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An interdisciplinary  
journal dedicated to  
advancing the art,  
science and practice  
of hypnosis



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# Editorial

Greetings and welcome to all our readers for this first online edition of the Journal. It has been a long time coming as we worked hard to get the website set up so it could be much more accessible to everyone. And I do hope you enjoy the four articles we have for you in this issue.

Before you get into the reading we would like to make here a sincere note of appreciation and thanks for all the hard work that our previous editor Julie Dietrich gave to the journal. Julie was thorough and committed to her work and the printed editions she produced are evidence to this. Her detailed notes given to me as the new editor have been valuable. Thank you Julie.

The first Article is by Tenley Fukui, Wright Williams, Gabriel Tan and Mark Jensen titled Combining Hypnosis and Biofeedback to enhance chronic pain management. The authors have presented an American Case Study exploring the potential benefits of using hypnosis and biofeedback together with CBT to improve chronic pain management. The results are very positive.

Tracie O’Keefe is our second author and she examines Clinical hypnotherapy for stopping alcohol addiction: Building resilience in clients to reduce relapses and remain clean and sober. She reflects on the power of clinical hypnotherapy to bring about deep unconscious change and so assist recovery, especially when linked with the hypnotherapist’s level of training and expertise.

Anand Chandrasegaran from Malaysia is our third author and we welcome his presentation of the combined use of hypnotherapy and CBT in a Malaysian context. His manuscript is titled: A Single Case Study: Utilising Cognitive Behavioural Therapy Techniques into Hypnosis for Irritable Bowel Syndrome. The combination of the two approaches proved quite successful and we hope that the author will continue this work and share more of his findings.

The final paper in this issue is from Spanish author Edgar Alfonso Acuña Bermudez – Transference and Countertransference in Clinical Hypnosis. It is interesting research linking classical notions of transference and countertransference and how they can be present and play out in hypnotherapy.

This article reminds me of the words of Milton Erickson who encouraged us to use the patient's resistance: "Resistances constituting a part of the problem can be utilised by enhancing them and thereby permitting the patient to discover, under guidance, new ways of behaviour favourable to recovery" (1948 – In Erickson, 1980, Vol IV, Chap. 4, p. 48)

Now that we have the journal online, we really encourage practitioners and readers to submit more articles that will benefit all – research practical demonstrations, reflections, literature reviews and more. If we want to help bring positive change in today's world we must become visible, so do not be afraid to share the learning and wisdom you have gained with all of us so all readers will also benefit. As Richard Bandler once said:

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**“There are all kinds of things we can do in this world to make it a better place but we must start with ourselves.”**

**Richard Bandler**

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Thank you to each and everyone of you and I look forward to our next issue.

Dr Ann Moir-Bussy

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journaleditor@asch.com.au

*EDITOR'S NOTE: The terms “subconscious”, “unconscious” and “unconscious processes” are interchangeable, and will vary from article to article. Individual authors will determine what terminology they prefer to use, as this is predicated on the models of psychology, hypnotherapy, psychotherapy and other modalities in which they trained. Similarly, usage of the words “client” and “patient” will also vary from author to author, depending on their background and qualifications.*

# Combining Hypnosis and Biofeedback to enhance chronic pain management.

Tenley Fukui, LPC, Wright Williams, PhD., Gabriel Tan, PhD., and Mark P. Jensen, PhD.

Sydney, NSW, Australia

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## Abstract

Hypnosis and biofeedback have demonstrated efficacy for chronic pain management. However, using hypnosis and biofeedback together may have additive or synergistic effects, resulting in better outcomes than if either are provided alone. In this paper we present a case study which explores the potential benefits of using hypnosis and biofeedback together with cognitive behavioral therapy (CBT) for improving chronic pain management in a patient with Postural Orthostatic Tachycardic Syndrome (POTS) and its co-occurring anxiety, depression, insomnia, attention-deficit/hyperactivity disorder (ADHD) and Dissociative Identity Disorder (DID) symptoms.

## Introduction

Over the last thirty years, cognitive behavioral therapy (CBT) has become a primary psychosocial treatment for clients with chronic pain. There is evidence for CBT's efficacy in many randomized control trials for treating numerous types of chronic pain (Ehde, Dillworth, & Turner, 2014; Knoerl, Lavoie Smith, & Weisberg, 2016). However, the client whose case study is presented here had already participated in a pain management clinic with CBT and biofeedback, and he felt that these treatments alone did not provide him with sufficient pain relief. By adding hypnosis and active biofeedback, the hope was that treatment could be more helpful for this complex case.

The most recent American Psychological Association's Division 30 (Society of Psychological Hypnosis) definition of hypnosis states that it is a "...*state of consciousness* [italics added] involving focused attention and reduced peripheral awareness characterized by an enhanced capacity for response to suggestion" (Elkins, Barabasz, Council, & Spiegel, 2015, p. 6). This definition emphasizes the importance of a client's state of readiness to accept suggestions as a key component of hypnosis.

Consistent with this idea, hypnosis often involves subjective phenomena reflecting changes in the subject's psychological and physiological state. Hypnosis has also been shown to be associated with subjective psychological states associated with brain oscillations (Jensen, Adachi, & Hakimian, 2015). In addition, hypnosis has been hypothesized to result in what O'Connell and Orne (1968) called "central relaxation" which includes a "relaxation" of the autonomic nervous system (ANS), as well as perceived muscle relaxation. Given that the ANS (Biondi & Valentini, 2014) and central nervous system CNS (e.g., Caro & Winter, 2011) are known to be influenced by biofeedback, it would be reasonable to hypothesize that using biofeedback that targets the biological responses associated with hypnosis (e.g., neurofeedback to enhance the power of theta oscillations; cf. Jensen et al, 2016) could potentially enhance the effects of hypnosis. Brain oscillations are also known as brain waves. Similarly, it would be reasonable to hypothesize that using hypnosis to target the same physiological responses that are the target of biofeedback could enhance the beneficial effects of biofeedback treatment.

The Association for Applied Psychophysiology and Biofeedback (AAPB) defines biofeedback as "...a process that enables an individual to learn how to change physiological activity for the purposes of improving health and performance" (Schwartz, 2010, p. 90). Precise instruments can measure physiological activity such as brain oscillations, heart rate variability, breathing, muscle activity, and skin temperature. These instruments can then "feed back" information to the user (Schwartz, 2010). The presentation of this information—often in conjunction with changes in thinking, emotions, and behavior—supports targeted physiological processes. Because these processes are also associated with and in some cases may underlie mechanisms associated with important outcomes (e.g., pain, anxiety, perceived stress, etc.), biofeedback can be used to help individuals get control over their sensations, perceptions, and mood (Kline, 1979).

Both hypnosis (Adachi, Fujino, Nakae, Mashimo & Sasaki, 2014; Jensen & Patterson, 2014) and biofeedback (Caro & Winter, 2011; Kubik & Biedron, 2013; Nestoriuc, Rief, & Martin, 2008) have demonstrated efficacy for chronic pain management. However, using hypnosis and biofeedback together (McGrady, Bush, & Grubb, 1997; McGrady, et al., 2003) may have additive or synergistic effects, resulting in better outcomes than if either are provided alone (e.g., Andreychuk & Skriver, 1975; Friedman & Taub, 1984; Jensen et al., 2016).

## **Case Study**

### ***Case Description and Initial Assessment***

The client was a 16-year-old male with Postural Orthostatic Tachycardic Syndrome (POTS), presenting with multiple co-morbid symptoms and problems including severe chronic pain, severe anxiety (Beck Anxiety Inventory Score = 41, BAI; Osman et al., 2002), mild depression with suicidal ideation (Beck Depression Inventory Scale = 17; BDI; Beck, Steer, Ball, & Ranieri, 1996), homicidal ideation, syncope, neuropathic pain (with allodynia), sleep apnea, headache, extreme fatigue, insomnia, gastrointestinal problems, bladder pain, heat intolerance, exercise intolerance, an elevated Dissociative Experience Scale score (DES score

= 67; Carlson et al., 1993), and ADHD (difficulties attending more than 15 minutes). His elevated DES score may have been due to his increased chronic pain (Fishbain, Cutler, Rosomoff, & Rosomoff, 2001).

The patient reported he had ADHD his entire life. He took Concerta for two years, but at the time he started with this therapist it had been recently discontinued. During the course of treatment, Focalin was added for ADHD symptoms and then discontinued as he improved with EEG biofeedback (see below). Although formal hypnotizability testing was never performed, his predisposition to nightmares (Belicki & Belicki, 1986), as well as his ability to easily access imagery (Ray, 1997) suggested that he had at least a moderate level of trait hypnotizability.

The American Autonomic Society defines POTS as a collection of multiple disorders (Raj & Sheldon, 2016). Specifically, in an individual with POTS, changing from a supine to an upright position causes an abnormally large increase in heart rate, called sinus tachycardia (Xu, Jin & Du, 2016). Clinical orthostatic symptoms may include dizziness, headache, chest tightness, chest pain, pale complexion, fatigue, presyncope, syncope, difficulty concentrating, lightheadedness, palpitations and tremulousness; bloating, nausea, diarrhea, abdominal pain, exercise intolerance, sleep disturbance and migraine (Jones, Shaw and Raj, 2016; Xu et al, 2016). Affective symptoms in POTS appear to be driven by vigilance of the physical sensations and symptoms associated with anxiety (Owens, Low, Iodice, Critchley, & Mathias, 2017). In addition, POTS often have comorbidities such as chronic pain (Ojha, Chelimsky, & Chelimsky, 2011; Pederson & Brook, 2017) and both depression and inattention (Raj et al., 2009).

The treatment of POTS is focused on symptom relief (Jones et al, 2016). Perhaps because there are multiple potential symptoms, there are no treatments that have been shown to be uniformly effective (Raj & Sheldon, 2016). The management of POTS includes both non-pharmacological and pharmacological treatments (Xu, et al., 2016). Non-pharmacological treatments include: oral rehydration salts, exercise, education about good sleep hygiene, biofeedback, coping skills training, counseling, tracking and avoiding symptom triggers and biobehavioral strategies (Bhatia, Kizilbash, & Ahrens, 2016; Heyer, 2017). Symptoms of POTS can be exacerbated by dehydration, heat, and exercise (Raj & Sheldon, 2016). Pharmacological treatments can include beta-adrenoreceptor blockers and alpha-adrenoreceptor agonists (Xu, et al. 2016).

The patient who is the focus of this case report was initially diagnosed by his physician with hereditary spastic paraplegia, an inherited disorder with spasticity and weakness of the lower extremities (Antczak et al., 2019). However, over the course of treatment he was eventually diagnosed with POTS. He reported he had severe pain in his entire body. Specifically, he presented with bilateral leg pain, hip pain, back pain, arm pain and hand pain, a unilateral foot drop, his leg would freeze; he would have intermittent blue, black or gray feet a couple of times per week; he would intermittently pass out in the shower. He reported that

he could no longer play soccer or attend school due to severe pain. During his initial interview he rated his worst pain intensity in the past week as a “10” on a 0 (“No pain”) to 10 (“Worst pain you can imagine”) numerical rating scale (NRS). His least and average pain in the past week were a “5” and “8,” respectively. He indicated in the past week his pain interfered with his mood at a level of “6,” (0 = “No interference” and 10 = “Interferes completely”), his mobility at a level of “7,” his normal work (including school and housework) at a level of “6,” and with sleep at a level of “9.” His score on the Modified Leeds Neuropathic Symptoms and Signs scale was a 24, consistent with a diagnosis of neuropathic pain with allodynia (Bennett, 2001). Following the initial interview, at the end of his first session he was taught diaphragmatic breathing for anxiety and pain relief. He was also provided a brief guided imagery experience to teach him that he could relax himself to better control his comfort level.

### **Treatment Plan**

During the second session, we discussed a tentative treatment plan. The plan was similar to that described in a case series study of patients with syncope and migraine pain (McGrady et al., 1997), as well as a controlled pilot study which used EMG and temperature biofeedback-assisted relaxation therapy with autogenics for treating a patient with POTS with co-morbid anxiety and depression (McGrady et al., 2003). Hypnosis was chosen to promote relaxation, reduce pain and improve mood. In addition, biofeedback was considered given evidence that biofeedback can decrease chronic pain (Jensen et al., 2009; Jensen, Hakimian, Sherlin, & Fregni, 2008; Sime, 2004; Jensen et al., 2013). A second reason for using EEG biofeedback, specifically, was to address the client’s ADHD symptoms. Previous research has shown that EEG-biofeedback improves attention in children and young adults with ADHD; (Monastra, Monastra, & George, 2002; Arns, De Ridder, Strehl, Breteler, & Coenen, 2010). Thus, my (TF’s) hypothesis was that this ADHD client might benefit using a similar sensorimotor rhythm (SMR) protocol (Egner & Gruzelier, 2001; Caro & Winter, 2011).

Although there is no strong evidence preferring one electrode site over another for EEG biofeedback when treating pain (Jensen et al., 2013), SMR training has been found to be useful in two published studies for treating both attention problems and pain (Caro & Winter, 2011), as well as for treatment of depression and anxiety (Kayiran, Dursun, Dursun, Ermutlu, & Karamursel, 2010). However, given that other researchers found that neurofeedback protocols should be individualized to be most effective (Bazanov & Aftanas, 2010; Hammond, 2010) this individual’s neurofeedback protocol was individualized as his symptoms changed (Jensen et al., 2013).

Thus, the plan was for the initial session to teach him diaphragmatic breathing and visualization to facilitate a reduction in anxiety, perceived muscle tension and pain intensity. The bulk of all of the following sessions (sessions 2 to 68) were to use cognitive behavioral therapy (CBT) to reduce suicidal ideation, homicidal ideation, anxiety/stress, pain and syncope. Our treatment goals also included improved sleep quality, anger management, improved family relationships, coping

skill development, avoidance of triggers for syncope, and the encouragement and maintenance of a moderate exercise routine.

The second session included training in self-hypnosis for relaxation and reductions in pain, stress, and muscle tension. This training continued through session 26. Each hypnosis training session was audio recorded, and he was asked to practice hypnosis daily by listening to audio recordings of the sessions and engaging in brief 2-3 minutes self-hypnosis “breaks” throughout the day (Jensen, 2011). He was also encouraged to practice diaphragmatic breathing for at least 5 minutes daily. EMG and temperature biofeedback were added to hypnosis treatment at the ninth session to train him to recognize increases and decreases in muscle tension, and to help him gain a sense of control over his discomfort and anxiety. I [TF] anticipated that this would also decrease his pain, given that temperature biofeedback and autogenic training were shown to decrease headache (Morrill & Blanchard, 1989).

EMG biofeedback training continued for the next 17 sessions (through session 26); training lasted about 20 minutes. During sessions 2-8 hypnotic suggestions were given for decreasing uncomfortableness, offering breakthrough pain relief, decreasing sleep ruminations, transforming pain, sensory substitution and decreased unpleasantness. As before, these sessions were audio recorded and the patient was encouraged to listen to the recordings daily between sessions. During sessions 2-8 topics discussed using CBT included: decreasing suicidal ideation, decreasing chronic pain severity, changing the meaning of pain (from a maladaptive view to an adaptive one), and anger management.

He had been reluctant to have “breathing” biofeedback where “he imagined a thermometer on his forehead,” since he had experienced no benefit from this treatment approach in a previous pain clinic where he was left alone in a dark room unattended to practice this exercise. He was introduced to EMG biofeedback to help him notice his muscle tension with the therapist (TF) actively attending his progress. Following the procedures described by Nestoriuc and colleagues (Nestoriuc et al., 2008), the patient was taught to decrease muscle tension through EMG biofeedback during sessions 9 – 26, and to decrease pain while simultaneously receiving hypnosis during these EMG biofeedback sessions. Temperature biofeedback was also administered during these sessions to promote relaxation.

Assessment was conducted using equipment and software by Stens Corporation. Biofeedback and neurofeedback treatment were conducted using a Nexus-10 instrument. The leg pain that had decreased during sessions 2- 8 when hypnosis alone was provided decreased even more with the addition of EMG biofeedback (see Table 1). By sessions 25 and 26 with hypnosis and EMG biofeedback his pain decreased to a level of “0” on the 0-10 NRS. For EMG biofeedback for sessions 9-26 his temperature biofeedback averaged 94° F.

**Table 1. Summary of treatments provided and treatment course.**

<b>Session Number(s)</b>	<b>Treatment(s) provided</b>	<b>Pre-/Post-Session Pain Intensity</b>	<b>Average EMG/EEG bandwidth power, Pre/Post Session</b>
1	Initial evaluation, breathing relaxation, visualization	8-6 (NRS 0-10)	
<b>Comments</b> Initial assessment and treatment planning.			
2-8	CBT, HYP	7-8/6 (NRS 0-10)	
<b>Comments</b> HYP suggestions targeted pain reduction, coping with pain and improved sleep. CBT targeted decreasing suicidal ideation, decreasing pain and anger.			
9-26	CBT, ego state therapy, HYP, EMG-BF	9/0 (NRS 0-10)	1.8/3.5
<b>Comments</b> CBT targeted anger, ego states, maturity. HYP suggestions targeted safe place for ego states. EMG-BF targeted muscle tension reduction.			
27-42	CBT, ego state therapy, EEG-BF	8/0 (NRS 0-10)	11.8/6.5 Theta 6.6/3.2 Beta 6.2/3.8 SMR
<b>Comments</b> CBT targeted cognitive distortions, pain and family relationships, decreasing hip pain. EEG-BF used SMR protocol (see Figure 1).			
43-57	CBT, ego state therapy, EEG-BF	7-8/4-5 (NRS 0-10)	6.5/3.7 Theta 5.0/3.5 Beta 4.8/3.5 SMR
<b>Comments</b> CBT targeted decreasing pain, ego states, and pain identity. EEG-BF used SMR protocol.			
58-66	CBT, HYP, EEG-BF	7/0 (NRS 0-10)	1) 7.3/6.9 Theta 4.33/0.3 Beta 3.9/2.7 SMR 2) 6.9/6.4 Theta 5.5/6.4 Alpha 36.3/8.9 Delta 3.1/3.7 High Beta
<b>Comments</b> CBT targeted stress and pain, pain alter and increase self-esteem. HYP suggestions targeted letting go of stress and increasing self-esteem. 1) EEG-BF to decrease depression. 2) Alpha theta protocol for sessions 65-66 to calm.			

67-68	CBT, HYP, EEG-BF	0/0 (NRS 0-10)	1) 6.5/8.2 Theta 2.7/7.1 Beta 2.9/5.5 SMR 2) 6.5/6.7 Theta 7.6/9.0 Alpha 9.4/10.5 Delta 2.9/3.7 High beta
<p><b>Comments</b>  CBT targeted decrease anxiety due to stress.  HYP suggestions targeted decrease stress and increase self-esteem.  1) EEG-BF used SMR protocol to reinforce improvements in ADHD symptoms.  2) Alpha theta protocol for sessions 67-68 to calm.</p>			

Note: HYP = Hypnosis; EMG-BF = EMG biofeedback; EEG-BF = EEG biofeedback.

Of note, at session 10, the patient reported that a new physician gave him the definitive diagnosis of POTS. He was prescribed Metoprolol and Fludrocortisone at this time, which was associated with improvements in syncope. He had already been taking salt pills which eliminated his dizziness. However, he continued to endorse symptoms of anxiety, nightmares and insomnia, all of which are often associated with POTS. He also endorsed symptoms of depression and anger, which are often associated with chronic pain. These topics were addressed during sessions 9-26 (Table 1), with CBT to teach him cognitive restructuring skills, using thought records (Majeed & Sudak, 2017).

During sessions 13-25, we discussed therapeutic issues including ego state problems which were addressed with ego state therapy (Phillips, 2013) after he mentioned there was “himself” and his “pain self” (see Table 1). Hypnotic ego state therapy can help with exploring traumatized dissociated parts of self and then strengthen internal and external boundaries (Phillips, 2013). As a part of this process, he was asked to draw an image of his pain during sessions 9 and 43; the drawings reflected how his vivid image of his “pain monster” became less frightening which correlated with his decrease in pain (Lemke, 2007).

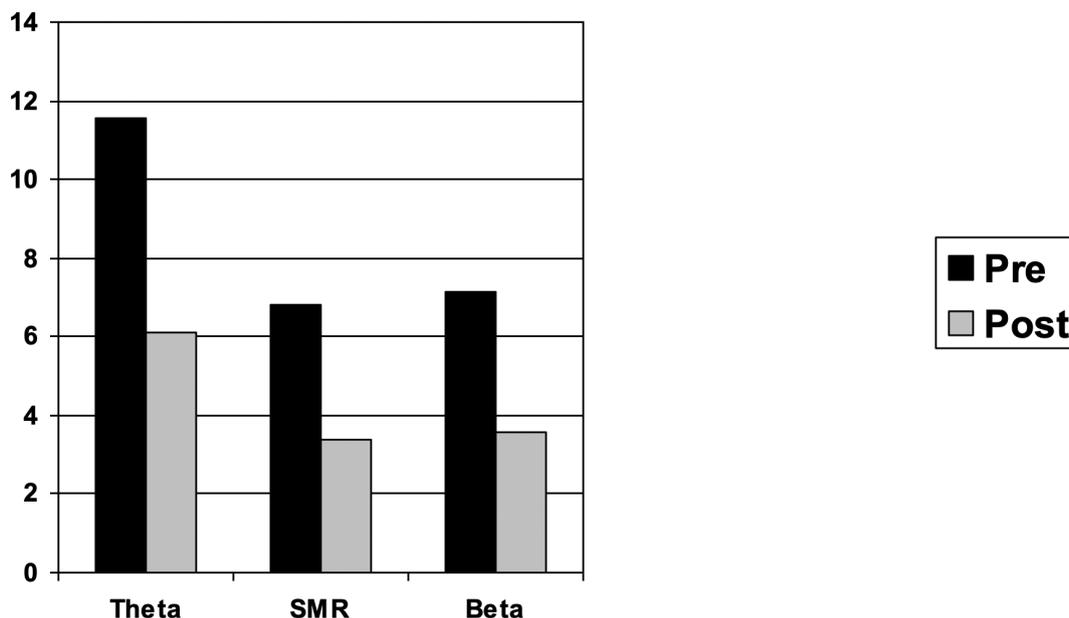
Interestingly, when hypnosis and EMG biofeedback were combined, the therapist (TF) noted a marked increase in EMG-assessed muscle tension when the therapist said the word “9.” The client reported that when he was nine years old, his family moved, and that this was a time of high anxiety for him. Discussion of his physiological response to the word “9” allowed him to connect his sensory disturbance with a time of emotional stress in his past and to allow him to be more aware of the impact of stress on his mind and body. This, then, facilitated his ability to achieve more complete relaxation through hypnosis and change maladaptive thoughts, thus changing his biofeedback measurements and pain level (see Kline, 1979, who describes a similar approach).

He was introduced to EEG biofeedback in session 27, and this continued through session 64. EEG biofeedback was utilized to decrease pain, decrease ADHD and promote relaxation to improve sleep. Each EEG biofeedback session lasted

approximately 20 minutes. No hypnosis was provided with the EEG biofeedback, because the client expressed a fear of falling asleep during the session and having “night terrors” during the session. Pederson and Brook (2017) found sleep disturbances due to nightmares is common in patients with POTS. Thus, the client wanted to use EEG-biofeedback primarily as a way to experience greater calm (Kluetsch et al., 2014).

For EEG biofeedback, he was started with a SMR protocol based on a previous study which found raising SMR alleviated ADHD symptoms (Egner & Gruzelier, 2001). The protocol reinforces 12-15 Hz (SMR) oscillations, while also inhibiting 4-7 Hz (theta) and 16-25 Hz oscillations (beta). SMR training is associated with improvements in anxiety, and has also been used to treat chronic pain, stress and attention deficit disorders (Kayiran et al., 2010). Thus, during sessions 27 to 42, he was given EEG biofeedback alone. This treatment did not alter pain consistently; sometimes it lowered pain, sometimes it did not (see Table 1). At Session 42 his Theta/Beta ratio decreased and his ADHD symptoms improved, perhaps allowing him to be able to focus long enough to decrease his pain (see Figure 1). During this session he commented he felt “his brain was re-wired,” and that he could concentrate better, do his homework better and his grades improved.

**Figure 1. Sessions 27-42, Average pre- and post-session EEG power in the theta (3-7 Hz), SMR (13-15 Hz) and beta (16-25 Hz) bandwidths.**



Given the improvements noted in his ADHD symptoms, the electrode training site was changed to T3T4 to target depression, for sessions 58-66. This resulted in decreases in self-reported depression symptoms. The electrode training site was then changed back to the ADHD placement of F7F8 for sessions 67 and 68 to anchor the improvements in ADHD symptoms. Of note, at session 64, his DES score dropped to 37, which is in the normal range. This drop could partially

be attributed to the fact that he grew older during the 4 years of treatment, as DES scores tend to decline with age (Berg & Melin, 1975); however, it is also possible that with his pain intensity decreasing, he no longer needed or had a “pain self.” In addition, during sessions 58-66 his Alpha brainwaves increased from 4.44 Hz to 10.80 Hz indicating he had learned to relax more to decrease pain. Also, increased alpha brainwave activity has been hypothesized to inhibit the processing of pain (Jensen, 2011).

During sessions 65-68, hypnosis was added to EEG and temperature biofeedback since the client was having less frequent nightmares. The combined treatments lasted approximately 20 minutes each for all four sessions. At the time of his 66th session, 6 months later, he was attending college. His appointments had run continuously until he took this break for a semester of college. He continued to experience pain relief with the use of self-hypnosis, but requested additional treatment to improve his pain-related thoughts and behaviors even further. Using CBT, we discussed his frustration with having to pace his activities due to his pain, his losses due to chronic pain, anxiety, difficulties focusing (ADHD) and socialization difficulties, with a goal of identifying and encouraging adaptive thoughts related to these issues. Although his ADHD symptoms had decreased as reflected by greater ease in being able to concentrate and better grades, he was still taking Focalin for these symptoms at this time.

Starting with session 65, the patient was administered hypnosis and neurofeedback following the alpha-theta feedback protocol; electrode placement was O2T4. This training has been shown to help one achieve a state of perceived “calmness” (Green, Green, & Walters, 1974). From this session on, alpha-theta feedback was provided with each hypnosis session through the final session (session 68). Treatment was discontinued at this time, 4 years after the initiation of treatment, given the patient’s significant gains across multiple outcome domains, and his sense that he could maintain these improvements on his own. Three years later he reported he was able to attend college, had no leg pain, was not taking Focalin and was doing well academically.

### **Summary and Conclusions**

Hypnosis was used primarily with this client with POTS to help manage pain, increase perceived relaxation, reduce anxiety, decrease episodes of syncope, improve sleep, improve mobility and improve the client’s ability to function better physically and socially. EEG biofeedback was used to facilitate improvements in the client’s ability to concentrate and decrease ADHD symptoms. EMG biofeedback was used to help him learn to relax muscle tension and reduce pain.

By the end of treatment, the client reported that he no longer experienced pain, that he was sleeping better, and that his ADHD symptoms had improved to the extent that he was able to discontinue ADHD medication, get his GED and attend college. As this is a case study, and the client was also receiving standard medical treatment in the form of oral rehydration salts, increased water intake, an adrenocorticosteroid, a beta blocker as well as 68 sessions of CBT psychotherapy,

hypnosis, and multiple biofeedback modalities (targeting improvements in pain, sleep, anxiety, the integration of ego states) it is not possible to draw conclusions regarding which specific aspects of this client's marked improvements to attribute to hypnosis and/or biofeedback. Although many adolescents and young adults with POTS improve with standard care; some do not (Bhatia et al., 2016; Sousa, Lebreiro, Frietas, & Maciel, 2012). In addition, most have more benefits from non-pharmacological treatments than pharmacological treatments (Bhatia et al., 2016). Thus, the current promising findings indicate that more research into the potential benefits for psychotherapy with hypnosis, biofeedback, and their combination for treating POTS is warranted.

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# Clinical Hypnotherapy for Stopping Drug and Alcohol Addiction: Building Resilience in Clients to Reduce Relapses and Remain Clean and Sober

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**Keywords:** Hypnosis, hypnotherapy, clinical hypnotherapy, substance misuse, substance abuse, addiction, addiction rehabilitation, addiction treatment, stopping addiction, drug abuse, alcoholism, problem drinking, sober, alcohol free, sobriety, drug free, clean and sober.

## **Abstract**

Clinical hypnotherapy is a powerful promoter of mental and behavioural change that can help clients experiencing out-of-control alcohol and drug use or addiction to move towards sobriety and recovery – fast – by assisting deep, unconscious change.

In clinical practice success rates clearly increase specifically according to the hypnotherapist's level of training, experience and reflective supervision. Hypnotherapists can learn to recognise addiction, devise staged treatment plans, and execute fast therapeutic change during substance withdrawal from the overuse of prescription drugs through to amphetamine and opioids withdrawal and helping clients build resilience to remain clean and sober on a long-term basis.

## **Introduction**

Substance Use Disorders (American Psychiatric Association, 2013) (World Health Organization, 2016), which are part of a class of substance-related disorders including misuse, dependency and abuse, involves a set of complex behaviours. Hypnotherapists working in this area must undergo extensive professional training and on-going supervision specifically in addiction.

The majority of treatments for addictions fail, including long-term residential care. McLellan, Lewis, O'Brien, and Kleber (2000) reported a 40% to 60% relapse rate. Since it is impossible to follow up relapsed long-term addicts and alcoholics as they are generally cognitively incapable of taking part in long-term studies, the rate is likely to be far higher.

Failure of treatment is generally through poor therapeutic techniques, inadequate staff training, inauthentic delivery of treatment by low-skilled professionals, low-skilled volunteers, fraudulent delivery of treatment, lack of commitment from the client and failure of the client to change their personality. Vogel (2018) discusses how acute care is also constantly let down by a lack of recovery capital which is the lack of social support, housing, employment opportunities and alternatives to being involved in crime or being criminalised.

[Glasner-Edwards](#) and [Rawson](#) (2010) clearly reviewed the move towards evidence-based treatment within the healthcare fields but unfortunately many hypnotherapy schools do not teach or understand evidence-based practice. Cowen (2015) found a lack of agreed training standards and the operation of evidence-based practice in hypnotherapy in Australia. Alcohol and drug addiction recovery therapy requires therapists to undergo training and supervision by therapists experienced in addiction, not simply hypnotherapy. Since addiction presents a life or death situation for clients/patients, therapists working in the field need to understand psychodynamics and the cognitive and behavioural psychological drivers of addiction in order to work with patients effectively.

[Booth](#), [Walton](#), [Barry](#), Cunningham, [Chermack](#), and [Blow](#) (2011) found extremely high levels of co-morbidity, including depression, and lowered cognitive functioning, in 15% of people experiencing alcohol and drug abuse/dependency, in 5,641 patients presenting to an inner-city hospital emergency department. As addiction is associated with a high level of mental distress and illness, hypnotherapists working in the field need to be trained as mental health professionals.

Addicts have always been historically amongst us and have included Caravaggio, Alexandra Feodorovna Zarina of Russia, Sigmund Freud, Winston Churchill, Princess Margaret, Betty Ford, David Bowie, Kurt Cobain, Ozzie Osborne, and millions of ordinary people throughout history. Today they include millions of people across the planet.

### **The level of training denotes the role of the hypnotherapist in addiction recovery**

Professionals using the title ‘hypnotherapist’ come from different sectors of the workforce who are trained in hypnosis, including psychiatrists, doctors, nurses, psychologists, psychotherapists, counsellors, social workers, naturopaths, and clinical hypnotherapists (Kirsch and Heap, 2006). The profession does not denote the level of training in hypnotherapy although the job title and recognition do indicate the primary profession. Hypnotherapy can be used as a primary or adjunct treatment in addiction cessation. There is also a need to distinguish between those practising hypnosis as dentists, in education or the corporate sector from those practising hypnotherapy as primary or adjunct professional skill.

Recognising addiction is dependent on the clinician’s primary discipline, socio-political perspectives, observational skills and ability the therapist

has to confront their clients about addictions. Outward physical signs include skin colour changes, perspiration, muscle tension or laxity, alertness, breathing irregularities, eye dilation or constriction, speech incompetency, mispronunciation, apraxia, short and long-term memory lapse, signs of brain damage and presence of psychosis. Is the client's history showing substance-induced psychosis, incongruity, evasiveness, obvious confabulation, memory loss, avoiding discussing substance abuse, displaying lack of cognitive ability and deviation from the client's known history? What does the blood essay, urine test, hair drug testing and obvious organ dysfunction suggest about the client's substance misuse (O'Keefe, 2018)?

Levels of training in hypnotherapy can range from a two-day course of 16 hours to several years and doctorate level specifically in hypnosis and related therapies. Competency in hypnotherapy also does not derive from which profession the professional practices but the level of training, practice and extended clinical supervision in hypnotherapy. No basic training in hypnotherapy covers the ability to help people with drug and alcohol addictions. In Australia anyone can advertise and practise hypnosis but some associations produce required minimum standards (Australian Society of Clinical Hypnosis, (n.d.) (Australian Hypnotherapists Association, (n.d.).

In many countries, including Australia, there are no laws against practising and advertising services for hypnosis, so there is a further class of people advertising as hypnotherapists who have a very low level of training, some with no professional insurance, low skills, no professional peer association, who do not engage in clinical supervision and may even be involved in hypnosis for entertainment (O'Keefe, 1998). These people cannot be considered as health professionals.

In varying countries and states there is a great variation on who can help people with addictions and what they may call themselves. For instance, in some places in the USA, there is licensing of addiction counsellors and psychologists ([Rieckmann](#), [Farentinos](#), [Tillotson](#), [Kocarnik](#), and [McCarty](#), 2011). In Australia there is no such licensing system but an individual offering therapeutic health services must comply to the guidelines set out by either the federal registration body or the state guidelines set out for registered (Australian Health Practitioner Health Regulation Agency, (n.d.) or non-registered healthcare practitioners such as in NSW (HCCC, (n.d.) including appropriate advertising, training and insurance.

### **Research on the efficacy of hypnotherapy in substance misuse recovery**

The use of altered states of awareness and hypnotic methods in the relief of substance abuse dates back to Egyptian, Greek and Roman times (Gauld, 1995). The popularist revival of hypnosis was initiated by Mesmer in the late 1700s, Braid in the 1800s, Charcot in the 1800s, and Hall and Erickson in the 20th century, which all led to it being used regularly as an adjunct and core treatment for substance abuse problems.

Hartman (1972) reviewed the reported successful use of hypnosis by several hypnotic practitioners in drug withdrawal in the *Journal of the National Medicine Association* sometimes in association with clinical drugs. Potter (2004) published utilising hypnosis over several years with clients recovering from substance abuse with a 77% success rate at one-year follow-up. Kaminsky, Rosca, Budowski and Yakhinich (2008) described using group hypnosis with street drug addicts obtaining a 90% success rate after six months, reducing to 70% after two years.

Crocker (2004) experimented with a small group of problem alcohol drinkers divided up into those who received hypnosis and a control group, resulting in a stronger reduction in alcohol after a 30-day review in those who underwent hypnosis. Pekala, Maurer, Kumar, Elliott, Masten, Moon and Salinger (2004) found hypnosis to be a useful adjunct treatment for improving self-esteem, serenity, and anger/impulsivity in chronic substance abuse individuals using self-hypnosis.

However, recent studies such as that conducted by Shestopal and Bramness (2019), which compared the effectiveness of hypnotherapy against motivational interviewing, fail outright to understand the nature, mechanics, qualitative nature and complexities of hypnotherapy administration.

Research in hypnosis has generally fitted into two hypnotic paradigms: intrinsic and instrumental hypnosis.

Intrinsic research into the effects of hypnosis are bound with examination of the hypnotic state, its effects on the body, mind and hypnotisability ([Jamieson and Burgess, 2014](#)).

Instrumental hypnosis research examines suggestibility and a person's responsiveness to suggestion (Oakley and Halligan, 2013). Such studies may quantitatively commodify intrinsic and instrumental factors but frequently ignore the variables of administration of hypnosis and hypnotherapy as the major variable in effectiveness of treatment. A further line of research points to the value of hypnotic suggestion in modulating cognitive control processes (Raz et al. 2006), which supports the instrumental use of hypnosis for studying psychopathology in a controlled environment (Woody and Szechtman, 2011).

Since many researchers into hypnosis limit their controls to a small number of variables in order to prove or disprove their hypothesis, the characteristics of the hypnotist's hypnotic education, substance abuse recovery education, practice, experience, delivery and personality, the client's psychodynamics and personal history are never factored into the delivery of the treatment effectiveness – all of which have direct causal links on the efficacy or not of the treatment.

As Jensen et. al (2017) suggest, we need to change the way we do research into hypnosis and its therapeutic applications. We need to validate qualitative clinical research, which takes place within real work situations, on an equal footing with

experimental and quantitative research and clearly consider administration factors.

Many experimenters, researchers and clinicians such as Erickson (1980a), Crasilneck and Hall (1973), Hilgard and Hilgard (1994) and Miltner and Weiss (2007) showed that intrinsically the hypnotic state, in of itself can reduce the activity of pain receptors. This supports the use of hypnosis in drug withdrawal which can give rise to pain, anxiety and the perceived fear that life without the substance will be painful. Indeed, this is observed in the thousands of substance misuse withdrawal patients I have worked with in my own clinic. A parallel to this can be seen in Tibetan Buddhist meditation and the use of the Tummo meditation state where monks endure long periods of extreme physical exposure to cold without experiencing a variation in their core body temperature (Benson, Lehmann, Malhotra, Goldman, and Hopkins, 1982)

Instrumentally we can also see from Erickson's (1980b) experiments and clinical work, and that of others, with pain control that hypnotically induced saddle-block and cataleptic hand anesthesia can be used and even transferred to other parts of the body to reduce physical discomfort without the use of pharmaceuticals ([Elkins](#), [Jensen](#) and [Patterson](#), 2009).

My own clinical experience with patients is that using such hypnotic intra and post-hypnotic suggestions can profoundly change cognitive processing in cases of substance misuse withdrawal, and thereby physiological function and experience. This has now involved patients with a 90% success rate due to hypnotherapy, immediately producing a life without the substance misuse that does not include withdrawal pain, anxiety or panic.

### **Cognitive behavioural therapy (CBT) approaches**

Tolin (2010) suggested that cognitive behavioural therapy (CBT) is more effective in treating psychiatric disorders and should be offered and be considered as a first-line psycho-social treatment. From a research perspective, however, it is actually the way in which therapies are measured that determines research outcomes. Nevertheless, CBT is recognised as having high levels of success in behavioural modification with many patients.

When emotional drivers are introduced, turning it into emotive cognitive behavioural therapy, it becomes more effective when amplified by the application of hypnotic interactions and suggestions to initiate cognitive, behavioural and emotional reprogramming in substance misuse withdrawal (O'Keefe, 2018). Emotion is a powerful neurological impulse when a person is in a non-resourceful state and always wins over logic.

### **Discussion**

Addiction is a complex of interrelated self-destructive thoughts and behaviours that make up the addict's dependent personality. Being clean and sober requires the addict to displace those self-destructive thoughts and behaviours permanently

and replace them with a new psychological structure that automatically operates a sober way of living. It must be a permanent change of sub-personalities and the whole maturing of the central personality.

The mistaken idea that clinical hypnosis or hypnotherapy are non-interactive commodities to be applied by reading a script from a book, or applied dogmatically without consideration of what the therapist brings to the session, leads to poor addiction recovery outcomes. No two clients, hypnotists, hypnotherapists or hypnotic experiences are the same so a hypnotherapist must always be leading their client, guided by their own training, study, practice, experience, and therapeutic reflection (supervision) towards a recovery via authentic hypnopsychotherapeutic intervention.

Since clinical hypnosis and hypnotherapy can never be nominalised into an inanimate or standardised application, it is intrinsically and instrumentally dependent on many interactive factors and variables between the participants, just as sailing is dependent on ever-changing winds and the skill of the sailor and crew. Intrinsically and instrumentally these variables promote or restrict the levels and effectiveness of the hypnosis experience and effectiveness of hypnotherapy in substance withdrawal.

In other words, the evolution of the hypnotherapist's automatically operating hypnotic personality and skills is one of the major variables in whether therapy will succeed or fail, not only with addiction recovery, but all therapy as it builds or destroys rapport. As any experienced hypnotherapist knows, it is rapport that magnifies or diminishes the hypnotic state and power of suggestion.

For a therapist to initiate an authentic clinical application of treatment for drug and alcohol addiction recovery, the therapist needs to be highly knowledgeable and experienced in the field of addiction separately from hypnosis. It is a vast field with many substances being misused and therefore many approaches need to be applied for recovery.

Building resilience and sobriety in a client is, in my view, built on the foundation of the therapist being resilient and sober. Clinical hypnotherapy is an interactive process, not simply active for the hypnotist and passive for the client as a receptacle for suggestion. Just as a well-trained hypnotist is always monitoring the client's responses, so is the client's unconscious monitoring the hypnotist's actions and responses in all sensory systems. When a client's unconscious notes even a small incongruency in the hypnotist, it lessens the effectiveness of suggestions and psychodynamic change.

We can see from studying highly successful therapists such as Freud, Jung, Perls, Rogers, and Satir, and successful hypnotists such as Mesmer, Braid, Esdaile, Charcot, Janet, Coué, Elman, Weitzenhoffer, Erickson, Weiss, Crasilneck, and Hammond that they all brought three elements to their practice: enormous study and training, considerable practice, and intellectual association. Although Janet, Coué and Erickson at times would claim not to be command hypnotists leading

their patients, all were and needed to be in order to guide their client.

In substance misuse recovery we can also see that the most effective movement worldwide over the past one hundred years has been Alcoholics Anonymous started by [Bill Wilson](#) and [Bob Smith](#), both of whom remained clean and sober for life after recovery from alcohol and drugs. The movement was so successful because it was led by clean and sober people, so their help and messages were authentic and congruent, leading people's unconscious to follow them.

Therapists are teachers but it is not the teachings that teach alone but the teacher teaching the teachings that teaches the addict to be clean and sober. Would you learn to drive from someone who cannot drive? Or learn to play tennis from someone who has never picked up a racket?

The majority of treatments for treating addictions fail, including long-term residential care, through poor therapeutic techniques, inadequate staff training, inauthentic delivery of treatment by low-skilled professionals and volunteers, fraudulent delivery of treatment, lack of commitment from the client and therapist which leads to failure of the client to change their personality. There is clearly a long-term lack of professional accountability in the substance misuse recovery industry including hypnotherapy.

The level of commitment needed by therapists to work with drug and alcohol addictions needs to be at 100%, just as the therapist needs to require the client to be 100% committed. That means the therapist does not offer sympathy or capitulates to the addiction but that the therapist lays down clear boundaries around what treatment entails and what is expected from the client and therapist.

Therapists need to coach addicts and require clients to display that 100% commitment in getting clean and sober at all times. When the client is not 100% committed, they are in denial about their addiction which a therapist can never ignore and they need to bring the client back to that commitment to therapy to be effective. This will only be possible when the therapist is also displaying 100% commitment to the outcome.

Cognitive behavioural intervention and delivery for stopping the addiction must happen early in treatment as drug and alcohol addiction is a medical emergency. Practised delivery of this change can be amplified with the effective instrumental use of hypnotic suggestion giving operational advantages over other forms of addiction cessation by delivering suggestions that appeal to the emotional drivers in the unconscious.

To work with people addicted to drugs or alcohol takes a lot of training that never ceases, as a therapist should always be adding to their armory of techniques and knowledge. We can never as therapists rest upon what worked with the previous client as therapy works best when it is interactive and developmental.

Treatment is fraudulent when the therapist is out of their depth, not constantly

developing their skills and knowledge around addiction recovery. The therapist's ego also gets in the way of their observations when they are using techniques in which they have no training, practice or supervision.

Authentic delivery of treatment for stopping drug and alcohol addiction requires the therapist to do what they teach, be someone who is fully committed to resolving their own life issues and a champion of the clean and sober direction and way of living so they are leading their client towards sobriety. Only then can the dynamics of the client's integrated major personalities develop into a central independent personality that is no longer dependent on substances.

In working with addicts, therapists need structure in their work or they become engulfed in the shared pathology of the addiction. Structure in a therapist's work gives them objectivity, processes, procedures and protocols to follow as they consistently help the client move through the different stages of recovery, changing and maturing their personality and creating resilience as a clean and sober individual.

#### **Guidelines for hypnotherapists working with drug and alcohol addiction**

1. Having a documented training in hypnosis and drug and alcohol recovery, and making the client aware of that fact, adds to the placebo effect of treatment. That also needs to include mental health training.
2. Therapists need to understand all of the substances being misused and the issues they produce, including physical, mental, emotional, legal and social, far more than the client does, otherwise the client will not have confidence in the therapist or the treatment.
3. Therapists need to be able to recognise addiction and address those issues, even when the client remains in denial.
4. Being trained, qualified and recognised in addiction recovery covers the therapist and client legally for insurance purposes in the event of malpractice or death. Therapists in this area also need to have fieldwork experience in the voluntary or government sector.
5. Treatment needs to be methodical, organised, staged with recognisable benchmarks driven by cognitive, behavioural and emotional change assisted by hypnotic interactions intrinsically and instrumentally.
6. Continual professional development and supervision specifically in addiction recovery and hypnosis increases results. Simply completing a training and relying on those skills and knowledge does not display professional enthusiasm about the treatment to the client.
7. Not only does the therapist need to hold the client accountable but they also need to hold themselves accountable for the continuing development of their skills and results produced.
8. Addicts are lost in their addiction; they do not know the way out and the therapist is the leader to guide them towards a clean and sober lifestyle. This is always most effective when the therapist is leading that life themselves because it increases rapport and congruency and the hypnotherapist becomes a mentor.

9. Resilience is built in a personality by raising the tolerance to stress levels for pain and discomfort, creating psychological stability and a sense of endurance. Hypnotherapists working in drug and alcohol misuse recovery need to be able to help their clients create all these abilities fast in order to cease addiction, and to do that they need to create it in themselves first and on a continuing basis.
10. Therapists need to understand the physical and lifestyle, exercise, diet, time management and relationship dynamics changes that the client needs to make in order to create a life that supports and promotes being clean, sober, healthy, happy and resilient.

### **Conclusion**

Clinical hypnotherapy for drug and alcohol misuse recovery can be highly effective when used by therapists with extensive training in both hypnotherapy and addiction recovery. Evidence to substantiate this can only be gathered qualitatively because quantitative research restricts the observation of the extensive number of variables involved in successful administration.

However, the extent of qualitative published cases by highly experienced hypnotherapists who are also trained in substance abuse withdrawal does lend considerable validity to hypnotherapy being used in accelerated recovery that is faster than other therapies, at times stopping the addiction in a single session. This can lead to a high level of resilience against relapse in substance misuse recovery due to deep unconscious change and training the client to tolerate higher real-life stress levels without resulting to a substance dependency relapse.

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# A Single Case Study: Utilising Cognitive Behavioural Therapy Techniques into Hypnosis for Irritable Bowel Syndrome

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### **Abstract**

This case report illustrates a non-pharmacological approach to the treatment of Irritable Bowel Syndrome (IBS) using hypnotherapy combined with Cognitive Behavioural Therapy (CBT). A 54-year old Caucasian lady, a school teacher (involved with teaching and administrative duties) who has been suffering from IBS for more than 20 years, presented herself to the physician clinic with complaints of indigestion. The desensitization approach, cognitive behavioural hypnotherapy (CBH), that the author applied for this patient, involved seven stages. The focus of the therapy for this patient was on the stress experiences at her workplace and home, contributing to the worsening of her IBS symptoms. This therapy approach has benefited the patient because it helped her control her bowel symptoms and gave the patient an in-depth insight into her emotional components, tied to her IBS symptoms. This paper presents an approach of CBH into a regular hypnotherapy session. It is hoped that further developments of CBH will strengthen the evidence-based practice of clinical hypnotherapy.

### **Introduction**

Irritable bowel syndrome (IBS) is not a common functional bowel condition in the Malaysian clinical context as contrasted to Western society. Symptoms supporting the diagnosis of IBS were prevalent among young Malaysians, with a prevalence figure of 15.8%, Tan YM et al. (2003). It is a functional disease that encompasses manifestations such as diarrhea and/or constipation, abdominal bloating, constant colicky pain, cramps, intermittent bowel movements, and a sense of inadequate evacuation Dalrymple et al. (2015). Many physicians in Malaysia lack understanding in comprehensively managing patients with IBS, involving current therapeutic protocols combined with the complementary medicine approach (in an integrative approach). This case report illustrates a non-pharmacological approach to the treatment of IBS using hypnotherapy

in combination with Cognitive Behavioural Therapy (CBT), also described as Cognitive Behavioural Hypnotherapy, CBH, Golden (2007). It is hoped that this case report can shine a light on a comprehensive approach to IBS treatment protocols for physicians in Malaysian clinicians.

IBS has proven to be a challenging treatment with conventional medical approaches because of the mechanisms behind IBS are ambiguous and complex. Diet modifications to suit individual patient's need, education of IBS disease process and reassurance to suffering patients, are the principles in standard medical treatments. Medications are used for symptomatic and for supportive modality in the treatment.

The insufficient progress of standard pharmaceutical care for IBS has contributed to considerable endeavors to analyse alternative therapies that can integrate current approaches and enhance results. Psychological approaches have proven most encouraging. A broad scope of psychological approaches has been scrutinized for IBS, including biofeedback, behavioural therapy, cognitive behavioural therapy, relaxation training, psychodynamic therapy, and hypnosis treatment Palsson et al. (2002), Green et al. (1994), Blanchard et al. (1995), Gelder (1968).

The pathophysiological mechanisms underlying gastrointestinal symptoms improving after hypnotherapy intervention remain inadequately interpreted (Palsson et al. 2002). Hypnotherapy is correlated with a substantial reduction in symptoms of depression, anxiety, and improvement in quality of life scores (Palsson et al. 2002), Barabasz et al. (2006). Pharmaceutical approaches alone are not effective in managing IBS. Cognitive behaviour therapy (CBT) has been identified to be effective in the management of IBS, (Bennett (1985), Green (1994), Payne et al. (1995), Gonsalkorale et al. (2006), Benson et al. (1981).

Hypnosis and relaxation approaches are appropriate in managing IBS because the dynamics throughout the gastrointestinal tract (GIT) system are influenced by the nervous system, Benson et al. (1981). GIT system is predominantly a parasympathetic system. Sympathetic nervous system involvement (anxiety/stress) can disrupt the normal function of GIT system and affects IBS progression, Green et al. (1994), Payne et al. (1995). Assimilation of CBT and hypnotherapy in the management of IBS, Barabasz et al. (2006), Benson et al. (1981) is a poorly studied subject. CBH (Cognitive Behavioural Hypnotherapy) has been tested to be a valuable mean in IBS treatment protocol, Golden (2007). The CBH protocol adopted by the author here included cognitive and behavioural strategies that have been used in the study by Golden (2007). The fundamental in cognitive therapy is the triggering events that cause emotional disturbance, and the thought process that is responsible for the maladaptive behavioural strategies Golden (2003)

The writer managed this patient's IBS symptom by combining CBT with hypnosis because this patient has several stressful work issues and at her home. Issues about coping strategies and maladaptive behaviours about IBS symptoms were

managed by utilizing CBT principles. Problems of chronic discomfort (chronic pain) from the constant abdominal cramps were managed by using hypnosis techniques as detailed in the Manchester IBS protocol (Blanchard et al. 2005).

This single case report presentation demonstrates the effectiveness of CBH therapy in managing IBS symptoms in a patient who has been suffering from IBS for more than 20 years in managing the abdominal symptoms and managing psychological stresses associated with her IBS symptoms.

### **Case Description**

A 54 years old Caucasian lady, a school teacher (involved with teaching and administrative duties) has been suffering from IBS for more than 20 years and presented herself to the physician clinic with complaints of indigestion. She was an expatriate who worked as a teacher in a school in Malaysia. She has been living in Malaysia for only the past six months. She has not quite acclimatised to the local culture and lifestyle. She has sought various treatments from gastroenterologists and general doctors, over the years since her youth, concerning her gastrointestinal symptoms. She described her cramps abdominal pain, scale 5/10 (VAS = Visual analogue scale). Nagging pain, at times, persisted throughout the day. She started having this problem at the age of 20. She had been extensively reviewed by medical specialists and been on medications to treat her symptoms. She had undergone three different gastro and colonic endoscopies, which showed negative findings. No anatomical or pathological diagnosis was made or told to the patients. Detailed medical investigations have ruled out pathological and anatomical disorders. The diagnosis of IBS was established when the patient was at the age of 25.

For this current hospital visit, the patient was seen at the physician's clinic and was assigned to the author's pain clinic for further assistance in managing her chronic pain. In the author's pain clinic, the patient was assessed. A general physical examination conducted showed negative findings. The patient was offered the first session of hypnotherapy as an approach to ease and managed IBS related abdominal discomforts and pain more effectively.

### **Intervention Planning & Implementation**

The desensitisation approach, Blanchard et al. (1995), Gelder et al. (1968) with CBH, that the author applied for this patient involved seven stages:

1. Initial Assessment / History taking. Behavioural assessment and hierarchy construction (Golden 2003,2007, Blanchard et al. 1995).
2. Cognitive therapy.
3. Hypnotic induction and relaxation training.
4. Hypnosis deepening
5. Utilisation of hypnosis. Gradual exposure to stressful situations that was known to trigger patient's IBS symptoms, through imagery visualisation and the use of therapeutic suggestions presented during hypnosis (in cooperating CBT concept into hypnosis)

6. Self-practice gradual exposure to stressful situations.

7. Termination of hypnosis

A detailed clinical account concerning the patient's signs and symptoms of the illness was taken, to gain understanding into the patient's abilities, resources, and experiences that can be utilised by the writer in constructing suggestions and alternative interventions, during hypnosis.

The purpose of the initial consultation was to allow the patient to become informed with hypnosis and the therapy setting. The second session had "gut-directed techniques" Blanchard et al. (1995) and Cognitive Behavioural Hypnotherapy, Golden (2007). At the end of every session, the writer would supervise the patient on her self-hypnosis skills. Self-hypnosis provided the patient with a set of coping skills. As part of her self-hypnosis training, the patient was trained to use hypnotic-induction strategies, deepening techniques, and hypnotic suggestions.

At the start of each session, the patient was scored by VAS (visual analogue scale). Their symptoms recorded on a weekly record sheet (patient's diary). For this patient, the VAS scoring (0-10: 0 no symptoms, 10 worst) concerning her IBS symptoms was:

- *Pain Severity*: 5-8 /10 every 4-6hours, precipitated by stress and emotional disturbances
- *Pain Frequency*: 8-12hourly /day: 6-8/10: aggravated by the improper choice of food.
- *Bloating*: with the onset of pain: 8/10 on most days
- *Bowel-habit dissatisfaction*: intermittent diarrhea and constipation every 6 hours, primarily precipitated by anxiety or stress factors.
- *Degree of life interference*: disturbance in patient's daily work activities. Poor work performance. When get caught in traffic jams, stress builds up, and this becomes one of the triggers for her IBS symptoms. 6-8/10

### **Precipitating factors before onset**

This patient's IBS symptoms triggered by the stress related to work, staff handling family issues, and spicy foods or cold/frozen foods.

Impact of symptoms: not able to focus or provide the best at work. The patient shies away from social functions.

*Coping strategies*: have not acquired any specific routines to reduce the severity of illness. Occasionally try to observe food choices.

The above questions were employed to gauge the patient's symptoms after each hypnotic session. The patient was further requested to complete this assessment daily at home in her diary.

### **Initial Assessment / History taking.**

History-taking, assessment, and understanding the patient's expectations helped to build rapport. The patient was educated about hypnosis, and misconceptions about hypnosis were clarified. In the initial phase, the patient's behavioural

pattern was assessed, and a stress/anxiety hierarchy, Blanchard et al. (1995), Gelder et al. (1968) associated with IBS, was constructed. As part of the behavioural assessment, the specific situations that provoke stress and triggers uncomfortable IBS symptoms were established. The role of CBH in managing IBS symptoms was explained to the patient. Clinical hypnotherapy used to help patients to learn mental skills and techniques that can assist them in controlling the physiological mechanisms regulating the GIT that are not automatically under their conscious control. A brief demonstration of hypnosis with “hand warmth on the abdomen and imagery” was shown to the patient to gain more confidence that hypnosis may help relieve her IBS symptoms. The patient was asked to relax and visualise her palms on the abdomen getting warmer and comfortable. The author emphasized that the patient will learn techniques that will strengthen with practice and that she would be required to do this regularly. Since therapy is not a passive process, her active engagement was thus requisite. She would be learning to cultivate control over her digestive system rather than allowing her digestive system to continue to control her.

### **Cognitive Therapy (CT)**

The author incorporated cognitive behavioural therapy techniques by identifying maladaptive patterns concerning her coping methods with IBS symptoms and identifying IBS trigger elements. A stress event hierarchy was then constructed, Golden (2003,2007), Blanchard et al. (1995). The patient’s stressful situation was broken down into specific stressful-producing situations, which are then rank-ordered from least to most stress-producing and graded on a scale from 1 to 100, where 100 is the most stress-provoking situation. In cognitive therapy (CT), the patient was taught to identify and to modify maladaptive cognitions. Therapeutic suggestions developed through cognitive-therapy techniques with Blanchard (1995), Gelder et al. (1968), and Golden (2003,2007) were used during imaginal desensitization (imagery visualization) for stress reduction. These hypnotic suggestions were used in the same way as the coping thoughts were used in the CBT approach.

The two-column method Golden (2003,2007) was simple for the patient to learn and to use on her own. The patient was guided to divide an A4 paper page in half vertically. On the left side of the page, the patient lists her anxiety or stressful-producing thoughts. On the right side of the page, therapeutic recommendations were listed. The objective was to develop a series of hypnotic suggestions that can be utilised during desensitisation steps when the patient is under hypnosis and for self-hypnosis practice. During the (CT) stage, the author and patient reviewed the adaptive and maladaptive issues about her IBS symptoms. These were as below:

#### ***Maladaptive***

- o Frequent wash-room visits, therefore the patient needed to be in the office all the time.
- o Avoiding meetings in the office, fear of the need to go to the lavatory, and embarrass herself.

- o Avoid eating food. Not able to adapt to food may cause indigestion and bloating symptoms.
- o Constant abdominal discomfort causing stressful thoughts.

### ***Adaptive thoughts***

- o Going to the wash-room is standard, as many other people in her office do. It is acceptable to be excused to the toilet if needed. Not to feel ashamed as many others do the same.
- o Proper food selection. Prevent taking spicy food—more fibre in the diet and healthy food habits.
- o Stress is part of the daily routine. Need to divert to positive thoughts preventing dwelling in stressful thoughts.

### **Hypnotic induction.**

A hypnotic induction procedure was selected for eye-fixation induction. Using “Peace” suggestions, as recommended by Blanchard (2005). The strategy for hypnotic induction was coupled with urging the patient to recite the word peace to herself on each out-breath, which also facilitated slowing down the breathing pace. It was suggested to the patient to envisage “peace”, breathing it into each segment of the body, and each cell bathed in a sea of a peaceful environment. Each breath’s rhythm can help the peace gently disseminate around the body, with each cell soaking up the peace. A posthypnotic suggestion was given later in the session so that the patient can use “peace” in the same way whenever they want to feel calmer and relaxed, Blanchard (2005). Once the patient was in a relaxed hypnotic state, the therapy session would be proceeded to step by step desensitisation process.

### **Deepening of hypnosis.**

Following a hypnotic induction, a deepening technique with counting and imagined gradual movement down to a different level: going downstairs, was used. This was followed by systematic physical relaxation.

### **The utilisation of hypnosis coupling with Imagery Visualisation.**

During hypnosis, therapeutic interventions used were combination systematic desensitisation, Blanchard (1995), Gelder et al. (1968) with CBH. Desensitisation was accomplished in imagination via hypnosis. Therapeutic suggestions targeted at reducing IBS symptoms and gastrointestinal functioning were delivered to the patient. Systematic desensitisation allowed the patient to confront her stressful circumstances in a steady process, one step at a time. Care was taken to ensure that the patient experienced success with one step before proceeding to the next step. Relaxation techniques and hypnotic suggestion were used to reduce anxiety during a patient’s exposure to feared situations. Self-homework assignments were given following successful imaginal desensitization experiences.

Therapeutic suggestions at reducing stress for this patient were developed for each item of a patient’s stress chart. After relaxation was induced, the author described an item from the patient’s chart and the two-column method. Following this, therapeutic suggestions were offered. For example, when she described being in her office, looking over the report files would trigger stress that she may not be

able to complete the task well. This would cause her to rush to the wash-room as the IBS symptoms being triggered. The adaptive approach the patient listed on the chart was “handling the file reports and being successful at completing the files.” Hypnotic suggestions used were as below:

*“Now, imagine sitting in your office... seeing the files on your table, feeling calm and in control... realising people in your office too are able to get the job done... without having to rush out of the office to the Bathroom. Successfully completing each file at your own pace... So, can you... and now imagine yourself being in your office desk... calm and relaxed... feeling in control.”*

After completing the first stress issue, the author gradually moved on to the next anxiety-provoking item. Throughout this process, the author looked for any physical expression that would indicate that the patient is experiencing anxiety. If this was elicited, the author would stop the process, and give relaxation suggestions. Once the patient calms down, the author would proceed to the next item on the list. In this case, the patient was comfortable throughout all the desensitisation steps. The patient was encouraged to use the same hypnotic suggestions during her self-hypnosis practice.

### **Self-Hypnosis Practice for Home/Self sessions**

The patient was encouraged to practice exposure at home, by self-hypnotic techniques. The patient was given homework (practice) based on their progress with imaginal desensitization/ imagery visualisation. The patient was instructed to gradually have exposure to the feared (stressful) situations, one step at a time, and to apply their self-hypnosis skills for anxiety-reduction during the practice sessions. Posthypnotic suggestions that were recommended for this patient was as below:

By practicing these techniques, you will gradually gain more control over your bowel with symptoms, being less intense.

The process takes time, practice, patience, and persistence. You are now becoming in control of your gut, rather than your gut controlling you. It's not going to control you anymore.

You could reduce the gut symptoms when needed by putting your hands on the abdomen. You would feel the warmth and comfort and bring to the picture of the gut system working normally, in your mind.

### **Termination of hypnosis.**

The author terminated the hypnosis session by gentle re-orientation to the current place and time frame. The patient returns to a fully alert state with normal physical and mental faculties. Feeling re-freshen and motivated, the patient awakens with feeling rejuvenated.

## Second week session

In the second week, symptoms were reassessment and reviewed. The patient was compliant with practices of self-hypnosis at home, once every day. The patient was satisfied with the change in her own thought process. She was able to make proper and calculated decisions regarding managing her IBS symptoms and manage the possible triggering factors to her IBS condition.

Based on the patient's progress diary, below is the outcome of the first session of CBH (one week ago):

- *Pain Severity*: 2-4 /10 every 12-24hours. As compared to previous pain severity (before starting patient on CBH protocol), in week two, there was a significant pain severity reduction. Previously abdominal pain triggered by every stressful event or situation. After self-hypnosis, rarely stressful events cause abdominal discomfort. Now symptoms more attributed to wrong choices of food.
- *Pain Frequency*: < 5 hours/day: 2-4 /10
- *Bloating*: occasional: < 4/10 on most days
- *Bowel-habit dissatisfaction*: intermittent diarrhea and constipation every 12-24 hours, mostly precipitated by wrong choices of food.
- *Degree of life interference*: minimal disturbance in patient's daily work activities. I can concentrate more at work.
- *Precipitating factors prior to onset*: able to identify triggering factors for her IBS symptoms and able to take preventive measures.
- *Impact of symptoms*: able to concentrate and provide the best at work, with self-hypnosis skills at the workplace.
- *Coping strategies*: started using self-hypnosis more frequently.

*In summary*: there is about 50% reduction (based on VAS SCALE of 0-100) in pain and IBS related symptoms. The patient was able to cope better with triggering factors.

In the second session, the patient's concerns were assessed. Her IBS symptoms based on the VAS scoring were explored. Self-hypnosis skills and experiences were evaluated and re-assessed. CT techniques used again to explore previous and new issues concerning IBS symptoms. Once explored, the patient was formally inducted into hypnosis, and a relaxation phase achieved. Under the hypnotic state, CT was re-employed, and allowed patients to utilised new positive adaptive strategies for each identified maladaptive issue earlier (via 2 column method). This was followed by Gut directed protocol, as per protocol by Gonsalkorale et al. (2006), by using Hand Warmth on the abdomen technique.

## Imagery Visualisation Exercise:

The patient was asked to imagine herself in any previously feared or avoided situations, but now with the gut functioning normally. For this patient, being in the office handling the teaching and administrative burden. The patient was made to visualize this stressful situation and create a healthy moving bowel system, Gonsalkorale et al. (2006).

### **Week Three:**

In week three, the patient's symptoms assessed, based on her progress diary:

- *Pain Severity:* 1-2/10 every 3-5 days.
- *Pain Frequency:* 3-5 days once, each discomfort lasting for < 5 mins will be relieved immediately with self-hypnosis at the event of the symptoms.
- *Bloating:* occasional: 5 days once
- *Bowel-habit dissatisfaction:* rare. Once every two weeks.
- *Degree of life interference:* minimal disturbance in patient's daily work activities. I can concentrate more at work.
- *Precipitating factors prior to onset:* able to identify triggering factors for her IBS symptoms and able to take preventive measures

These symptoms showed that the patient was able to concentrate and provide the best at work, with self-hypnosis skills at the workplace.

For Coping strategies, she uses self-hypnosis more frequently now, able to relax faster with the onset of severe discomfort.

*In summary:* there is about 90 % reduction (based on VAS SCALE of 0-100) in pain and IBS related symptoms. The patient was able to cope better with triggering factors.

There was a generally remarkable reduction in the patient's IBS symptoms, and the patient was able to manage the abdominal discomfort more. She managed to solve the family issues she had, and this gave further confidence to her that she was able to manage her stressful events in her daily life. The patient was able to make healthy food choices.

The patient was followed up two months later via email. The patient reported that her IBS symptoms were in a more controllable state, and the patient has been able to practice hypnotic skills regularly with minimum effort. There were no further follow-ups for this patient. This therapy approach has benefited the patient because it helped the patient control her bowel symptoms and gave the patient an in-depth insight into her emotional components, which was tied to her IBS symptoms.

### **Limitation of this report**

This report is a single study utilising CBH as an approach. This approach may not be suitable for all patients. Larger patient samples with controlled trials needed to verify the effectiveness of this approach.

### **Discussion & Conclusion**

The focus of therapy for this patient was on the stresses at the workplace and home that the patient had, which were contributing to the worsening of her IBS symptoms. Controlled experimental researches are required to establish the efficacy of CBH in treating IBS. More studies looking into the role of CBH with desensitization models could be compared with a hypnotherapy treatment treating IBS. This paper presented an approach of CBH into a regular

hypnotherapy session. It is hoped that CH's further developments will enable the strengthening of the factual position of hypnotherapy and reinforce the clinical validity of the integrative approach.

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# Transference and Countertransference in Clinical Hypnosis

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Keywords: Transference, Countertransference, Clinical Hypnosis, Psychotherapy, Hypnotherapist, Psychoanalysis.

## Abstract

In clinical hypnosis, the transference relationship, present in neurotic patients, becomes especially important in a psychotherapeutic process. It is pertinent that from the initial time of psychoanalysis, and throughout, the links are established either indirectly or directly. This was observed when working within a hypnotherapeutic orientation. The phenomenon of transference appears systematically, and the differences lie in the management of this situation. It is in the way of working, which distinguishes the hypnotherapist, who, by noticing in the “here and now”, works with the orientation of therapy under clinical hypnosis, is never applying clinical methodology only to his patient. He observes it in its entirety, and from there, he can perceive a change in color, a repeated gesture, or a muscular contracture to interpret transference elements.

## Introduction

In this article, we demonstrate the presence of transference in therapy with clinical hypnosis, an opinion that not all hypnotherapists endorse.

For this, we use the same definition as Freud used in his findings and comments on transference. We also consider the concepts of Jung and M. Klein and conclude that the study of the type and management of transference in other models of therapy, such as psychoanalysis, is a decisive element in the diagnosis and prognosis. of a clinical picture.

On the contrary, in therapy with clinical hypnosis, it is perceived that the patient can project into the therapist healthy and sick aspects of his personality and that this is what determines the characteristics of the transference relationship. In therapy using clinical hypnosis, the concept of transference is often not facilitated or given importance. In clinical hypnosis, analysis is not usually used (except in hypnoanalysis).

Techniques are used to facilitate the transference situation, such as projections of the patient towards the therapist, which hinders therapy application.

Writing about transference in clinical hypnosis is an issue that seemed like a forbidden one. Generally, Hypnotherapists do not talk about transference, as it seems that this is not a significant phenomenon or does not exist if when working with clinical hypnosis.

In the protocol books of therapy with clinical hypnosis, the word transference is not even mentioned. However, it is known that there are many situations in the application of the protocol in which transference can occur and may even have therapeutic relevance. Many other hypnotherapists endorse this notion.

From the above introduction, we can now define what is understood by therapy and what we understand by transference to see from that perspective.

Generally, therapy is a process in which a patient is subjected to a protocol or clinical techniques to obtain changes in their way of facing situations. Therapy assists in the disappearance of psychic and physical discomforts that limit them in their life. Patients can learn from their experiences to structure favoring behavioral changes and assume or modify their behavior changes. Usually, this is done individually and occasionally in groups. This definition is limited to what therapy does with the patient. This is because we intend to talk about this type of therapy. After all, significant structural changes can be obtained with diverse experiences.

Why talk about certain existential situations that can favor cognitive and behavioral changes? The concept of therapy could be broadened in such a way that, of course, any action or situation that favored a behavioral change or increased self-perception in each individual would fit within it. However, this does not correspond to what we call therapy itself.

In summary, it is evident that when talking about therapy with clinical hypnosis, it refers to a protocol that involves a patient or several patients with a therapist, during a session, and with a determined clinical purpose.

Grinberg, L. (1990) defines transference: "It is essentially a displacement on the person of the therapist (he conceives it only as an analyst), of friendly, hostile and ambivalent emotions that come from the childhood. The patient projects their irrational emotions, carriers of conflict, their fantasies, and expectations; that is to say, the primary process" He adds: "In transference, the individual transfers his memories of previous significant experiences, changing the reality of his objects, endowing them with the qualities of the past, judging them and treating them as he did in his past. " The same author admits, later, that the transference is "a general phenomenon discovered versus exploited by Freud to transform it into a technical tool of the first magnitude in the therapeutic process of analysis". (p.146).

Perhaps with this definition, it is clear what a therapist understands by transference. Even more surprising is the categorical affirmation made by some hypnotherapists, that in therapy with clinical hypnosis, there is no transference. However, it is crucial to understand the concept of transference and countertransference to understand how it intervenes or is controlled or controlled in therapy.

It is appropriate to resort to the source and quote some of the first passages verbatim, in the work of Freud, where he refers to transference.

Thus, the first time that Freud (1912) is “complicated,” so to speak in the relationship with a patient, describing it as follows:

*“There came a day in which I needed to check something that I suspected long ago. One of my most docile patients, with whom I had obtained the most favorable results utilizing hypnotism, surprised me one day after I had managed to free her from painful memories by throwing her arms around my neck when waking her from the hypnotic sleep. At that moment, a servant knocked on the door, and I avoided a painful explanation, but from that day, we decided by a tacit agreement to cease the continuation of the hypnotic treatment. Sufficiently modest not to attribute that incident to my attractiveness, I supposed to have discovered with him the nature of the mystical element that acted behind hypnotism. To suppress it, or at least isolate it, I had to give up hypnotic treatment”. (p.198).*

Furthermore, it is precisely here when Freud commits one of his career’s significant errors, both regarding his perception of hypnosis and understanding (what he would later define as) the transference as a counterproductive element to the therapeutic process. Later, when referring to this fact -before calling it transference- he uses expressions such as: “love,” “very nice relationships,” “favorable attitude,” “patient behavior that ends up conquering the doctor’s sympathies,” etc.

Finally, he uses the word with which he intends to define this phenomenon, which, unfortunately, is joined to a causal explanation. This is understandable since he needed some theory that would allow him to define this situation and continue his work. This is how it says:

*“This new fact, which we are so obliged to accept, we designate with the name of transference. Treat yourself (note that you use the conditional), then, a transfer of feelings about the doctor’s person, because we do not believe that the situation created by the treatment can justify the genesis of them. We suspect instead that all this affective disposition has a different origin “. (p. 215).*

So far, the textual quotation of Freud (1914), and with it the core point to which, after describing a phenomenon, he gives it a name and allows to formulate a working hypothesis. Furthermore, as we will see in another quote, attribute an origin to it.

He says later:

*“It would be foolish to want to avoid this phenomenon. Without transference, there is no possible analysis. It would help if you did not believe that the analyst believes the transference. On the contrary, the analysis is limited to revealing the transference and isolating it. It is a general human phenomenon that decides the success of any medical influence and generally dominates a person’s relationships with those around them. It is easy to discover the same dynamic factor to which hypnotists have given the name suggestibility, a factor that involves hypnotic rapport, and whose lack of constitutes the cathartic method’s defect. In cases where this tendency to emotional transference is lacking or has become totally negative, as in precocious dementia and paranoia, exercising a psychic influence on the patient also disappears”.* (p.221)

Moreover, with this definition (in which we did not want to add or remove a comma), Freud arrives at one of his most unfortunate deductions (except possibly the libidinal theory). That time would prove absolutely wrong.

The lack of guarantee of the hypnotic rapport to which Freud referred was based much more on an inefficient use of the protocol, as well as on the ignorance of what is now understood as focalization (a concept completely unknown at that time) and that Freud improperly called catharsis.

It is known how much Freud worries, in the beginning, to find himself with this fact and how at that moment, it seemed possible that criticisms of his new method (psychoanalysis) arose from here, as a method that in one way or another used the suggestion. His doubt is not surprising, because although he realizes that it is not the analysis that creates the transference, he emphasizes that this technique allows this phenomenon to be present. The above is in contrast to his first findings, in which the presence of an intensely positive transference is evident. When he used the hypnotic method, which highlighted his contradictions and grave errors, clinical hypnosis became the victim and condemned to be ostracised by the faculty for more than fifty years in favor of psychoanalysis.

By developing his method of free association and framing the therapeutic work with greater rigor *“he sees in the transference - as Grinberg (1990) says - the field in which the reminiscence of the past, under better conditions, allows rectification of the destinies of life affective and instinctive of the analyzed one”.* (p. 317)

Patients who do not see how this can occur do not consider themselves treatable with this method, which is another grave error. We know how later eminent analysts have shown not only that there is transference in these pictures, for example, in narcissistic neuroses (today called narcissistic personality disorder), but also how the negative transference can and should be treated.

Psychologists and psychiatrists who departed from the Freudian orientation to detect these errors and not agree on many fundamental aspects focused on the

phenomenon of transference from different angles. However, we do not know of any that denied the existence of this phenomenon. Thus, Jung (1960), in his book *Psychology of Transference*, says:

*“There may be almost no relationship of a certain intimacy between human beings without allowing the phenomenon of transference to arise in it, in a stimulating or disturbing way”.* (p.159)

Later he adds:

*“The author (referring to Freud) esteems his own influence in an excessive way. The transference is far from being a doctor’s creation. Often it exists already in all its power before it has occasion to open its mouth. The interpretation of Freud’s transference as an artificial disease is valid insofar as the transfer of a neurotic is equally neurotic, but this neurosis is neither new, nor artificial, nor created, but is the same old neurosis, and the only novelty is that the doctor is now involved in it, more as a victim than as a creator.”* (p.181).

Elsewhere Jung says:

*“The transference is as unlikely to be provoked as a creed. A creed only has value when it subsists by itself. An imposed faith is nothing more than a fiction. Anyone who believes that the transference must be forgotten forgets that this phenomenon is only one of the factors of therapeutics and that apart from that, the term transference is the one that corresponds in German to the projection, which is not a phenomenon that could be brought about”.* (p.178)

Later, in a note referring to the above, says:

*“This is for example that the doctor feels behind the patient, and also, imagine that the transference is a product of their technique, being instead a perfectly natural phenomenon that can happen to him as well as to the teacher, to the doctor who only treats illnesses and -last but not least- to the husband.”*(p.179)

Perhaps, as is proven by this quote, there is a certain lightness in Jung attributing to Freud the saying that the doctor creates the transference. Undoubtedly, such a generalized and universal phenomenon cannot be created, and that is what Freud says with all clarity and honesty. The therapy creates the transference neurosis, and that was the only way that it seemed possible to undo the patient’s neurosis. One could say that, by dint of being consistent with his theory. Freud finds a way to repeat in the “here and now” what occurred in the “there then” to correct the affective deformity. In other words, not finding an efficient way to control the transference, so that it does not interfere in the therapy, it looks for a way to control the appearance and development of it, which is highly effective for

the proposed purpose.

In summary, from the clinical hypnosis approach, it is clear that it is not possible to confuse the phenomenon of transference with the neurosis of the transference created by other techniques such as psychoanalysis. The phenomenon of transference is universal and is present in every human relationship. The patient transfers not only the infantile experiences or emotions, but the patient can project on the therapist's healthy and ill aspects of his personality, and this determines the characteristics of the transference relationship. Regarding the expression and definition of countertransference, the therapist transfers the patient. How this transfer is made depends not only on the characteristics of the patient, it also depends, as is logical, on the character structure of the therapist. In this sense, it is worth observing how the hypnotherapists themselves have realized that even when the "framing" gives guarantees of an absolute "objectivity" on the clinical material on which they base their interventions, what is obtained from the patients is determined in part, by the characteristics of the therapist. Acuña (2017).

It has even come to describe the countertransference neurosis, which, in principle, would be a highly disturbing element in the course of hypnotherapy. In reality, countertransference is a decisive element in the therapist's role as an interpreter, and in the behavior of the therapist when it is the object of complex transference expressions on the part of the patient. It seems that the therapist can apply the same thing Jung says about the patient. That is, if the therapist is neurotic, his countertransference will be equally neurotic.

### **Conclusion**

From the antecedents mentioned above it is where we start concerning the concepts of transference. Moreover, this orientation has been with a backdrop against which the therapist becomes disoriented when approaching his patients, whatever the type of therapy used. This is how it was observed that when working with a hypnotherapeutic orientation, the transference phenomenon appears systematically, and the differences lie in the management of this situation.

In this context, therapy with clinical hypnosis emphasizes the patient's cognitive restructuring and gives the instruments to favor this, greatly facilitating the task. Furthermore, the first surprise is the ease with which one can handle transference situations, which can be tortuous with other methods or approaches.

In our view, it would seem that in general, hypnotherapists do not "cultivate" the transference, just as they do not cultivate neurosis in the patient. From the beginning, they are alert to return the patient to his vigil if they generated projections during the session.

The patient is not allowed to hold others responsible for what happens to him (this would be the same as accepting our structural failure, cognitively speaking), nor does he accept being the repository of parts or aspects, which he must assume.

Instead of creating a neurosis, clinical hypnosis therapy emphasizes what a non-neurotic relationship can be for the patient. The latter is in total agreement with what the School of Psychology of the Self describes as a “therapeutic alliance.” According to Zetzel (1980), the real relationship is the nucleus around which a more mature therapeutic alliance can develop, even in the case of a psychotic patient.

It is the way of working that distinguishes the hypnotherapist. Through the realization in the “here and now,” the therapist who works with therapy orientation under clinical hypnosis is never applying clinical methodology only to his patient. He watches it in his whole, and from there, you can perceive a change of coloration, a gesture that is repeated, or a muscular contracture, to interpret transferential elements.

In clinical hypnosis, it is also not accepted that the patient transfers his own abilities or sees us as the almighty father or mother, able to alleviate his disorder with a simple “snap” of fingers.

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Transference and Countertransference in Clinical Hypnosis

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