Cognitive Hypnotherapy in Addressing the Posttraumatic Stress Disorder

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Abstract

The article presents a case study in which the posttraumatic stress disorder (PTSD) was approached in an integrative, psychiatric and psychotherapist manner. The client, a highly hypnotizable person aged 65, diagnosed with PTSD and panic attacks, required, on the psychiatrist’s recommendation, specific pharmacotherapy combined with psychotherapy. The psychotherapeutic intervention consisted of 23 sessions using cognitive-behavioural hypnosis techniques that led gradually to treating the symptoms, while the psychiatric treatment was no longer needed. This case study highlights the characteristics of an integrative approach that combines psychological and psychiatric intervention techniques.

Keywords: posttraumatic stress, hypnosis, cognitive-behavioural therapy

1. Introduction

Hypnosis, as a means of directly accessing the unconscious, can be used as adjuvant treatment in eclectic, psychodynamic and cognitive behavioural therapies. The inclusion of the cognitive behavioural therapy and hypnosis was facilitated by similar techniques and theoretical positions, such as the similarity between the cognitive strategies used in cognitive behavioural therapy and Milton Erickson’s therapeutic model. There are several clinical models that provide different perspectives for this integration (Chapman, 2006), such as the Cognitive Skills Model (Diamond, 1989), the Cognitive Development Model (Dowd, 1993) and the Cognitive Behavioural Hypnosis Model (Kirsch, 1993). Hypnosis has been combined with the cognitive behavioural therapy in treating anxiety disorders, pain, obesity, depression, hypertension, smoking cessation, etc.

The posttraumatic stress disorder (PTSD) is the only mental disorder with an easily identifiable etiology (Fontaine & Fontaine, 2008). According to the DSM-IV-TR criteria (American Psychiatric Association, 2003),
PTSD is a syndrome following the exposure to an extreme stressor. Extreme traumatic events are considered natural disasters, war, hostage taking, family or urban violence, rape, serious accidents and many other situations involving life threatening and the observation of another person's death. These events are even more traumatic when they appear suddenly and unexpectedly. The central issue in trauma is not pain or fear, but helplessness and weakness (Spiegel, 2001). The symptoms of PTSD refer to repeated intrusions of painful memories, efforts to avoid thoughts, feelings or activities that stir up memories, the inability to recall important aspects of the trauma, the feeling of being detached or estranged from the others, a decreasing interest in activities usually pleasant, a narrow range of emotions and the sense of a futile future. If individuals suffering from PTSD are in a spontaneous dissociative state during and immediately after the trauma, hypnosis can be helpful in getting to traumatic memories by recreating that precise kind of mental state (Spiegel, 2001). It is considered that people who have suffered trauma are rather easily hypnotizable, because patients with PTSD present dissociative symptoms and in hypnosis they can evoke traumatic memories (Dafinoiu & Vargha, 2003). The present case study examined the effects of adding hypnosis to a cognitive-behavioural treatment for treating PTSD. Bisson (2005) showed that the combination of hypnosis and cognitive behavioural therapy may reduce some acute stress disorder symptoms. Lynn et al. (2012) considered that hypnosis is fundamentally a cognitive-behavioral intervention which can be a useful adjunct to evidence-based cognitive-behavioral approaches for treating PTSD.

2. Case Study

2.1. Case history

D. is a retired person aged 65, who turned to a psychologist upon the psychiatrist's recommendation; he was diagnosed with delayed-onset PTSD and panic attacks. He has two daughters aged 34 and 40 years.

2.2. Main complaints

D. accuses intrusive thoughts about his wife’s death, nightmares, panic attacks, upper limbs’ tremor, avoidance behaviour.

2.3. Current disorders history / personal history and social / medical history

The year 2003 brought in the unexpected death of the client’s alcoholic wife, two days after an altercation during which he hit her in the presence of their younger daughter. The reason for the aggression was the fact that the mother forbade the daughter to visit her, because of her reproaches concerning alcohol abuse. Hence D.’s belief that “I sinned by caring more about my children than about my wife”. There had been an investigation, and at the police station, D. sent his son-in-law to give a statement, while he remained waiting nervously in the car. He feared the police since the communist times, when he was questioned concerning some illegally purchased gas cylinders. Prison was associated to death, because he felt incapable to adapt to the prison environment. The cause of his wife’s death, established by the forensic expert, was a hematoma caused by the oblique roof of the cellar (where the beverage was kept) that she seldom hit with her head.

Posttraumatic stress started half a year after his wife’s death. The symptoms evolved over six years, and in 2009, when he turned to the psychotherapist, the client was under psychiatric treatment with Rivotril, Rexetin and Mirzaten. In the past three years, D. has been showing avoidance behaviour in using the cellar and decided to stop producing wine (behavioural symptoms). He was thinking: “I was wrong to make wine; if there was wine in the cellar ... she drank” (cognitive symptoms). Intrusive thoughts, that preserved the feelings of guilt, were also his wife’s words who, right after the fight, said: “you slapped me forever”. The emotional symptoms consisted in dysfunctional negative emotions in the form of guilt: “I’m to blame for my wife’s death”, “I am guilty for not acting in time, I should have taken her to the doctor for the hematoma, and solve her drinking problem”. The
comparison between the idealized past and current feelings of loneliness further deepened his depression. D. describes himself as an honest, faithful and workaholic person. The patient has a brother and a sister. He describes his parents as good educators who knew how to educate him without using coercive or punitive methods. At 8 years old he fell into a well and almost drowned. Premorbidly, he rarely experienced panic attacks. He was also suffering from somatic diseases, such as prostate problems and vertigo syndrome.

2.4. Mental status

The patient was auto- and allo-psychically well oriented.

DSM –IV diagnosis : Axis I (clinical disorders): posttraumatic stress syndrome, panic attacks, although he also presents symptoms of depression, they have a secondary character compared to PTSD diagnosis and do not involve a separate diagnosis; Axis II (personality disorders): nothing clinically significant; Axis III (somatic diseases or other medical conditions): prostate problems, vertigo syndrome; Axis IV (psychosocial stressors): son-in-law consuming alcohol; Axis V (GAF- global assessment of functioning): GAF 50 (current: 2009).

2.5. Case conceptualization

Perhaps the traumatic event in the childhood (when the client fell into the well) turned during his life into a predisposing factor which, when experiencing another traumatic event (his wife’s death - trigger) and in the presence of other favouring conditions (for instance, alcohol consuming son-in-law), generated the onset of the clinical symptoms.

2.6. Intervention plan

2.6.1. List of problems

Panic attacks, unresolved grief, guilt, nightmares, tremor, intrusive memories, avoidance behaviour regarding the cellar.

2.6.2. Therapeutic objectives

The therapeutic objectives aimed at establishing a psychological report adjusted to psychotherapy, identifying and correcting dysfunctional beliefs, stabilizing and reducing the symptoms, treating traumatic memories, resuming daily activities, preventing relapse by identifying and preparing for risk.

2.6.3. Therapy progress

The establishment of the hypnotherapeutic relationship involved a process carried out in four stages (Linden, 2001). Firstly, there is the stage of psychological assessment, secondly, the educational stage during which the client is presented the concept of hypnosis (Enea & Dafinoiu, 2011), the third step consists in assessing hypnotisability (Enea & Dafinoiu, 2008; Enea & Dafinoiu, 2013), and the fourth stage is the practice of hypnosis and learning self-hypnosis.

The psycho-diagnosis, which involved the analysis of the data from the clinical interview (SCID), the P. A. Questionnaire, the Freiburg Personality Inventory, as well as the clinical observations, have shown a depressive-anxious configuration based on a personality structure with anxious-avoiding elements. The patient met 7 of the 13 panic attack criteria and he manifested the symptoms of re-experiencing predominance, avoidance and symptoms of hyper-excitation. There were no signs of experiencing psychotic or dissociative episodes.

The first issue addressed during the treatment was the issue of panic attacks (including panic about panic). The psychological evaluation revealed that the patient had two panic attacks a day. The therapeutic intervention aimed to eliminate the panic attacks involved the acquisition of specific strategies for managing anxiety, as well
as hyperventilation control and relaxation practices (isometric exercises, progressive muscle relaxation). The assessment of the level of hypnotizability showed that the patient was highly hypnotizable.

The identification and correction of dysfunctional beliefs was conducted simultaneously with the treatment of the traumatic memories by using the systematic desensitization version of the cognitive-behavioural hypnotherapy within which the therapeutic suggestions are identified through the cognitive restructuring technique called the Two-Column Method (Chapman, 2006). The aim of this method is to generate a set of rational thoughts that can be used as hypnotic suggestions to reduce the patient’s anxiety. In the wake state, the client was instructed to split a page into two columns; on one side of the page he put down the thoughts provoking anxiety and on the other side of the page the therapist listed the hypnotic suggestions later used in hypnosis, during the systematic desensitization. Also, in the treatment of traumatic memories during hypnosis were used: the age regression and progression, the emotional bridge (Hawkins, 2006) and the inhibition of intrusive images (through the technique “Stop”, exposure to traumatic memories, and the “anxiometer” technique). The technique “Stop” means blocking automatic intrusive thoughts by shouting aloud the word “Stop”. The “Anxiometer” is a mental imagery technique for assessing and modifying the level of anxiety, practiced during trance (Dafinoiu & Vargha, 2003). During trance, in the imaginary plane, the client was exposed to ranked anxiogene situations with the indication to evaluate and modify the level of anxious manifestations developed. The hierarchical list of anxiogene stimuli included the following situations with respect to which the systematic desensitization was carried out during trance: secured environment (a swim in the sea in Constanța); remembering the incident when he hit his wife (anxiety 20%), waiting for the result of the autopsy at the morgue (anxiety 30%), waiting in the car for his son-in-law to give the statement to the police (anxiety 50%), the way to the hospital by car, when his wife was in coma (anxiety 60%), signing the document by which he gave the consent for his wife’s surgical intervention (anxiety 60%), his son-in-law under the influence of alcohol (100%-panic attack), passing nearby the cellar (anxiety 100%), the appearance of any police officer at home (anxiety 100%). Simultaneously, hypnosis was used in identifying and modifying cognitive schemes, which are considered to operate at subconscious level, predisposing and helping in preserving automatic thoughts, dysfunctional behaviours and feelings of the client. Changing these schemes prevents relapse when the client is facing similar situations in life (David, 2006).

Addressing the issue of the unsolved mourning involved considering all the aspects related to his wife’s death. He idealized their relationship, which indicated a tendency to protect himself from the difficulty of acknowledging the feelings of hate and anger in a relationship (Lendrum & Syme, 2004). The patient was reassured that after a close person dies, it often happens to experience a wide range of feelings such as guilt, shame, fear or anger. The man was encouraged to think about what he felt about his wife and their relationship. The patient worked on accepting and encouraging the expression of feelings other than guilt. He began to experience a variety of new feelings such as anger, because she did not accept to receive help with her drinking problem, relief because she was not paralyzed.

The identified regret categories were: acts that he did, but he wishes he didn’t do (hitting his wife), acts that he did not achieve, but he wishes he did (forcing his wife to go to a rehab clinic), acts that others did, but he wishes they didn’t (he wishes his wife hadn’t had drinking problems), acts that others did not do, but he wishes they did (he wishes his wife had stopped drinking), comparisons between his present life and the past when his wife was alive. The 10 steps for moving beyond regrets were applied (Beazley, 2004): listing the regrets, regrets examination, changing toxic thought patterns, grieve losses, identifying compensations, identifying the lessons, developing compassion for and learning to forgive others, forgiving oneself, maintaining a life free of regrets. Other therapeutic techniques were used, such as metaphors, the empty chair technique and the “Box of Memories” (Chapman, 2006), as a means of adapting to the past. Of the psychotherapeutic prescriptions that the client had to accomplish, we mention: the application of rational thoughts during self-hypnosis, the paradoxical prescription not to avoid intrusive thoughts and to plan the time for reliving the memories, the task to clean and use the cellar (this last task was accomplished after the eighteenth session).
3. Conclusion

The present case study adds further evidence to the accumulating research (Lynn et al., 2012; Bryant et al., 2006) that integrating hypnosis with cognitive-behavioral treatment may increase benefits for clients suffering from PTSD. The intervention took place over 23 sessions, with a follow-up at 3 and 6 months. During the tenth session, the assessment revealed the absence of panic attacks and limb tremor. Consequently, the psychiatrist decided to eliminate the treatment with Rivotril and Rexetin, keeping only half the dose of Merzaten. At the end of the treatment, the patient no longer needed psychiatric treatment. The client’s strengths were the high level of hypnotizability and an increased motivation for psychotherapy, reflected in the application of psychotherapeutic prescriptions. The motivation came from the desire to increase the quality of his life. The limit of this research is that it used a case study for showing that hypnosis improves treatment outcome, but the generalization of this result needs randomized clinical trials.

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References