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HYPNOSIS IN COMPLEX TRAUMA AND BREAST CANCER PAIN: A SINGLE CASE STUDY

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Abstract

This case study addresses the effect of hypnosis on a range of problems associated with complex trauma (i.e. spouse abuse). It begins by exploring the specific symptoms that were generated in complex trauma and identifying that hypnosis is an appropriate treatment for these problems. A four-phase framework of treatment, taking into consideration the specific features of complex trauma which are distinct from single-episode or non-interpersonal trauma, was adopted. Breast cancer pain, another source of distress to the client, was also discussed. The therapeutic outcomes are described with reference to data collected from pre-, during and post-treatment, as well as from verbal feedback regarding Ms S's feelings about the therapy. The results indicate that hypnosis incorporated in the four-phase treatment framework could effectively eliminate the symptoms of complex trauma. Copyright © 2007 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

Key words: breast cancer pain, case study, complex trauma, hypnosis, phase-orientated treatment framework

Introduction: characteristics of complex trauma

According to the literature, the term 'complex trauma' refers to various forms of traumata that occur repeatedly and cumulatively, usually over a period of time and most often are of an interpersonal nature. It includes repetitive childhood physical and sexual abuse, all forms of domestic violence and attachment trauma occurring in the context of family and other intimate relationships, community violence, POW status, and the displacement of populations through ethnic cleansing, refugee status, relocation and human trafficking and prostitution. Spousal abuse, like Ms S's situation, is also included in the variety of complex trauma (Courtois, 2004; Chaikin and Prout, 2004; Taylor, Asmundson and Carleton, 2006).

Studies reveal that the features that are generated from complex trauma are more pervasive and complex than that of a single or non-interpersonal trauma. Some clinicians were aware of its complexity and tried to enumerate its characteristics. In Pelcovitz, Vander Kolk, Roth, Mandel, Kaplan and Resick's study (1997), they grouped the survivors' symptoms into seven areas of impairment, which were: difficulty in regulating anger; alterations in self-perception; dissociative episodes; idealizing a sexually abusive parent; inability to trust others; a sense of hopelessness; and somatization problems. In 1999, Allen et al. identified five clusters of associated features including alienated,

withdrawn, aggressive, suffering, and adaptive (Taylor et al., 2006). Their classifications were similar. Although they advocated that the ways of clustering needed to be further improved, their studies showed that apart from the symptomatic response to single trauma (e.g. dissociative episodes, difficulty in regulating anger, anxiety, withdrawn, alienated), some ancillary problems which were not exhaustively included in the diagnostic criteria of post-traumatic stress disorder (PTSD) in DSM-IV could be found from the survivors of complex trauma (e.g. alteration in self-perception, inability to trust others, idealizing a sexually abusive parent, suffering).

Recent studies also support that multiple-exposure participants have significantly higher levels of depression, anxiety, post-traumatic stress symptoms, self-hatred, self-destructive behaviours, interpersonal problems, and somatic problems than all other groups, including victims with no trauma exposure, exposure to a serious 'non-criterion A event', or exposure to unique non-interpersonal events due to the extensive psychological damage which accompanied it (Green, Goodman, Krupnick, Corcoran, Petty, Stockton and Stern, 2000; Ide and Paez, 2000; Clements and Sawhney, 2000; Brunet, Boyer, Weiss and Marmar, 2001; Chaikin and Prout, 2004; Courtois, 2004).

Consistent with the findings of the studies, Ms S – who experienced a long history of being battered by her husband – manifested not only the emotional responses to trauma, but also a variety of psychological problems that survivors of complex trauma have (e.g. negative self-image; distrust in people; negative social and moral value, etc.). She believed that she was inferior and deserved to be treated badly.

Considering the specific symptoms that are generated from complex trauma, two focuses of treatment – the first on facilitating change in target symptoms (e.g. the anxiety symptoms, intrusive thoughts about the trauma) by emphasizing the processing of the traumatic material; the second on enhancing self-efficacy and instilling hope in the client's psychological well-being – cannot be discounted in treating complex trauma.

The pain after breast cancer surgery

There are two main kinds of surgery used to treat breast cancer. The first is breast removal surgery (mastectomy) in which the whole breast is removed; the second is breast saving surgery (lumpectomy) in which the lump and lymph node in the breast are removed. Some women report pain, swelling, or numbness in the arm after undergoing breast cancer surgery.[1]

Ms S underwent breast saving surgery (lumpectomy) and radiation treatment in 2004. She reported pain, swelling and loss of strength in her right arm, shoulder and chest following treatment.

The pain that followed the breast cancer surgery caused considerable physical disability and emotional distress to Ms S. The reason was that the pain not only further hampered her confidence in taking care of herself; it also affected her job performance which resulted in her receiving reprimands from supervisors and customers. When she was scolded, she fell into an extremely anxious state which in turn led her to experience flashbacks of the traumatic experiences and negative feelings of being battered.

Although her doctor suggested she exercise to reduce the swelling and take pain relief medicines whenever she felt pain, these measures could only relieve the pain for a short while.

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Phase-orientated treatment framework

Hypnosis has promising results in pain management, reducing symptoms of PTSD, enhancing self-efficacy and instilling hope (Gafner and Benson, 2001; Macrae, 2001; Evans, 2003; Evans and Coman, 2003; German, 2004; Kozlowska, 2004; Tang, 2004; Detering, 2005; Perkins, 2005; Salerno, 2005).

There is numerous literature which discusses the use of hypnosis in the treatment of PTSD as defined in DSM-IV (for example, it includes cases of PTSD following accidents, natural disasters, or abortion; Walters and Oakley, 2002; Carter, 2005; Perkins, 2005). Brown and Fromm's three-phase framework, which has clear treatment focuses and procedures, is widely adopted by clinicians for treating PTSD and dissociative disorders (Brown, 1995; Walters and Oakley, 2002). The three stages include

(1) stabilization (management of intrusive re-experiencing symptoms, coping enhancement, etc.);
(2) systematic uncovering (graduated process of integrating memories, associated affect about the trauma into consciousness, using primarily free recall and secondarily memory integration methods under certain conditions); and
(3) post-integrative relational and self-development (Brown, 1995).

The focus of this treatment framework is directly on managing the symptomatic responses to the traumatic event(s) (e.g. intrusive thoughts or amnesia).

Considering the special features of complex trauma that are mentioned above (e.g. the vulnerability of the survivor, the negative self-perception of the survivor), apart from dealing with the symptomatic responses to the traumatic events, the mental preparation of the client (e.g. mental strengthening) is crucial before going onto deeper work. According to literature, many clients may not let go of their symptoms until they feel strong enough to do so. So, enhancing the self-efficacy of survivors who have experienced years of depression, anxiety and dissatisfaction with life is important at the first stage of treatment (Gafner and Benson, 2001; Stafrace, 2004; Shim and Haight, 2006). Under the circumstances of this case study, a four-phase framework of treatment that was modified by the three-phase mode was adopted in order to accommodate the needs of survivors of complex trauma such as Ms S.

The first and second phases are added before stepping into the stages of treating the trauma. The first phase focuses on preparing the client for treatment; the second phase on mental strengthening. The third phase, which is similar to the first and second phases of the three-phase framework, is on dealing with the trauma. The last phase, which is similar with the third phase of the three-phase framework, is on personal growth and future development. The hypnotic techniques that are used in each phase can be varied from case to case.

The four-phase framework

- *The first phase* concentrates on building resources, for example, gathering information from the client in order to enable understanding the formation of the problem and using this information during hypnotherapy; introducing hypnosis to the client; or practising induction techniques for relaxation with the aim of helping the client to progressively familiarize themself in a hypnotic state.

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- *The second phase* focuses on restructuring the survivor's negative beliefs in order to increase their self-efficacy. As mentioned before, this is crucial groundwork preceding treatment of the third phase because it can reduce the negative effect (e.g. mental collapse, resistance and anxiety) which can occur when dealing with traumatic events.
- *The third phase* focuses on restructuring the survivor's negative feelings and perception about their past traumatic experiences in order to facilitate their emotional processing.
- *The fourth phase* targets personal growth and future development, the purpose of which is to prevent a relapse.

Positive messages on further enhancing the survivor's self-efficacy are suggested in each session. This is necessary as it can foster their self-efficacy. The scripts of hypnosis are tailored to the survivor's particular needs and their negative self-perception. Audiotapes of the sessions are also made for the survivor's home practice.

More details about the application of the four-phase treatment framework to Ms S's condition are shown as follows.

Case study

Ms S, 46 years old, suffered from symptoms of complex trauma after having a long history of being battered by her husband, and pain disorder after undergoing breast cancer surgery.

Assessment

The following measures were administered before, during, and after therapy to assess Ms S's general levels of distress: The Impact of Event Scale (IES: Horowitz, Wilner and Alvarez, 1979); The Beck Depression Inventory (BDI: Beck and Steer, 1993); The Beck Anxiety Inventory (BAI: Beck and Steer, 1993).

The pre-therapy results indicated that the traumatic experiences had a moderate to severe impact on Ms S (IES = 49). The BDI and BAI were administered and the results indicated she had severe depression (BDI = 37) and severe anxiety (BAI = 35), but no suicidal ideation. She rated the severity of her pain at 7–10 based on the Subjective Units of Discomfort Scale (10 being at the most severe end of the scale).

Ms S scored 25 on the Creative Imagination Scale (Barber and Wilson, 1978), indicating she was in the medium to high range for imaginative suggestibility.

The therapy

Hypnosis was used to reduce her pain level and eliminate her symptoms of complex trauma (i.e. PTSD symptoms, alter her negative self-perception as well as improve her general mental health). Ms S received a total of 28 sessions spanning one and a half years.

First phase – building resources

Session 1

Ms S was informed of the PTSD diagnosis and the formation of her problems Hypnosis was introduced to Ms S with her consent on using it as a technique to achieve symptoms reduction and enhance self-efficacy through treatment. Some essential information was gathered with the aim of facilitating the progress of treatment during hypnotherapy (e.g.

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it was found that a natural environment was Ms S's preferred place for relaxation). Induction technique (e.g. progressive relaxation) for relaxation was practised.

Session 2

Induction and deepening techniques for relaxation, like progressive relaxation, breathing or garden script (Allen, 2002: 19–20) were practised with Ms S in this session with the aim of helping her to progressively familiarize herself with a hypnotic state. Natural environment imagery (e.g. a garden) was used as an 'anchor' to access the good feelings of her preferred safe place whenever she needed.

Second phase – mental strengthening

The purpose of this phase was to increase Ms S's self-efficacy and help her to generate a positive self-image. The themes of the suggestions were based mainly on her negative beliefs about herself (e.g. 'I cannot protect myself', 'I am a trouble maker', 'I am inferior', etc.)

Considering pain was the immediate concern in Ms S's situation, pain management was handled in this phase in order to enhance her sense of control and confidence to deal with the trauma. The focus of sessions 3 to 5 was therefore on pain control and healing.

According to Barber (1996), identifying the nature and source of the pain when the client first presents a complaint of pain is important, as clinicians can understand whether the pain signal indicates an injury or a disease that requires timely treatment. Moreover, it is helpful in formulating imaginative and effective hypnotic treatment plans. In view of the function of pain in this case (i.e. the pain of the arm alerted Ms S to her physical condition and reminded her to exercise to reduce the swelling in her arm), the technique of 'transfer of pain' or 'displacement' (Barber, 1996: 90), which transfers the pain from one part of the body to another where the pain is less disabling, was used.

Sessions 3, 4 and 5

Ms S was led into trance by breathing relaxation and counting technique (counting down from 20 to 1). Following induction and deepening techniques, direct suggestion positively focused on imagining a comfortable natural environment, such as a garden (it was mentioned in the first two sessions) or hot spring, was given. While she was in a deep trance, suggestions for pain control were given. It was suggested to her that she unite the pain in her right shoulder and transform it into a red ball. Then, the red ball rushed from her shoulder to her upper hand, lower hand and reached her palm. It then became smaller and moved to the tip of her little finger. Positive suggestions which were comprised of enhancing self-efficacy and the ability of assertiveness were suggested for increasing her confidence in controlling her pain. Post-hypnotic suggestion was made: 'Whenever you feel the pain of your hand, there is a voice in your inner-self which will ask you to transform the pain to a ball and then it will rush to the tip of your little finger immediately.' An audiotape was prepared and given to Ms S for home practice.

Ms S was responsive to the hypnotherapy. After three sessions on pain control, she reported that she had greater mastery over her pain than ever before. The remaining pain in the tip of her little finger did not bother her too much. Instead it served to remind her to do exercise to remove the swelling of her hand. Her pain did not interfere with her daily work performance. The treatment produced a ripple effect, and her anxiety of being scolded in her workplace was diminished.

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Session 6

Ms S was led into a deep trance by Breathing Relaxation Exercise, Stair (Allen, 2002: 19–20) and the imagination of a safe place (i.e. a garden). Direct suggestion focused positively on enhancing her self-efficacy was made after she fell into a deep trance. The suggestion was given as follows: 'You see a screen in the sky. On the screen, you see that you dare to express yourself calmly. You are different from your past. . . . The positive feelings form a power inside you and make you feel confident'. Ms S raised her finger to verify the acceptance response. Post-hypnotic suggestion was made as follows: 'Whenever you feel anxious, you can immediately feel your inner strength, and this strength helps you face your difficulties calmly and confidently.' This suggestion was repeated three times. (The concept of the screen, to follow, was based on an idea in one of the Milton H. Erickson's age regression techniques: Regression with the Visual Hallucination Screen Technique; Hammond, 1990. It has been used in treating an anorexia nervosa case by Hornyak, 1996.)

Session 7

Ms S reported that she felt good as she was able to express herself with confidence in her workplace and could achieve a sense of control by 'switching off the screen' when she thought about the unhappiness. (I did not mention this skill in session 6, but she could generalize what she had learnt in that session to manage unhappy experiences in daily life.) In this session, after she was led into a deep trance by breathing and stair script, it was suggested that she was in a garden. She looked at the sky and there was a screen. She saw her 'present self' (i.e. a positive self-image that was formed in the previous sessions) on the screen. A cruel customer was standing in front of her. She used a remote control to freeze him and then her 'present self' emerged to express herself calmly and confidently in front of him. Positive messages were suggested in the session, so that the stronger part of herself was reinforced. When she was out of the trance, Ms S reported feeling relaxed. A tape was prepared and given to her for home practice.

Enhancing her self-efficacy was important to enable Ms S to believe she had greater mastery of her own mind and inner potential. It would also facilitate her dealing with her traumatic experiences in the next phase.

Third phase – dealing with traumatic experiences

The purpose of the third phase was to eliminate Ms S's negative feelings about her past traumatic experiences so as to facilitate her emotional processing. Before starting the hypnotherapy, Ms S was told that she would be imagining parts of her negative experiences in the sessions. The notification before treatment was important, so she would not be astonished when it was suggested in trance. She was also notified that if she felt uncomfortable at any time during the hypnotherapy, she could let me know by telling me or by raising her finger, and I would help her handle the discomfort in the trance.

Sessions 8, 9 and 10

In sessions 8, 9 and 10, age regression technique was used to help Ms S go through the traumatic experiences. Considering the uncomfortable feelings she might have if she was put back to the intense situation in the first session of dealing with her trauma, a more psychologically distant technique of hypermnesia was chosen (Yapko, 2003). It was suggested Ms S see her past negative experiences in a screen after she was in a deep trance in her safe place. She expressed in the trance that she saw the negative experiences (e. g. she saw the hideous face of her ex-husband; her in-laws scolding and pushing a table

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at her; their not believing what she said), and these thoughts made her feel very anxious and distressed. It was then suggested that she use the remote control to stop the scene. Then, a 'present self' full of confidence and strength (making use of the confidence that she had formed in the previous sessions) was standing next to her 'past self' (her vulnerable self) to protect her from being hurt.

This technique came from Joan Murray-Jobsis's *Suggestions for Creative Self-Mothering* (Hammond, 1990: 328). It is a useful technique to help clients re-parent themselves, providing some restitution for the lack of nurturing and mothering that some clients experienced, and it helps to foster self-love and self-acceptance.

In addition to the above technique, another which could help Ms S differentiate her past from the present was used in the sessions. The suggestion was given: 'Your 'present self' is looking at them [her ex-husband and ex-in-laws]. You discover they are different from the past. Their hair has turned white and their physical condition is now weaker than before. They are unable to do anything to hurt you. When you look at yourself, you are different. You are now becoming stronger and mature . . .' This technique was crucial as it could eliminate Ms S's negative feelings and restructure her traumatic experiences by helping her differentiate the past from the present, and by reassuring her that she was now a grown-up who could protect herself. A hypnotic mourning ritual, in which Ms S said goodbye to her 'past self', was suggested to indicate the end of her past. This technique was modified by Ronald A. Havens' *Saying Goodbye to the Abused Child: An Approach for Use with Victims of Child Abuse and Trauma* (Hammond, 1990: 334).

Sessions 11, 12 and 13

With a view to further eliminate her negative feelings and restructure her negative perception about the past experiences, age regression technique (revivification) was used to help Ms S work through old memories. By adding new understandings and insights to her old memory, it helped her to re-shape the memory and reach new conclusions (Yapko, 2003).

In sessions 11, 12 and 13, after Ms S was led into a deep trance, a suggestion was given: 'Go back to the happy experiences which you have forgotten . . . you can remember all of them in trance . . .' Then, it was suggested she take a train back to the time after she got married. Although she encountered difficulties in the past, she did not forget the positive experiences she had. Examples of her happy experiences included a time when her sister-in-laws cooked porridge for her when she was sick, and a time when her mother, siblings and relatives supported her after learning of her difficulties. The purpose of recalling the positive experiences was to help her restructure her distorted thinking about the past experiences (e.g. she was not supported or understood by others; she was helpless and lonely). Alterations to cognitive processing in a trance help the client create alternative interpretations of the traumatic events to enable her to abreact, work through and restructure her thinking about the trauma, and resolve the conflict. Afterwards Ms S commented that she could remember the positive experiences she'd had and understood only her ex-husband and ex-in-laws, not everyone, had mistreated her in the past. Her pent-up emotions were released.

Positive messages, which were focused on enhancing her positive self-perception and had been suggested in the second phase (e.g. 'she could protect herself', 'she was strong', 'she had already tried her best' or 'it was not her fault'), were reinforced in each session. After six sessions of treatment at this phase, Ms S reported that she had gained in confidence and felt calm when traumatic events were mentioned.

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Fourth phase – future orientation

The fourth phase focused on enhancing Ms S's psychological well-being by instilling hope and promoting personal growth and future development with a view to helping her get rid of the traumatic experiences and start a new life. Eight sessions were hypnotic sessions and four were used to review Ms S's progress, for feedback and to deal with ad hoc issues. For example, in session 14, her relationship with her son and granddaughter was discussed. In sessions 16, 19 and 20, her relationship with her colleagues and some practical skills in avoiding making calculation mistakes in her job were discussed.

Session 15

In this session, she was led into a deep trance through a counting technique and imaging in a comfortable environment (i.e. a hot spring). Direct suggestions positively focusing on increasing her confidence to solve problems in her daily life were suggested, with the goal to further sustain her self-efficacy. The client reported that she felt dared to speak up for herself and was not anxious about it. Moreover, her relationship with her son improved and she felt his concern.

Sessions 17 and 18

In these two sessions, a metaphor about the early process of a plant's growth from a seed was suggested to facilitate her to grow. This technique came from Alcid M. Pelletier's *The Prominent Tree Metaphor* (Hammond, 1990: 139). The suggestion given was:

You see a plant has grown from a seed. It is growing bigger and bigger, and later it becomes a tree. During the process, it encounters the hot sun, strong winds and rain. Yet, these obstacles did not weigh down the tree. On the contrary, the tree learned to overcome all the obstacles and developed a hard outer bark to protect the tenderness within. We, like the tree, encounter a great deal of happiness as well as difficulties in our life. Our experiences make us stronger and more mature.

This metaphor helped her accept that she would experience happiness and unhappiness in life. Although we cannot control it, we can learn something from it. The goal was to help her use an alternative way to see her experiences.

Sessions 21 and 22

In sessions 21 and 22, age progression technique was added to the metaphor. The goal was to guide Ms S subjectively into the future, where she had the opportunity to imagine and experience the consequences of current or new choices. The suggestion given after The Prominent Tree Metaphor was: 'You are looking at the sky and see the summer's early dawn ('dawn' implies 'hope' and 'lively' in the Chinese culture). You feel relaxed and you can see your future from it as well.' Ms S said in the trance that she saw her granddaughter had grown up and she had her free time to do voluntary work. The purpose of this technique was to instill hope in Ms S to face her new life.

Sessions 23, 24 and 25

In these sessions, direct suggestions positively focusing on further increasing her confidence to solve problems in her daily life were suggested. The themes were aimed directly at the negative self-perception about herself. Rose's (1990) red balloon technique was used to help Ms S further 'offload' her negative feelings.

Ms S's psychological condition was assessed again in order to review her progress after receiving 25 treatment sessions. The results indicated she was making good prog-

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ress (IES = 5, little to mild impact; BDI = 3, minimal depression; BAI = 6, minimal anxiety).

Follow-up

Sessions 26, 27 and 28

Ms S's mental attitude gradually changed. She became more positive and was able to function more effectively in her daily environment. She reported taking vocational leave and travelled with her family members whenever she wanted to take a break. She enjoyed her life and did not care about comments from others. She got on well with her colleagues and family members. She understood that she could not avoid all the difficulties in life, but the most important thing was that she had confidence to handle them now. She would try her best to earn as much money as she could at this stage, and planned to retire several years later. Moreover, the pain did not bother her anymore.

Treatment sessions were tapered to weekly, biweekly, then monthly, and the case was terminated after one and a half years of hypnotherapy. Apart from her self-report, post-therapy results also indicated that she was responsive to psychotherapy (IES = 2, little to mild impact; BDI = 3, minimal depression; BAI = 3, minimal anxiety).

Conclusion

Phase-oriented treatment is widely used by clinicians for treating PTSD. The concept of phase-oriented treatment is not new; it was first created by Pierre Janet in the 1880s for treating what we today call PTSD. The three-phase treatment framework, proposed by Brown (1995), is adopted for treating PTSD and dissociative disorder as defined in DSM-IV. The focus of this treatment framework is on directly managing symptomatic responses to the traumatic event(s) (e.g. intrusive thoughts or amnesia).

Literature shows that symptoms generated from complex trauma are more pervasive than that of single or non-interpersonal trauma. My own experiences of working with survivors who have experienced complex trauma are consistent with such literature. That is, apart from the general emotional reaction to the trauma (e.g. anxiety, dissociation, intrusive images, etc.), ancillary problems are found in survivors of complex trauma (e.g. alterations of self-image, change of social or moral values). With a view to conclusively accommodate the needs of survivors of complex trauma, apart from dealing with the symptomatic responses to the traumatic events, the mental preparation of the client (e.g. mental strengthening) is important at the first stage of treatment. The rationale behind this is many clients may not let go of their symptoms until they feel strong enough to do so. (Gafner and Benson, 2001; Stafrace, 2004; Shim and Haight, 2006).

Under the circumstances, a four-phase framework of treatment, which was modified by the three-phase mode, was adopted in this case study. The first and second phases, focusing on preparing the client for treatment and mental strengthening, were added and stressed at the beginning of the four-phase model. The third phase, which is similar to the first and second phases of the three-phase framework, is on dealing with the trauma. The last phase, which is similar to the third phase of the three-phase framework, is on personal growth and future development. The hypnotic techniques that are used in each phase can be varied from case to case.

The effectiveness of hypnosis techniques incorporated into the four-phase treatment framework can be noted from the remarkable treatment outcome of Ms S. By understanding the formation of her problem and applying the technique of hypnosis appropriately, her progress was vivid and rapid. Since this is a single case study, the four-phase treat-

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ment framework which emphasizes mental strengthening at the beginning of the treatment needs to be repeated with complex trauma cases in order to make strong claims.

Note

1 As shown in an article about breast cancer: 'The lymph nodes and ducts which help drain fluid from tissue serve an important function in our body. If the lymph nodes are removed, fluid may back up in the arm and cause swelling. This extra fluid buildup puts extra pressure on the normal tissues, which can be uncomfortable to the client. Moreover, nerves in the armpit can become painful after they have been moved out of the way to remove the lymph nodes. This nerve damage pain can be shooting, cold, hot, tingly, pins or needles in the armpit going into the chest and shoulder and down the inner part of the arm' (Bosompra et al., 2002).

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