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THE VALUE OF USING HYPNOSIS IN HELPING AN ADULT SURVIVOR OF CHILDHOOD SEXUAL ABUSE

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Abstract

This report describes the successful treatment of a 33-year-old Chinese woman who had affect dysregulation and chronic trauma symptoms resulting from an intra-familial childhood sexual abuse. A strategically phased multimodal treatment tailored to the needs of the client was used. The treatment framework consisted of three phases: training on affect management, strengthening the ego and re-processing the trauma. Hypnosis was utilized as a means for grounding and stabilizing the overwhelming emotions; for addressing the negative self-schema; and also for re-processing the traumatic memories in a safe and controlled way. Data from self-reports, observation and objective measures indicates a significant reduction in the trauma symptoms. Copyright © 2007 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

Key words: affect management, childhood sexual abuse survivor, hypnosis, PTSD, strategically phased multimodal treatment

Introduction

Childhood sexual abuse (CSA) can be regarded as a form of complex trauma which usually comprises a series of traumatic events that occur within the context of interpersonal relationship (Oz, 2005). Without clinical intervention, the abused child may grow up to face life-long struggles with trauma-related symptoms, including poor affect regulation, hyperarousal, intrusive experiencing, self-destructive behaviour, unmodulated sexual involvement and other psychological as well as psychiatric problems (van der Kolk, Pelcovitz, Roth, Mandel, McFarlane and Herman, 1996). For instance, it was reported that about 48% to 85% of CSA survivors show a lifetime prevalence of post-traumatic disorder (PTSD) (e.g. Roth, Newman, Pelcovitz, van der Kolk and Mandel, 1997). Furthermore, it is also reported that CSA survivors may experience disturbances in their sense of self, including a distorted body image and a biased belief of themselves as helpless and damaged (van der Kolk et. al., 1996; Meston, Rellini and Heiman, 2006). In fact, it was suggested that the long-term consequences of CSA are largely related to the disturbances in the self schema (Putnam, 1990; Dutton, Burghardt, Perrin, Chrestman and Halle, 1994).

Given the multitude of problems that CSA survivors may have, effective treatment may require a strategically staged multimodal approach (van der Kolk et al., 1996), targeted at managing the intense affect, modifying the distorted self-schema and resolving the trauma impact. The following report describes the successful treatment of a Chinese woman with a history of CSA using a strategically staged multimodal treatment approach.

History

May[1] is a 33-year-old Chinese woman living in Hong Kong. She was born before her parents were formally married. In the old days, premarital pregnancy was considered as bringing great shame to the family. Because of this, she was entrusted to her grandmother since birth. But her grandmother died when she was 8 years old, and she returned home to live with her parents and the other five siblings. Returning home was not a good experience for May. She felt estranged, isolated, and not welcomed by her family, particularly her mother who seemed somehow biased against her.

May's family history appeared to be complicated with her father battering her mother and her father sexually abusing her when she was 15 years old. She disclosed it to her mother, but she refuted her complaints and blamed her for framing the father up. With the progression of the abuse, she ran away from home to seek shelter from her relatives. The news of the incest spread around the family circle, bringing shame to her parents. Her mother was so furious that she forbade May from returning home again.

May married in early twenties and had two daughters out of this marriage. Her marriage dissolved six years later and she agreed for her ex-spouse to have custody of the children. She worked to support herself but often changed her job in order to avoid the sexual harassment that happened in the workplace.

May firstly consulted me in 2003. She felt very upset that she was unable to visit her children. She dropped out from therapy after two assessment sessions but consulted me again in 2005 after she had terminated a relationship with a man. This man was described as very controlling and possessive. When she wanted to leave him, he stalked after her and threatened to kill her. With help from the police and a social worker, she finally left him.

Presenting problem

May looked miserable and gloomy on the second consultation. She had lost the motivation to work and felt her life was no longer worthwhile. Vague suicidal idea was present but she had no concrete plan of ending her life. Intrusive mental activity included flashbacks, during the day, of how her father molested her and her mother rejected her after the disclosure of the abuse. In her sleep, she had nightmares which included being chased by her father and threatened by her previous partner. She would awaken from these and could only fall back to sleep an hour or so later. If she still could not sleep, she would drink a glass or two of beer.

May tended to see herself as damaged, broken and not lovable (e.g. 'I'm no good, so mother hates me, husband divorces me . . .'). She believed that men are dangerous and they always wanted to take advantage on her. She avoided intimacy, feared rejection, yet craved love and protection. She developed relationships with men in the hope of feeling loved but this would only further traumatize her, making her feel worse and hurt.

Emotionally May wished to connect with her mother (her parents had divorced by that time), but her mother was very critical of her. She felt angry with her mother but at the same time she yearned for her love and protection. Her mood alternated between intense emotions of anger, sadness and anxiety, making her feel overwhelmed and confused. Sometimes she felt so upset that she either locked herself up to cry or she went to the pub to drink with her friends.

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Treatment Framework

May primarily sought treatment for dealing with problems of affect regulation. She said she wanted the treatment to help in 'balancing her emotions'. In order to suit her needs, the psychological treatment was planned strategically by using a multimodal approach. The treatment was basically an integration of cognitive behavioural and emotion focused therapies, combining with a variety of experiential techniques, such as hypnosis, body sculpting and mindfulness skills. The goals of the treatment were as follows:

- affect management training;
- ego strengthening;
- trauma resolution.

The first stage of affect management training included helping May to identify own feelings, to connect these feelings to experience, to express and communicate her feelings in an appropriate way, and to adjust to shifts in emotional experience so that she could return to a comfortable state of arousal. The second stage focused on enhancing her ego strength and self-esteem. The final stage worked on desensitizing her to become habituated to the conditioned stimuli that triggered off the symptoms, and at the same time to reintegrate the trauma into her meaning system.

The therapy

There was a total of 14 sessions with nine of these sessions including hypnotic intervention. The first two were spent on developing rapport, taking history and psychological assessment. May was educated about PTSD and the associated problems of mood disregulation and distorted self image. Given the nature of her problems, it was explained that a multimodal treatment approach (van der Kolk et. al., 1996; Paivio and Shimp, 1998) that included hypnosis would be used. Her hypnotic capacity was assessed in the third session. She scored 3 out of 5 on the Stanford Hypnotic Clinical Scale for Adults (SHCSA; Morgan and Hilgard, 1978), suggesting that she had moderate hypnotizability.

Phase one: affect management training

Phase one began by encouraging May to process her emotions by having an empty-chair dialogue with her mother. Empty-chair dialogue is a method deriving from Gestalt therapy. It is used to facilitate emotional processing of unresolved bad feelings toward significant others (Greenberg and Malcolm, 2002; Elliot, Watson, Goldman and Greenberg, 2004). In this dialogue, May expressed her fury toward mother for 'bad-mouthing' her as a prostitute. She also blamed her mother for abandoning her. She became very emotional whilst expressing her feelings. These painful emotions were acknowledged as a normal reaction to an unusual situation. She was also helped to name the different emotions she experienced, and at the same time she was asked to connect these feelings to the physical sensations that she experienced in her body.

Hypnosis was also used in this phase to facilitate grounding and containment of overwhelming emotions. Induction included instructing her to go into a trance by closing her eyes and attending to her breathing. Suggestions to breathe in comfort and to exhale tension and discomfort were made. Deepening constituted a 1–10 counts. In trance, she

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was asked to spend time relaxing herself in a place that she found safe and comfortable. Barnett's Yes-Set Method of ego strengthening (Hammond, 1990: 120) was used to enhance her self-esteem, to accept her own feelings and to promote self-regard.

When May was in trance, she came up with a picture of a small and helpless orphan who begged for her mother's love. This imagery was utilized as the theme of her therapy. May named the therapy journey as 'the growing of an orphan'. In order to allow her to experience her growth experientially, she was put into different sculptures to illustrate the process of how a small child grows into a strong and big adult, for examples, sitting on the floor to pretend her very small child self, kneeling down to pretend her older child self, and standing up to represent her present grown-up self.

During sculpting she was instructed to be aware of her body sensations and the associated feelings. This was a way to connect her affect with her physical experience, as well as to create the phenomenology of solution for her to experience. May reported feeling enlightened after the exercise. She came to the understanding that she was no longer a weak and dependent child, and from then on she had to stand up her for herself and to move forward.

Phase two: ego strengthening

In phase two the main focus was to establish a new self-identity and to develop a capacity for of self-love. Session 6 focused on helping May to narrate the abuse from an alternative point of view as if she was an adult witnessing the abuse again. This helped her to externalize the problem (Kamsler, 1998) and expanded her awareness of affect. She began to be aware of the multitude of feelings associated with the abuse, including helplessness, fear, self-blame, giving up, and feeling contaminated. She also came to the understanding that there was a wounded child inside her. But this wounded child was not totally bad. It had plenty of positive characteristics, including self-appreciation, resilience, courage, self-love and sacrifice. Therapy suggestion included saying goodbye to the abused child (Hammond, 1990: 334), and the possible co-existence of flaws and virtues within a person. Posthypnotic suggestion focused on integrating her personal strengths into self-identity.

Session 7 began with May describing her dislike for herself. She believed she was rotten and flawed. As she recounted her unpleasant childhood, she became agitated and emotional. She was asked to be aware of these emotions and the associated body sensations. Then she was put into trance with a suggestion to accept these feelings and sensations as normal since her life journey was tough and difficult. A metaphor of riding in a boat drifting down the river of life was used in the suggestion. The boat encountered various obstacles in the trip. Sometimes it was easy for her to steer the boat against the obstacles, but sometimes she had to find alternative way to bypass them. There might be slight damage to the boat as it made its way through these obstacles, but the difficulties only reminded her of her courage and persistence. Posthypnotic suggestion included a new self-identity as a brave pilot who had fought nobly and successfully in the river of life. In debriefing May reported to feel hopeful and she was clear of her wishes in life.

An age regression to a happy childhood experience in session 8 resulted in her going back to her 4-year-old self when she travelled with her grandmother in a boat. She suddenly experienced abreaction when she visualized the 4-year-old May growing up to an 8-year-old. She described how the 8-year-old May had entered into a frightening, dark tunnel. She refused to explore what was inside the tunnel but indicated her desire to escape from it as soon as possible. She finally made her way through the tunnel and on

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the way she left a big burden there. On debriefing she reported that the burden represented her yearning for mother's love.

May made steady progress in therapy. Sleep was improved with decreased nightmares. But from time to time she would be upset by her mother's criticism, and sometimes she felt like giving up on life. Session 9 focused on reinforcing the resilience that dwelled inside her. Positive suggestions based on the script by Murray-Jobsis's on finding and nurturing early life experiences, (Hammond, 1990: 326–8) were made. She was reminded that the little girl inside her had grown up, and on her way had flourished in capacities, competency and mastery. As an adult now, she could find alternative sources of solace, care and support that went beyond that her parents could provide. The session ended with suggestions of reliance on self for validation.

Phase three: trauma resolution

May had significant improvement in her intrusive experience after two phases of treatment. The frequency of having nightmares dropped and the intensity of intrusive images decreased. In phase 3, hypnosis was mainly used to provide a safe and controlled context for May to become habituated to the conditioned stimuli (e.g. mother's scolding, rejection and criticism) that triggered off the symptoms and also to restructure the meaning of the trauma.

An age regression to the scene of the childhood abuse was made in session 11. May was instructed that whenever her anxiety went up to 8 or more (Subjective Unit of Distress ranges from 0 to 10) she should signal me to pause. Her anxiety was ranged from 4 to 6 during the exposure. She was able to relax herself during the process. After the exposure, suggestions on self-reinforcement (Hammond, 1990: 149), letting go of the past and dumping the 'rubbish' (Hammond, 1990: 313) were given. Posthypnotic suggestion included visualizing two little angels standing by her side, one representing resilience, and the other hope for the future. In debriefing she reported that these two little angels looked like her daughters. She was delighted to have them supporting her and she felt strong enough to continue her life.

Split-screen technique (Spiegel and Spiegel, 1987: 229–32) had also been used in another session of trauma desensitization. It was suggested to May to visualize her safe place (the scene of riding in a boat with her grandmother at age 4) on one side of the screen and the disturbing image on the other. Suggestion of toleration and coping with the distressing image and the associated affect was made. When comfortable control was achieved, it was suggested that the images alternated between negative and positive (Desland, 1997). This shift occurred for several times until she was no longer disturbed by the negative images. The session ended with a suggestion of being able to stay calm and distant from the intrusions.

Integration work started after trauma exposure. May experienced an internal struggle between moving forward and giving up. In view of these conflicting aspects of self, a two-chair dialogue between her good and bad selves was used to facilitate the processing and integration of these two different parts (Elliott et. al., 2004: 219–41) in session 13. She was guided into an acceptance of these conflicting feelings and needs. Compassion and respect were facilitated. She was helped to negotiate between the two conflicting selves as with how their different as feelings and needs could be accommodated and integrated. Hypnosis was then used to reinforce the integration of these two different selves into a stronger, peaceful, resilient and unified person.

May was also taught mindfulness skills (e.g. experiencing the here and now body sensation, observing and attending to breaths, distancing and non-attaching to feelings

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and thoughts; Linehan, 1993: 63–9) for emotional containment in case she experienced flashbacks again. The issue of setting personal boundaries was also addressed in this phase. Cognitive intervention included clarification of the possible misinterpretation of neutral or friendly gestures of male colleagues as sexual harassment and the ways to differentiate them.

Results of psychological tests

May had been assessed on the Beck Depression II (BDI-II; Beck, Epstein, Brown and Steer, 1988) and the Trauma Symptom Inventory (TSI; Briere, J., 1995) in her first consultation in May 2003 (baseline). She dropped out from therapy after the assessment. She was again assessed on these two measures in her second consultation in May 2005 (pre-treatment). Post-therapy assessment was done one year later after the completion of the three phases of treatment (see Figures 1 and 2 for the results).

As shown, her score on the BDI-II at baseline is the same as her post-treatment score. This was not consistent with her clinical picture (she appeared to be mildly depressed) and her score on the Depression subscale of the TSI (she got a T score of 61 on this subscale, which is 1.1 standard deviation above mean, though it did not reach the range of clinical significance) at baseline. It was noted that she mainly endorsed on the items of self-blame, lethargy and indecisiveness on the BDI-II, but not on those items that check on low mood. This is likely due to the use of different Chinese wording to describe 'sadness' on these two measures. The one used in BDI-II seems to have a connotation of more severe depressed mood, whereas the one in TSI appears to be mild. As I have no opportunity to verify with May (she dropped out from therapy immediatley after the baseline assessment), this remains to be my hypothesis.

Nonetheless, the pre- and post- treatment data indicate a significant improvement in her symptoms of depression, anxiety, intrusions, sexual distress and personal identity. When her baseline and pre-treatment TSI profiles were compared, it showed that without

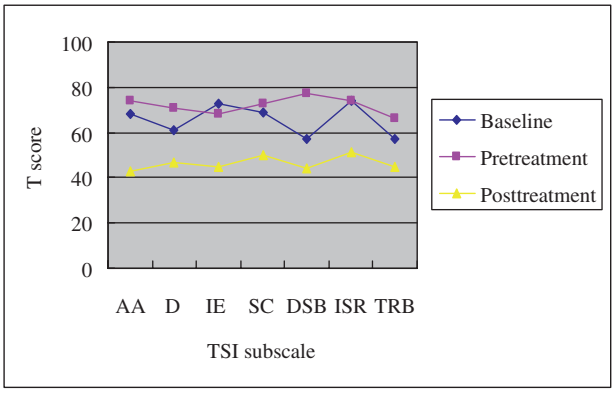

Figure 1. This graph illustrates client's improvement in trauma symptoms before and after receiving the 14 sessions of psychological treatment. This is reflected by her scores in various subscales of the Trauma Symptom Inventory (TSI), namely AA (Anxious Arousal), D (Depression), IE (Intrusive Experience), SC (Sexual Concern), DSB (Dysfunctional Sexual Behaviour), ISR (Impaired Self Reference), and TRB (Tension Reduction Behaviour). The baseline was obtained in May 2003. She dropped out from therapy after this assessment. This graph also shows that without therapy client's symptoms persist and some have actually increased in severity. All symptoms dropped below clinical level (i.e. T score less than 65) in post-treatment.

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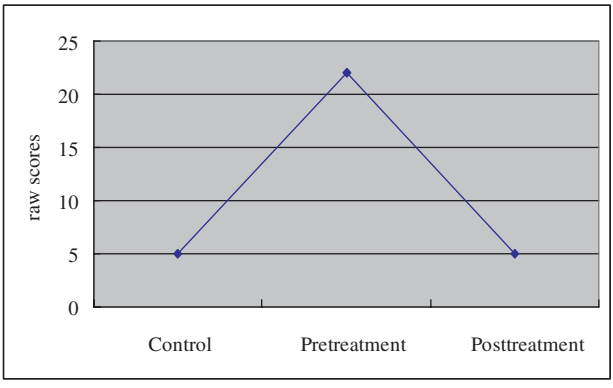

Figure 2. BDI-II scores in Baseline, pre-treatment and post-treatment.

receiving therapy her symptoms persisted and some had actually increased in severity (e.g. depression, anxiety, sexual distress and dysfunctional sexual behaviour). However, all these symptoms dropped below clinical level in post treatment. Such significant improvement cannot be explained away by other extraneous factors but to the effect of the therapy.

Discussion

This case demonstrates the effectiveness of a strategically staged treatment to manage the trauma symptoms in an adult survivor of childhood sexual abuse. Although the client in this case suffered from PTSD, she sought treatment primarily for dealing with problems of affect dysregulation and not for the typical PTSD symptoms of intrusion and hyperarousal. In view of this, the psychological treatment was planned firstly to help her to manage the labile mood and then to support her ego strength before reliving her traumatic experience.

This case also illustrates the successful use of a multimodal approach to CSA survivors. This is an individualized tailor-made approach that incorporates cognitive behavioural and emotion focused therapies, and at the same time uses hypnosis and other experiential techniques, including mindfulness skills, chair-work and body sculpting, as the tools to facilitate the change. All these techniques have proved to be effective in ameliorating the symptoms.

This case also highlights the importance that hypnosis has as an effective adjunct in psychotherapy. When hypnosis is used in conjunction with emotion processing by chair-work, it serves as grounding and containment; at the same time, it helps to consolidate what is learned in the process. Hypnosis also allows access to traumatic memories in a safe and controlled manner, as well desensitizing the client to his/her previous trauma.

Note

1 May is a pseudonym.

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