

Hypnosis for Complex Trauma Survivors: Four Case Studies

Maggie Wai-ling Poon
Hong Kong, China

Abstract

This report described a phased-oriented treatment of complex trauma in four Chinese women. Two women were survivors of childhood sexual abuse, one was a rape victim, and the other was a battered spouse. A phased-oriented treatment that tailored to the needs of the clients was used. The treatment framework consisted of three phases: stabilization, trauma processing, and integration. Hypnotic techniques had been used in these phases as means for grounding and stabilization, for accessing the traumatic memories, and for consolidating the gains. Data from self-reports, observation and objective measures indicates a significant reduction in the trauma symptoms after treatment.

Keywords: Complex trauma, phased-oriented treatment, stabilization, trauma processing, hypnosis.

Complex trauma refers to a type of trauma that occurs within an intimate relationship. The most common examples are childhood abuse, sexual assault, and domestic violence. Individuals exposed to complex trauma may suffer from a variety of psychological problems including the development of posttraumatic stress symptoms, anxiety, depression, affect dysregulation, disruption of one's sense of safety, relational difficulty and distorted self perception (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996; Curtois, 2004). The severity of these complex conditions varies according to the age and developmental stage at which the trauma occurred. In general, the younger the age the trauma occurs, the greater the effect will be (Van der Kolk, 2005).

Address correspondences and reprint requests to:

Maggie Wai-ling Poon
Clinical Psychological Unit 3, Social Welfare Department
14/F Cornwall House, Taikoo Place
979 King's Road
Quarry Bay, Hong Kong
Email: maggie@cuhk.edu.hk

Given the multiplicity of the problems faced by abuse survivors, complex trauma conditions are known to be difficult to treat (Curtois, 2004; Ford, Courtois, Steele, Van der Hart, & Nijenhuis, 2005). For fully effective treatment, it has been proposed that the treatment strategy should include a strategically staged, multimodal and transtheoretical approach (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996; Cloitre, Cohen, Koenen, & Han, 2002; Curtois, 2004; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005). Some proposed a three-phased treatment approach (Cardena, Maldonado, Van der Hart, & Spiegel, 2000; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005) and some adopted a four-phased approach (Philips, 2001). These three- or four-phased approaches all closely parallel the basic sequence of recovery from trauma, despite using different terminology in their descriptions. In general, treatment for complex trauma can be grouped into three stages: stabilization, trauma processing, and integration.

Apart from the staged approach, psychological treatment for complex trauma usually integrates skills from other theoretical approaches (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane, & Herman, 1996; Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005). Hypnosis is one of the techniques that has been found to be very useful in treating complex trauma (Spiegel, 1996; Desland, 1997; Kozłowska, 2004; Kwan, 2006; Poon, 2007a, 2007b). In the initial stage of treatment, hypnosis can be used for relaxation, sense of mastery and ego strengthening (Philips, 2001). In the second stage, hypnosis provides a platform for safe remembering of the traumatic memories. And in the last stage, hypnosis can be used to reframe the meaning of the trauma. This helps to achieve a more integrated personality functioning in the victims (Spiegel, 1993, 1996; Smith, 1993; Degun-Mather, 2001; Gafner & Benson, 2001; Kozłowska, 2004; Kwan, 2006).

This paper reports the psychological treatment for four Chinese women suffering from complex trauma. Two women were survivors of childhood sexual abuse (CSA) and the other two were victims of interpersonal trauma (rape and domestic violence). The treatment consisted of three phases integrating hypnosis with other therapeutic approaches (e.g. cognitive-behavioral therapy, emotion focused therapy and mindfulness techniques). All women were assessed to be moderately to highly hypnotizable by using the Stanford Hypnotic Clinical Scale for Adult (Morgan & Hilgard, 1978) prior to the commencement of treatment.

Background and Clinical Presentation

Table 1: Demographics and nature of abuse

Client	Type of Trauma	Nature of Trauma	Age*	Duration/Frequency of Trauma	Abuser
Ms. A	Childhood sexual abuse	fondling of breasts, exposure of genitals, attempted vaginal penetration	15	1 year; occurred 4-5 times	Father
Ms. B	Childhood sexual abuse	Fondling, digital penetration	8	2 years, multiple incidents	Cousin
Ms. C	Sexual assault	Date rape	17	single incident	Boy friend
Ms. D	Battered spouse	Degrading, diminishing calling names, pushing, threatening, once strangled	27	8 years; multiple incidents	Husband

*when trauma occurred

Ms. A, 33-year-old, was referred for therapy in relation to her affect dysregulation. She had frequent mood swing alternating between intense anger, sadness and sense of emptiness. Vague suicidal ideation was present, but was never put into action. Self was viewed as damaged, broken and misunderstood. She engaged in sexual experimentation in order to seek love and protection. Alcohol was used regularly to numb herself. She was particularly angry at her mother's rejection and disbelief upon disclosure of the sexual abuse.

Ms. B was 20 years old when she was referred for treatment of panic attack, unexplained anxiety and social withdrawal. When seen, her affect was flat with no gesticulations. She tended to block out her feeling from her conscious awareness. All she could feel was a strong sense of being unsafe. She developed panic attacks whenever she was away from home by herself. She also had nightmares with themes of dying or being chased by men. My interview with her revealed a non-disclosed history of childhood sexual abuse.

Ms. C, 21-year-old, was referred for therapy because she had flashbacks, nightmares (e.g. being chased by monster, raped by men), tension, panic attacks, depressed mood and thoughts of ending her life. She was startled, shaky and agitated on interview. She experienced a date rape five years ago. She managed to cope with the after effect until her pet dog died a year ago when she then developed a full blown diagnosis of posttraumatic stress disorder (PTSD).

Ms. D, 35-year-old, had experienced eight years of battering by her husband. She decided to leave him after she had had a near death experience of being strangled by him. At the time of referral, she suffered from trauma symptoms that included disturbed sleep, nightmares, flashbacks, anxiety, easy startling, and avoidance of cues that reminded her of the battering.

The Therapy

Four women were assessed either with the Trauma Symptom Checklist (Briere, J., 1995) or the Impact Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) at different phases of the treatment. The Trauma Symptom Inventory (TSI) was developed by Briere (1995). It is an instrument with good psychometric properties. It assesses posttraumatic stress symptoms and other psychological sequelae of trauma (e.g. self and other relations). The TSI asks participants to report how often various trauma symptoms have been experienced during the previous 6 months. Ten subscales are formed from the participants' responses. The subscales and their reliability alphas are as follows: Anxious arousal (AA, $\alpha = .86$), Depression (D, $\alpha = .91$), Anger/Irritability (AI, $\alpha = .90$), Intrusive Experience (IE, $\alpha = .89$), Defensive Avoidance (DA, $\alpha = .90$), Dissociation (DIS, $\alpha = .82$), Sexual Concern (SC, $\alpha = .87$), Dysfunctional Sexual Behavior (DSB, $\alpha = .85$), Impaired Self Reference (ISR, $\alpha = .88$), and Tension Reduction Behavior (TRB, $\alpha = .74$). T scores are used to interpret the severity of the stress symptoms. A T score of 65 or above is considered clinically significant.

The Impact of Event Scale (IES), developed by Horowitz, Wilner and Alvarez (1979), is another well validated instrument designed to assess posttraumatic stress symptoms. It is a 15-item self-report measure to assess the intrusion and avoidant symptoms in the respondents. The cut-off point for the total scores is 26, above which a moderate or severe impact is indicated. An unpublished local data indicates that IES is a good measure (reliability alphas for Intrusion and Avoidance subscales and Full scales are 0.92, 0.81 and 0.90 respectively) in assessing trauma symptoms in the Chinese population¹.

Phase one: Stabilization

Ms. A: This phase was focused on stabilization and management of her affect dysregulation (Kinniburgh, Blaustein, & Spinazzola, 2005). As she held strong pent-up emotions towards

her mother, the treatment began by exploring and educating her on feelings about the abuse. Given her initial resistance of using hypnosis, a Gestalt two-chair dialogue between her mother and her (Greenberg & Malcolm, 2002; Elliott, Watson, Goldman, & Greenberg, 2004) was included to help her make contact with a constellation of emotions surrounding the abuse. Acknowledging and naming of the painful emotions was coached during the process. She was also asked to connect these feelings to the physical sensations in her body. When she agreed to try hypnosis, it was used with a view to facilitating grounding and containment of her overwhelming emotions and to generating a personal safe place. This helped to increase her emotional awareness and the ability to return to a comfortable state of arousal after feeling overwhelmed. After 10 sessions of work, she became stabilized and was ready to move on to reliving her trauma.

Ms. B: The first phase began by educating her on feeling words that describe different emotions. Given her worry about using hypnosis, a Gestalt two-chair dialogue between her rational and fearful selves was introduced. This helped her to make sense of her anxiety and fear. Projective tasks like mutual story telling and drawing were included to enhance her emotional awareness and expression.

She agreed to use hypnosis after several sessions. Hypnosis was then used in a way that helped to reduce her tension and to enhance her perceived competence in problem solving. She generated a beach scene as her safe place in hypnosis, and whenever she felt fearful and anxious, she was instructed to visit this place in her mind again. Cognitive-behavioral techniques (e.g. keeping record of the frequency, beliefs and feelings of panic attack, disputation and challenging of dysfunctional thoughts) were also included to manage her panic attack. Through this work, she became more capable to identify and express her feelings, and consequently, her frequency and intensity of panic attacks decreased. As her functioning improved and restabilized, materials about her childhood abuse surfaced through intrusive mental activities during the day and in her sleep. It took 22 sessions' work on stabilizing and learning self regulation before she was ready to work on her trauma.

Ms. C: As she tended to dissociate and blank out when she was asked to establish an imagined safe place, mindfulness techniques (e.g. experiencing the here and now body sensations, observing and attending to breathing, distancing and non-attaching to feelings and thoughts; Linehan, 1993) was taught for emotional containment. When she discovered a comfortable body part, hypnosis was then used with suggestions on focusing this "body safe place" (Philips, 2000) to expand her feeling of calmness and serenity. Through practicing self-hypnosis, she could maintain this tranquil state when she had flashbacks at home. The stabilization work took eight sessions before moving on to the next phase of trauma reliving.

Ms. D: She readily generated a childhood pleasant scene as her safe place. Hypnotic suggestions were focused on finding comfort, serenity and sense of safety in this place. Suggestions on strengthening a sense of control, self competence and self worth were included in the hypnotic suggestions. This took a period of 6 sessions that resulted in the development of adequate personal resources for the subsequent work on the trauma.

Phase two: Trauma processing

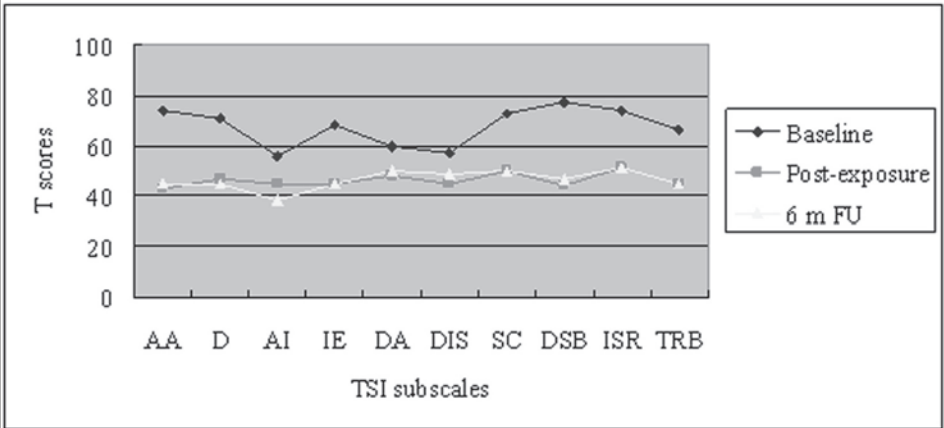
The hypnotic techniques of trauma reprocessing were very similar in these four women. Hypnosis was used to provide a safe and controlled context to acquire habituation to the conditioned stimuli that triggered off the symptoms. The women were instructed to review their earlier traumatic experiences while in trance, during which they reported their subjective level of distress on a scale ranged from 0 to 10. If the anxiety went up to 8 or above,

or any level that they felt intolerable, they should signal me for a pause, and at the same time recall their safe place to relax. The exposure would be continued once they gained comfortable control over the memories.

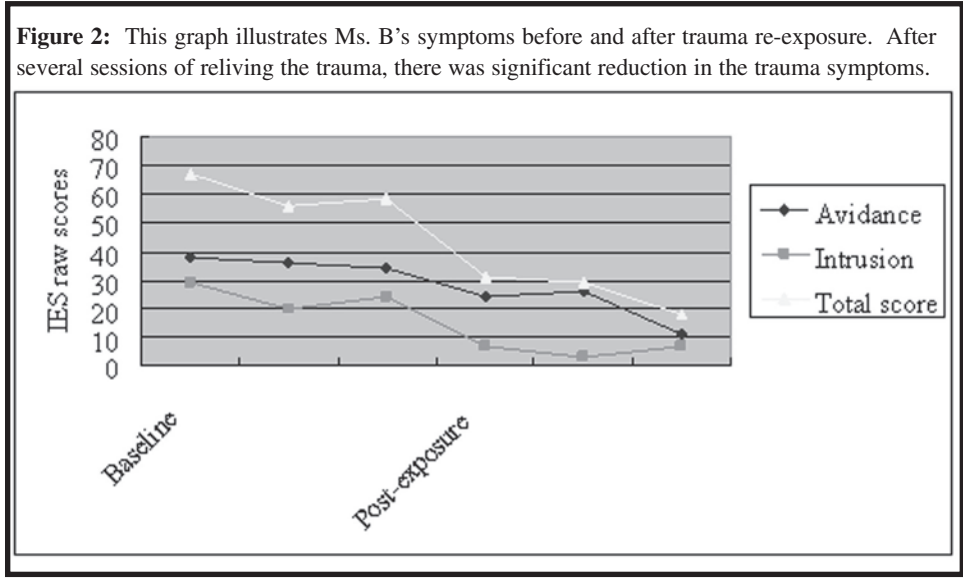
Split-screen technique (Spiegel & Spiegel, 1987, pp. 229-232) had also been used in the desensitization process. The women were suggested to visualize their safe place on one side of the screen and the disturbing images on the other. Suggestions of toleration and coping with the distressing image and the associated affect were made. When comfortable control was achieved, suggestions on alternating images between negative and positive images were made (Desland, 1997). This image shift was made for several times until they were no longer disturbed by the negative images. The desensitization would be repeated for different traumatic memories if necessary. Positive suggestions on safety when having flashbacks were typically made after the exposure.

Ms. A: Four sessions had been spent on the trauma re-exposure that resulted in complete resolution of the trauma symptoms. Figure 1 showed her scores on TSI in different stages of treatment.

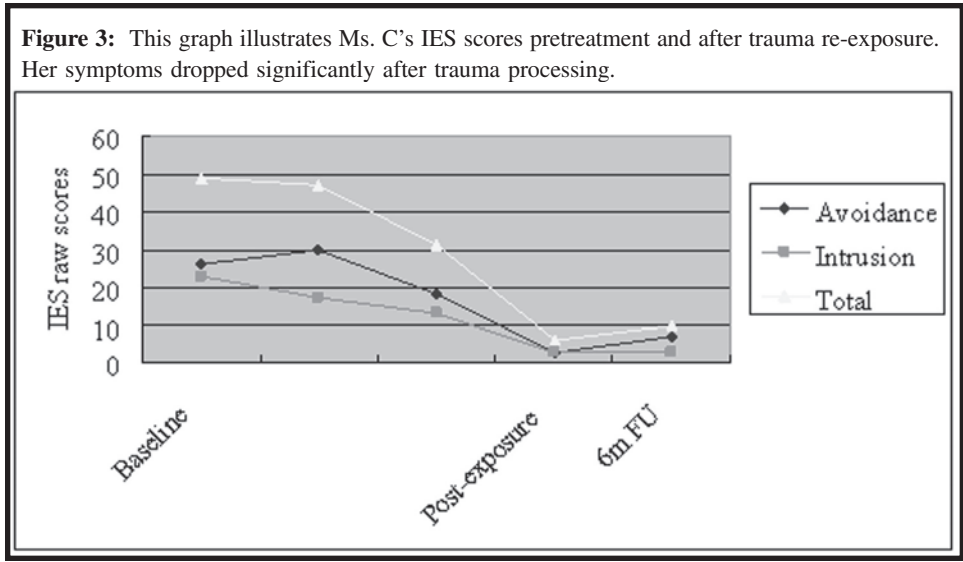
Figure 1: This graph compares Ms. A's trauma symptoms pre-treatment, after trauma reliving and at 6-month follow-up. All symptoms dropped below clinical level (i.e. T score less than 65) after trauma reliving and the gains could be maintained at 6-month follow-up.



Ms. B: The exposure work was carefully planned and conducted according to her wish and readiness. It was also interspersed with sessions on relaxation and discussion of the effect of past trauma in her present life experiences. After five sessions' work on direct trauma exposure, there was a significant reduction in her intrusions. However, avoidant behaviors (e.g. emotional numbing and avoidance of triggering stimuli) persisted immediately after direct exposure. Another session of revisiting the trauma in trance was done several sessions later. This resulted in significant reduction of avoidant behavior. Figure 2 showed her scores on the IES at different stages.

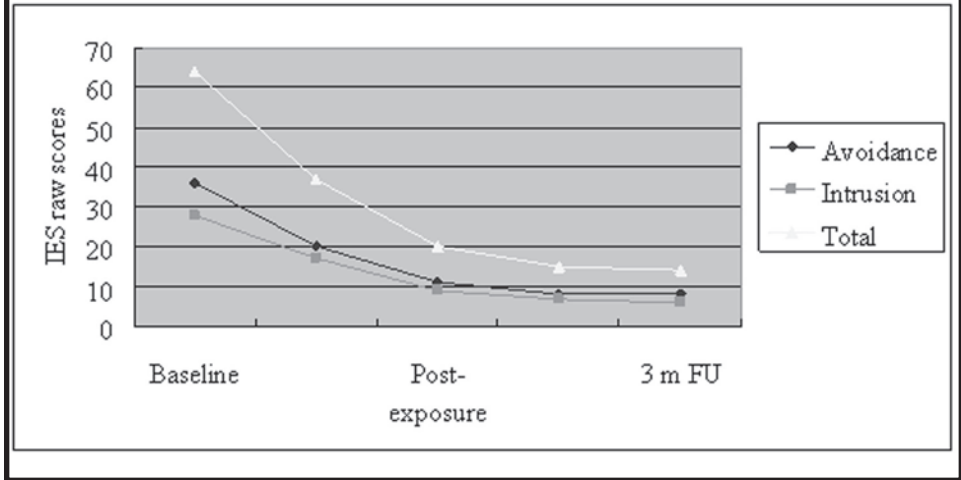


Ms. C: Three sessions had been spent on recalling the rape trauma that resulted in complete resolution of the trauma symptoms. The improvement can be maintained 6 months following trauma re-exposure. Figure 3 showed the IES scores at different stages of treatment.



Ms. D: Six sessions had been spent on working through the traumatic memories. There was significant reduction in the symptoms after the re-exposure. The improvements could be maintained at 3 month follow-up. Figure 4 showed her IES scores in different phases.

Figure 4: This graph illustrates Ms. D's IES scores pretreatment, after treatment and at 3 month follow-up. Her symptoms dropped significantly after treatment and the gains could be maintained at 3 month follow-up.



Phase three: Integration

Ms. A: The goal of this phase was to fine-tune the affect regulatory skills that she learned in phase one and to work on the development of more consistent, yet flexible, interpersonal boundaries. At the time of writing, she resumed working full time and was able to keep a job for nearly a year. This was a big improvement given she had not been able to maintain a job for more than one month in the past. Most important, she started to develop non-sexual relationships with men.

Ms. B: When she gained comfortable control over the intrusions, we shifted the focus of treatment to working on the daily tasks that would improve her interpersonal and work skills. This helped her resume a normal life in order to expand her life experiences and to enhance the sense of safety and self-control. At the time of writing, she began to experience a more fulfilling life by having a job after she had isolated herself at home for two years.

Ms. C: We focused on correcting her distorted beliefs about dating in this phase. This was important given she believed that if she dated a man, it implied that she agreed to have sex with him; and if she refused, the relationship would end. Apart from this, assertion training and self protection skills were also included. At 6 month follow-up, she became more capable to refuse men's advancement in her relationship with them.

Ms. D: This phase was focused on evaluating and consolidating the therapeutic gains by using hypnosis. She was instructed to visualize herself in the future or to write an autobiography in which she described herself as a persistent, competent, tough and confident person who had successfully overcome a big obstacle in life. At the close of the therapy, she was looking forward to examining the possibility of returning to work.

Discussion

This case study illustrates a phased-oriented integrative approach in the treatment of four survivors of complex trauma. Although the phases of treatment in these women were the same, there were slight variations in focus in order to meet their needs. In phase one treatment, the emphasis was placed on emotion regulation for Ms. A and Ms. B, and on containment of intrusions for Ms. C and Ms. D. In phase three treatment, while the overall focus was on integration of therapy gains into daily life, Ms. A and Ms. B required longer training on relational skills. This skill training frequently requires intensive input from the therapist and can be the most time consuming among the three phases in complex trauma treatment (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005).

The present study suggests that the age the trauma occurs and the duration the trauma lasts can affect the treatment outcome. While Ms. A and Ms. B are both survivors of childhood sexual abuse, Ms. A became symptom free after trauma re-exposure while Ms. B's avoidance symptoms are somewhat difficult to treat. It is noted that Ms. B experienced the abuse at a younger age and with a higher frequency than Ms. A. As for Ms. C, given the single incidence of her trauma, she required the least number of treatment sessions to achieve complete resolution of symptoms than the other women.

The treatment results of these four women show that hypnosis is an effective clinical tool in the treatment of complex trauma. Apart from using observation and self-report as indicators of treatment effectiveness, the treatment progress was also evidenced in the women's scores on the clinical scales of objective measures. Their scores dropped significantly after the second phase of trauma re-exposure, and this improvement could last for several months after treatment. It should be noted that hypnosis is not presented in this paper as the only approach in trauma therapy, rather it highlights the importance that hypnosis is an effective adjunct in psychotherapy. When used within a therapy framework that is grounded in principles of effective psychotherapy, hypnosis is an invaluable intervention tool. However, as shown by this case study, adequate rapport and explanation about hypnosis must be provided before clients feel comfortable to use the tool, especially in survivors of childhood abuse who tend not to trust people easily (Courtois, 2004).

Given that the aforementioned results were only based on four clients, conclusion regarding the efficacy of hypnosis in treating victims of complex trauma cannot be drawn at this stage. It is hoped that the continuation of applying hypnosis in trauma cases will enable data to be accumulated over a period of time, and this will definitely help in further evaluating the effectiveness of hypnosis as an adjunct in the treatment of complex trauma.

Footnote

¹Liaison Group on Test Management (2005). *Findings of Impact of Event Scale study using Hong Kong samples*. Clinical Psychological Services Branch, Social Welfare Department, Hong Kong.

References

- Briere, J. (1995). *Trauma Symptom Inventory: Professional manual*. United States: Psychological Assessment Resources, Inc.
- Cardena, E., Maldonado, J., van der Hart, O., & Spiegel, D. (2000). Hypnosis. In E.B. Foa, T.M. Keane, & M.J. Friedman (Eds.), *Effective treatments for PTSD* (pp.247-279). New York: The Guildford Press.
- Cloitre, M., Cohen, L.R., Koenen, K.C., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology*, *70*, 1067-1074.
- Courtois, C. (2004). Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training*, *41*, 412-425.

- Degun-Mather, M. (2001). The value of hypnosis in the treatment of chronic PTSD with dissociative fugues in a war veteran. *Contemporary Hypnosis, 18*(1), 4-13.
- Desland, M. (1997). Posttraumatic Stress Disorder. *Australian Journal of Clinical and Experimental Hypnosis, 25*(1), 61-73.
- Elliott, R., Watson, J.C., Goldman, R.N., & Greenberg, L.S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change*. Washington, DC: American Psychological Association.
- Ford, J.D., Courtois, C.A., Steele, K., van der Hart, O., & Nijenhuis, E.R.S. (2005). Treatment of complex posttraumatic self-dysregulation. *Journal of Traumatic Stress, 18*(5), 437-447.
- Gafner, G. & Benson, S. (2001). Indirect ego-strengthening in treating PTSD in immigrants from Central America. *Contemporary Hypnosis, 18*(3), 135-144.
- Greenberg, L.S., & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology, 70*(2), 406-416.
- Horowitz, M., Wilner, M., & Alvarez, W. (1979). Impact of event scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.
- Kinniburgh, K.J., Blaustein M., & Spinazzola, J. (2005). Attachment, self-regulation, and competency. *Psychiatric Annals, 35*(5), 424-430.
- Kozłowska, K. (2004). Hypnosis and memory of abuse. *Australian Journal of Clinical and Experimental Hypnosis, 32*(2), 189-205.
- Kwan, P.S.K. (2006). The application of hypnosis in the treatment of a woman with complex trauma. *Australian Journal of Clinical and Experimental Hypnosis, 34*(2), 204-215.
- Linehan, M.M. (1993). *Skills training manual for treating borderline personality disorder*. New York: The Guilford Press.
- Morgan, A.H. & Hilgard, J.R. (1978). Stanford Hypnotic Clinical Scale for Adults. *American Journal of Clinical Hypnosis, 21*, 134-137.
- Philips, M. (2001). Ericksonian approaches to dissociative disorders. In B. B. Geary, & J. Zeig (Eds.), *The Handbook of Ericksonian Psychotherapy* (pp. 313-332). Phoenix, AZ: The Milton H. Erickson Foundation Press.
- Philips, M. (2000). *Finding the energy to heal*. New York: A Norton professional book.
- Poon, W.M. (2007a). The value of using hypnosis in helping an adult survivor of childhood sexual abuse. *Contemporary Hypnosis, 24*(1), 30-37.
- Poon, W.M. (2007b). Using hypnosis in a battered woman with posttraumatic stress disorder. *Australian Journal of Clinical and Experimental Hypnosis, 35*(1), 63-74.
- Smith, W. (1993). Hypnotherapy with rape victims. In J. Rhue, S. Lynn, I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp. 479-491). Washington, DC: American Psychological Association.
- Spiegel, H. & Spiegel, D. (1987). *Trance and treatment: Clinical uses of hypnosis*. American Psychiatric Press, Inc.
- Spiegel, D. (1993). Hypnosis in the treatment of posttraumatic stress disorders. In J. Rhue, S. Lynn, I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp. 493-508). Washington, DC: American Psychological Association.
- Spiegel, D. (1996). Hypnosis in the treatment of posttraumatic stress disorder. In J. Rhue, S. Lynn, I. Kirsch (Eds.), *Casebook of Clinical Hypnosis* (pp. 99-111). Washington, DC: American Psychological Association.
- Van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F.S., McFarlane, A., & Herman, J.L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry, 153*, 83-93.
- Van der Kolk, B.A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress, 18*(5), 389-399.