities which took place that bound these relationships together.

Gibney (2003, pp. 110–111) refers to Gustafson’s “malignant basic fault” in relation to those clients who deteriorate on entering long-term psychotherapy. They have been treated harshly and inconsistently in earlier intimate relationships. Once offered support and containment in therapy, they become afraid they will be too vulnerable with the therapist and any long-term therapy creates problems for both parties in the therapeutic alliance.

At this point in time it was important to allow Sally to request contact,

rather than the therapist, so she did not feel overwhelmed by positive affect in the therapeutic relationship. Anger could increase stress, negative emotions and itching. This could be triggered by those closest to her. So I was not prepared to enter such a parallel process. At this point, any long-term approach was deferred until symptoms abated.

Even though Sally's initial request was for "psychoanalysis," there was no other indication that she wanted long-term therapy for the treatment of the problem. This stance emanated from Sally but, in terms of her presentation, is clearly justifiable with respect to the psychological literature.

During conversational therapy it became important for the therapist to balance catastrophizing with containment (Gibney, 2003) and for the client to reframe angry thoughts instead of distracting herself or ruminating about them (Denson, 2009). Containment was achieved by respectful, empathic listening, which helped the client address and work through angry thoughts.

We worked on the grief regarding her current diagnosis. We talked about how a past diagnosis was also affecting the current levels of grief in her life. We used a narrative approach to re-author the past. Redefining Sally's understanding of the past would in turn help her to reconstruct the present and allow her to realize that she could look forward, with hope, to the future (White, 1989).

Sally used self-hypnosis. Between sessions, she used this before going to sleep at night, similar to the way she had been using daytime meditation. This was specific, linked to her desires, was goal-oriented and engendered hope. Sally was very concerned about privacy and confidentiality and was secretive about aspects of her life. These concerns highlight the importance of the use of self-hypnosis, where the client wants to be self-directed in a very private way.

Sally particularly enjoyed using imagery in a creative way to address her itch. Her literary background and experience as a high school teacher had predisposed her favourably to the use of metaphor. This indirect hypnotic approach (Kane & Olness, 2004), allowed us to refer to sexual matters in a symbolic way, as Sally found it hard to put private activities into words.

## **SUITABILITY FOR HYPNOSIS**

The Hypnotic Induction Profile (HIP) (Spiegel & Spiegel, 1978) was used in the second session to elicit Sally's level of hypnotizability. She was successful in all categories. She was highly hypnotizable.

There were no contraindications. Sally had come for treatment to prevent

developing a reactive depression. Sally was:

- an English teacher thoughtful and intelligent with the use of words,
- highly creative in the mediums of poetry and paint,
- able to enjoy Buddhist meditation tapes at home,
- a highly private and secretive person with two very personal and chronic illnesses,
- highly responsive to suggestions in conversational therapy,
- highly motivated, and
- developing good rapport.

Her profile suggested that positive outcomes would result from utilizing hypnosis during therapy. This would empower Sally and optimize our brief therapeutic alliance.

## **SESSION 1**

I was able to reflect back, or seed positive suggestions and hypotheses about what may have been going on for Sally in her life. When bullied and teased as a teenager, being angry and mean was a way of keeping her true self hidden but safe. This in itself was why she was a successful high school teacher, because she understood what it was like to suffer as a student.

Sally was also very self-reflective. I was easily able to emphasize patterns or recurring themes in her life by carefully listening to the words she repeated about different chapters of her life and which emanated from her. Those most often repeated were “anger” and “meanness.”

We continued to reframe these negative emotions using psychoeducation around grief. We talked about her diagnoses creating loss of health and early transition of aging genitalia and how this led to feelings of sadness and guilt. She felt she was being punished for her reckless past. These emotions in turn can be masked by anger and meanness. This was a normal grief response. Sensibly, she was seeking support to prevent developing an entrenched reactive depression.

As therapist, the language I used to begin to enhance self-efficacy took a narrative approach by externalizing the problem of anger and meanness. Narrative therapy relates significantly to “postmodernism,” which believes there is no one objective “truth.” Within a narrative approach our lives are multi-storied as opposed to single-storied. Narrative therapists see stories as events, linked in sequence, across time according to a plot. The meaning we have attributed to them forms the plot. As the story develops it invites the

teller to further select only certain information, while ignoring other events, as the same story is repeatedly told. Epston and White (1992) see these stories as describing and shaping people's perspectives on their lives' past, present and future. These stories can be oppressive or inspiring. A person coming to therapy has a "problem-saturated" story that can become their negative identity.

Narrative therapy does not focus on experts solving problems. It is collaborative and non-blaming. The questions used when mapping the influence of the problem externalize the problem. The problem is the problem. The person or relationship in question is not seen as the problem. Externalizing the problem reduces guilt and blame.

Externalizing the problem enables the narrative therapist to focus on people working together and discovering through conversations the hopeful, preferred, and previously unrecognized and hidden, possibilities contained within themselves as, so far, unnoticed story-lines. In essence White (1989) referred to this as the "re-authoring" of people's stories and their lives.

It is important to emphasize that the brief rendition of narrative therapy below does not adequately express the disorderly process of this sort of conversation—the ups and downs of the narrative journey we can refer to as brief psychotherapy in this case. Gibney (2003, p. 142) refers to psychotherapy which can be brief and just as effective as long-term psychotherapy. The process of the transference and countertransference developed within the first session in this case richly informed the narrative content, allowing ideas to flow quick and fast.

During conversational narrative therapy (Epston & White, 1992) we could use the positive way Sally had managed her chronic disease hepatitis C (past new-old story) to deconstruct the thought attributed to her feelings of inadequacy and of not being capable of managing LS (present problem-saturated story). Sally was reminded, with gentle unique outcome questioning, that she had managed the hepatitis C competently in the past (new-old story). Sally could do this again with LS (future re-authoring). She had a map in her head and was very resilient because she remained competent with up-to-date information and connected with her doctors, support group, therapist and family.

We took the same narrative approach regarding Sally as being an authentic, calm, competent and capable caregiver (a new-old dominant story), rather than someone who was always angry and mean (old problem-saturated story). When Sally was a high school teacher she decided that being bullied as an adolescent at school better informed her about how high school students

can suffer (past deconstruction). Therefore this experience contributed to her being a much more competent and caring teacher than if she had never been bullied as a student (new-old story). We conversed about stories of her being a calm and capable tutor and babysitter (present reconstruction). Exploring unique outcome questions, Sally could consider herself to be an authentic and loving mother, wife and daughter (future re-authoring) (White, 1989).

When deconstructing the old story and using the re-authoring approach described above, the therapist is “not simply pointing out positives. Instead, this approach actively engages persons in unravelling mysteries that the therapist can’t solve” (White, 1991, p. 33).

Recalling experiences of the new story in the past will strengthen the new story. The significance is about the person deciding “whether they want to maintain the ‘old story’ as their dominant story or side step that story (path) and give another well-trodden path (the new-old story) dominance in the future” (Hewson, 1991, p. 7).

The conversational therapeutic work done in the first session was followed up with hypnosis in sessions 2, 3 and 4. It was important to affirm the cognitive changes already achieved. These ideas, which emanated from Sally herself, were seeded to become positive suggestions during hypnosis.

This first session became an extended session. A lot was achieved in the first hour. It was important Sally rejoin her children, who were playing in the nearby park, with a reduction in negative emotions present. She was stiff and fidgeting with anger. She wanted to achieve something tangible. In the additional half hour, we utilized an affect bridge (Desland, 2008) using an indirect approach to induce hypnosis.

### **Affect Bridge**

Sally closed her eyes and recalled the excessive negative emotions of grief, guilt, anger and anxiety she felt when telling her sister about her current diagnosis. She reported feeling “tight and stiff all over” her body. She found other memories of being “furious” with her parents recently, then feeling “impatient” with her children and “annoyed” with her husband. She left the house saying to them she needed time to herself, “a swim”... her “joke of water therapy.” This then stirred memories of childhood. When sick with a temperature her mother would “cool her down” with a cold facecloth. Her mother used to say how they needed to go for a swim in their pool after long, hot, trying days at school in summer ... she remembered being “cranky and

tired before going swimming ... cool, calm and refreshed after ... like a new person ... laughing and happy.” A smile appeared on her face. I suggested she feel that smile as “joy in your heart and that whenever you smile your anger and meanness will dissipate.” She opened her eyes when ready. She had relished that joy in silence for a good five minutes. When debriefing I asked what she remembered. Sally said she “enjoyed having a peaceful rest floating freely in the water.” She presented as being in a light trance. The phenomena noted were relaxation, eye closure and slowing of muscular control and activity.

## **SESSION 2**

The HIP was also used to allow Sally to experience and enjoy the hypnotic experience. Her hand levitation created an intense smile. Other parts of this procedure became cues for her to induce trance under self-hypnosis. We recorded the session so she could practise at home. Sally also practised a guided self-hypnosis in this session. She decided to anchor this procedure by watching her hand touch her forehead when wanting to go into trance, then close her eyes and lower her hand to her lap taking three deep breaths and going into a deeper trance. Then she would consider whatever she most desired at a particular time and place in her life. This could be reducing anger in situ or planning to be calm during a future stressful day.

After session 2, Sally practised hypnosis between sessions before going to sleep at night, in a similar way to her earlier use of daytime meditation.

We used her cues for this self-hypnosis to induce and deepen trance at each session. Sally had total control of this. I would use yes-sets, to prime her about “looking forward to going into trance.”

A yes-set refers to a technique used by Milton Erickson (Kane & Olness, 2004). It involves three to four questions placed together in conversation about truisms. The conversation between the therapist and client is structured so that the client must respond with the word “Yes.” The effect of yes-sets is to enhance the client’s suggestibility and trance effect.

At the end of the trance phenomena, I would make an indirect suggestion, instructing Sally, “And anything else you need to hear, you can hear now. And then come on back, knowing it will be okay.”

## **SESSION 3**

Sally returned smiling and the most relaxed I had seen her. She reported being calm and thoughtful when her two-year-old son had a tantrum that morning.

She said she wanted to feel as peaceful as possible for the entire session.

We taped guided imagery I had pre-prepared, taken from Hammond (1990, pp. 223, 228) for the treatment of itch and reducing other dermatological irritation. I was able to use resources gained from the affect bridge made in the first session—her idea of “water therapy.” Living in the same locality, I knew what the most available stimuli were. The “ocean, waterfalls, creeks, rock pools, sea breeze, sand, sea grass, mud and clay” were all natural experiences Sally often enjoyed. In various situations, Sally could be “enjoying floating or bathing, sitting or standing in water”; using words like “cool,” “refreshing,” “relaxing,” “comforting” and “relieving.”

We also had Sally “making a cooling, healing ointment from moist clay, wet sand or mud” depending on where her imagery had taken her. She would apply this to her “affected areas of skin, how she wanted and when she wanted.” It was a very private experience with no ideomotor signalling.

#### **SESSION 4**

Sally had requested recording another script with different ideas for the last session. We were going to address her intimate relationship with her husband in a non-directed way. I used a script by Dr Kay F Thompson, described by Kane and Olness (2004), titled “Rose.” Auld (2008) rewrote the version I closely followed. This script proved an effective utilization of indirect hypnosis. This method was highly appropriate for a very personal and private problem (Appendix 1).

This script uses the metaphor of a seed growing, struggling and developing thorns (possibly representing anger in Sally’s case) to protect itself. Eventually it produces a bud, which opened to become an exquisite rose (possibly representing the vulva in Sally’s case) with beautiful colour, perfume and full soft petals. Direct positive suggestions stating her goals were made as posthypnotic suggestions. Milton Erickson emphasizes “speaking the client’s experiential language” (Lankton, 2008, p. 474). This was applied in this case (Appendix 2).

Feedback, while still in trance immediately after the metaphor, included Sally saying the experience was almost “orgasmic” as she felt tightness flow out of all body parts, including her genitals. Debriefing after coming fully out of trance, Sally said she would make the spare room in her house her private space for herself to paint, write, meditate and use self-hypnosis. It would be her space. She enjoyed this session most of all. The calm disposition Sally

displayed as she said goodbye was the most striking change noted from the restlessness and her stiff, tight physical appearance of late. The mean and angry expression on her face and in her voice, ever present over the past few days, had also disappeared.

## OUTCOMES

The affective component of Sally's trance response, that of feeling "orgasmic," appears to express a specific aspect of Sally's problem that she was not willing to discuss openly. This important component of Sally's trance response has the potential to be utilized to enhance her therapy goals because "orgasmic" sexual excitement is directly linked to her very personal concerns around sexual intimacy which are at the core of her problem. Being highly hypnotizable, Sally is able to use trance with the therapist and via self-hypnosis as a resource for establishing and rehearsing better alternatives: "love and understanding," as developed during psychotherapy, rather than "anger and meanness" from her own previous problem-saturated experience.

Sally did not return for long-term psychotherapy. After six months, a follow-up phone call was made. Sally was happy with her progress and using self-hypnosis most evenings before going to sleep at night. She had not been using the cortisone cream during the cooler months, but knew she may need to again in summer, when her itch was exacerbated by hot humid weather. She felt she was as free of anger and meanness as the "average mother." She was fortunate to experience "joy" in her heart "most days."

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## APPENDIX 1

### ROSE

(After Dr Kay F Thompson, Kane & Olness, 2004; Auld, 2008)

*It will flow very, very well, and very comfortably ... flowing into a performance that is like the real stage play of your life ... where you know exactly every line, every angle, every move and everything will go very, very well.*

*When you think about it ... it's almost as though four years ago, somebody planted a seed ... and that seed had to struggle and dig in, because it was planted on some ground that was pretty rocky,*

and didn't have much soil around for nourishment. And the seed survived, and it sprouted, and that tentative little plant started up ... and it really had a rough time in that rocky ground as it worked its way up ... turning this way and that, looking for the warmth of the sunlight among the rocks that stood there trying to beat it down and prevent its growth.

And then, even though it needed the rain, the rain was very hard when it came, so that it was overwhelming in its lesson of moisture and absorption. It was pelting, overpowering, pushing the seedling down, exhausted.

And the wind came along, too, and would blow it one way, and then the other way, and it would have to go the way of each gust, blowing that direction until it had to change.

But it was persistent, and it struggled, and it worked, and it grew.

Then it had to learn to look out for the little-green-sprout-eating animals, the rabbits, the deer. And finally the rocks came in handy, because it could hide behind them to protect itself. And gradually it developed a protective device of its own. It grew thorns, so that the animals would not be able to feed from it anymore.

And so the thorns helped it, and it was stronger and taller to withstand the rain and snow, and the yearly seasonal beatings ... down it got. And every once in a while, there was a little more sunshine, and some warmth. And finally summer came along.

And the sun shone bright and warm, and everything was so easy and friendly and nice ... and what do you know? The sprout grew a bud, and the bud became a blossom, and the flower was a rose of such exquisite and subtle beauty and colour that everyone stopped to exclaim!

And it was so surprising in its beauty, its strength and its colour that people could admire—saying, “Gee, I never would have believed something this good could have come from that seed.” But only the thing that was responsible for the seed being planted originally could look, and think, “Of course, I knew it could do just this.”

And maybe this is kind of where you are, because you have blossomed with this kind of struggle for survival, and you're still here, and you value the survival even more. Anything that has this much invested in its growth has to be stronger for it. What you have now is worth so much more because of what you have gone through to get it.

And you have a right to say, “Hey, I'm proud of myself, I've made it ... and when I [insert client's goals here] I'm going to be able to be calm, secure and display my competence and capabilities. And for some reason I don't need to be able to understand, I can be content.” And you can say this because it's okay for you to believe in yourself, just as you know I know you will do whatever you need to do. And anything else you need to hear, you can hear now. And then come on back, knowing it will be okay.

## APPENDIX 2

Near the end of this script, Sally's goals were embedded into the script as a posthypnotic suggestion: *When I communicate with my loved ones, especially my husband and daughter, I will get rid of meanness and anger and communicate with love and understanding.* Here, this client is able to picture her maladaptive coping mechanism disappearing and being replaced by a better alternative, developed during brief psychotherapy, resulting in symptom-free functioning—a powerful incentive in itself.

## INFORMATION FOR AUTHORS

1. Contributions should conform to the style outlined in the *Publication Manual of the American Psychological Association* (5th ed., 2001), except that spelling should conform to the *Macquarie Dictionary*. Page references in the following notes are to the *Publication Manual*. The attention of authors is especially drawn to the organizational overview in the fifth edition (pp. xiii–xxviii).
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