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Hypnosis in the Desensitization of Fears of Dying

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ABSTRACT

This paper describes two cases in which hypnosis was successfully used, in the context of an integrative approach to therapy, to treat pathologically obsessive fears of death. The hypnotic interventions employed in each case are described in detail. The cases illustrate how hypnotherapy can be adapted to clients with widely differing clinical contexts and demographics, with one involving a 40-year-old African-American man (Lawrence), and the other, a 36-year-old white woman (Betty). The latter case illustrates how clinical knowledge, transmitted via a published case of Milton Erickson's, provided the author the idea for developing a novel solution to the client's pressing clinical problem.

Key words: obsessive fear of death; hypnosis; hypnotherapy; multimodal therapy

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1. CASE CONTEXT AND METHOD

The Cases

The two cases presented here have in common their presenting problem: pathological fear of dying. (Note that the names and other identifying characteristics of the clients have been disguised to preserve their anonymity; and both clients gave their permission to have their case written up for publication.) In both cases, hypnosis, within the broader framework of an integrative behavioral/experiential approach to therapy, is the treatment technique that seems to have helped. Both cases have been written up many years after they were conducted, employing the author's memory and written clinical records. This presents substantial methodological limitations to cases, since working from session transcripts, employing quantitative and standardized self-report measures, bringing in peer supervision reports, and related strategies are clearly ways to enhance the quality of information about therapy cases that were not available in the present cases. On the other hand, I believe that these two cases show the dramatic, positive effect of hypnosis for a very disturbing symptom (persistent and at times intense fear of dying) when other techniques were not working. Moreover, the second case has very positive, 7-year follow-up data. And so I would offer that these two cases have important lessons to offer, in spite of their methodological limitations.

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Hypnosis and Behavior Therapy

Long before the advent of cognitive-behavior therapy, hypnosis was in use as a rapid, direct, operationally specific, symptom-focused method of psychological healing. Not surprisingly, therefore, hypnotic techniques were part of the armamentarium of early behavior therapy. Wolpe and Lazarus (1966) recommended hypnotic induction as an effective way to produce the state of deep relaxation required for systematic desensitization. And Wolpe (1984) reported a case in which a flight phobia was cured by hypnotic suggestion. There have been a few reports of hypnosis as an adjunct in cognitive-behavior therapy, and a meta-analysis of these found that they enhanced treatment outcome (Kirsch, Montgomery, & Sapirstein, 1995).

That hypnosis can profoundly alter experience in laboratory situations, e.g., raising pain thresholds, has been amply documented; and there is reasonably good evidence for its effectiveness in a variety of clinical applications (Rhue, Lynn, & Kirsch, 1993). Nevertheless, hypnosis has not found a firm footing in behavior therapy. I suspect this is due to its avowed mentalism -- all the talk of the "unconscious mind." (Of course, systematic desensitization, despite its behavioral rationale, is utterly mentalistic in its employment of visual imagery.) Also, the ongoing disputes among researchers about the nature of hypnotic phenomena probably impeded its acceptance. In the early post-war decades the debate was cast in terms of the question, is hypnotic behavior due to a truly altered state of consciousness or is it simply an artifact of the social psychology of the hypnotic situation? The questions have since become more subtle but the controversy over the nature of hypnosis persists (Kirsch & Lynn, 1995).

Another bar to hypnosis in behavior therapy has been the overwhelmingly rationalist bias of the prevailing therapeutic ideology in behavior therapy: *cognitive*-behavior therapy. A theory of psychopathology and psychotherapy that posits dysfunctional, irrational thoughts as the origin of complex psychophysiological problems such as depression leaves little room for a technique that capitalizes on imagery and other extra-logical mental processes.

Multimodal behavior therapy (Lazarus, 1989), by contrast, is congenial to hypnosis. First of all, in according equal ontological validity to all the factors constituting psychological life -- affect, sensation, and imagery as well as cognition and behavior --multi-modal therapy provides a theoretical framework consistent with the mentalistic emphasis of hypnosis. Second, in its advocacy of technical eclecticism, and implicit acknowledgement that the mechanisms of action of all psychotherapeutic techniques are obscure, multi-modal therapy does not consign hypnosis to illegitimacy simply because its effects have been explained in contradictory, and sometimes implausible (i.e., "animal magnetism") ways. For clients who request it, Lazarus will use hypnosis within a multi-modal approach (Lazarus, 1999). Although the therapeutic approach described in this article is not, strictly speaking, multi-modal therapy, it is multi-modal in spirit.

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2. THE CLIENTS

Case A: Lawrence

Both clients were seen in my private office. Lawrence, who was referred by a employee assistance program (EAP) counselor at his work. He was a tall, healthy-looking, 40-year-old, African-American man. His chief complaint was, "I have a fear of my own mortality." His only other complaint was that he suffered from middle insomnia -- awake and watching TV for 30-45 minutes several nights a week -- which he couldn't explain, but denied all other symptoms of major depression. He had a good, non-dangerous job, responding to emergencies resulting from equipment malfunctions in a high-tech environment; he lived in a nice neighborhood and denied any fear of being the victim of criminal or random violence; and he said that his marriage and family were fine. This was his second marriage. His 20-year-old son and 14-year-old daughter from his first marriage lived with him and his second wife, along with a daughter and 6-year-old son from the current marriage.

Case B: Betty

Betty was 36 when I met her. She had been married, happily overall, for 16 years and had a nine year-old son who was doing well. She worked in a responsible management job in a large corporation and had been referred by its medical department.

Betty's presenting problem was a continuing and daily obsessive fear that she or her husband or son would be struck by fatal cancer. This obsession interfered in her life every day and manifested itself in a variety of ways. This manifested itself anytime she, her husband, or her son had any physical symptom, leading her to jump to the conclusion that this was a sign they had cancer and would surely die from it. She would seek out television, newspaper, and magazine stories about cancer, and newspaper obituaries. On the days before her yearly gynecology exam, her fears of cancer would exacerbate.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT: HYPNOSIS IN MY PRACTICE

My own adoption of hypnosis is closely connected with my movement away from a strictly cognitive-behavioral approach. When I was first hypnotized, during my internship at a VA hospital in 1975-1976, I still identified strongly as cognitive-behavioral, and so I didn't think much of it. A psychologist from another VA hospital visited and gave a presentation on hypnosis. I remember him identifying himself as a cognitive-behavior therapist and wondering what a nice cognitive-behaviorist like him was doing messing with hypnosis. At the end of the presentation he announced that he would do a brief induction. I don't remember what happened in the 15 minutes following that; I was in a hypnotic state. Indeed I had experienced an amnesic trance, which I later learned is characteristic of some highly hypnotizable subjects. Despite this

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striking demonstration of the reality of hypnosis, I did not follow up on it simply because my strict cognitive-behavioral, therapeutic ideology forbade it.

I did not set out to learn hypnosis until ten years later. Over the intervening decade I had moved from a narrowly cognitive-behavioral therapy model to an approach that -- although still directive, problem-oriented, and short-term -- was much more experiential. The first step in that process was my being, in operant terms, "shaped up" by the contingencies of the clinical situation such that I was making extensive use of the Rogerian techniques I had scorned as a "scientist" in graduate school. I discovered that not only was reflection a fine way to keep the conversation going, but that a carefully crafted summary reflection of affect could function as a powerful tool for cognitive restructuring. I was influenced in this connection by reading the work of second-generation students of Rogers (e.g., Wexler & Rice, 1974), who recast Rogerian ideas into formal, information-processing terms. For me, a major theoretical advantage of this updated experiential approach over cognitive therapy was that it took account of the fact that cognitions are not merely covert behaviors--sentences people say to themselves--but entities that are, at any given moment, held in a specific semantic relation to each other; i.e., they exist with reference to each other within a cognitive *structure*. My use of Rogerian techniques convinced me of the crucial importance of tracking the moment-to-moment changes in the client's feeling state -- his or her "experiential flow". That, in turn, led me to an appreciation of the centrality of the individual's ongoing non-verbal, bodily encoded experience -- in short, feelings -- in organizing behavior. (Much later, I found empirical support for these speculations in my reading of neuroscience [Damasio, 1994]). When asked, nowadays, by clients who are sophisticated regarding systems of psychotherapy to describe my approach I tell them that it is theoretically experiential but operationally behavioral.

I took an introductory course on hypnosis accredited by the American Society of Clinical Hypnosis, but felt comfortable using it clinically only after taking an intermediate course from Joseph Barber, who taught a conversational, "permissive" as opposed to "authoritarian" method of hypnotic induction (Barber 1996); e.g., instead of "Your muscles are becoming heavy and slack," rather:

> As you become as relaxed as you'd like to become, and as you let the entire weight of your physical self be supported by what you're reclining on, and as you just let all your muscles go, you may be feeling a pleasant feeling of heaviness in your body, like you might feel after taking a swim. And I don't know where you're feeling that heaviness most, and it doesn't matter that I know. All that matters is that you enjoy this experience.

My first success in hypnosis came in the treatment of a case of facial pain caused by inoperable nerve damage due to a whiplash injury. The client and I were able to discover imagery that was successful in alleviating the pain, but it lasted only for the day she was hypnotized. So I made a tape of the hypnosis for her to listen to at home. Daily hypnotic practice with the tape prevented the pain from recurring. I later read (Chavez, 1993) that such daily practice is often decisive in the hypnotic treatment of pain.

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A quick glance at the *Handbook of Clinical Hypnosis* (Rhue, Lynn, & Kirsch, 1993) will indicate that success has been claimed for hypnosis in a dizzying variety of conditions, ranging from smoking cessation to warts. In my own experience, though, hypnotic suggestions are not strong enough to overcome the client's ambivalence; so they can be used only when the client is absolutely unambivalent about them. Accordingly I limit my use of hypnosis to the treatment of anxiety disorders and chronic physical pain.

My understanding of hypnosis is that trance is a naturally occurring human state, characterized by narrowly focused concentration. Consequently, a trance screens out a good deal of environmental information that would otherwise be in our attentional field, producing to one degree or another the experience of dissociation. We all go into trances all the time without knowing it: when we are absorbed in a book or a movie, or simply daydreaming, or when we are physically active in behaviors that require intense focus, such as practicing a musical instrument or an athletic move like a golf swing. Paradoxically, driving is also an occasion for trance states. Many clients have had the experience of driving from point A to point C and then realizing that they have no recollection of having passed point B in between.

It is noteworthy that the situations conducive to trance states are individual rather than interpersonal. Hypnosis is, then, most accurately characterized not as an altered (in the sense of unusual) state of consciousness, but rather as the unusual mobilization in the interpersonal context of persuasive communication of a state of consciousness usually reserved for non-interpersonal contexts. Specifically, in the hypnotic situation, the client's highly concentrated state combines with a distinctive set of (more or less explicit) interactional rules to give the therapist persuasive advantages not available in ordinary therapeutic conversation:

1. The client is in a physically passive, recumbent position, with eyes closed.

2. The client is forbidden from talking, unless directed to by the therapist.

3. The therapist is allowed to repeat messages in a way that would be heard as inappropriate in ordinary conversation.

4. The therapist is allowed to use metaphors with a deliberate, denotational concreteness that would be regarded as implausible (by adults, although not necessarily by children) in ordinary conversation. For example, to a woman who has been the victim of a crime, the hypnotherapist might say, "The caring and concern of your son, the caring and concern of the county prosecutor, the caring and concern of your doctor, my caring and concern -- all of our caring and concern for you are an invisible shield, sort of like an invisible dome that surrounds and covers you, and follows you wherever you go and whatever you do, and protects you from all harm."

I explain all this to clients by way of preparing them for hypnosis. Giving the client an adequate understanding of hypnosis is, I believe, crucial to its success. At the very least it facilitates the client's attaining a trance state by neutralizing the anxieties about hypnosis that clients almost always bring with them. Among the other points I make during the preparation stage are:

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1. Hypnosis is nothing like what is commonly portrayed as hypnosis in the movies or on television.

2. Most importantly, hypnosis has nothing to do with my having power over the client or with the client's being "suggestible" or "weak willed."

3. Trance is a normal human state, and people go into trance states without even knowing it all the time.

4. People can go into hypnotic states because they have, in varying degrees, the capacity to focus concentration and the capacity to experience vivid visual imagery; and clients can "be hypnotized" for the same reasons that they can become absorbed in a suspense or romance novel.

5. When "the therapist hypnotizes the client," the therapist is merely issuing a set of instructions for the client to achieve on purpose what the client often does inadvertently; and if the client chooses not to follow these instructions the client will not enter into a hypnotic state.

6. Just as people use novels to achieve certain emotional and even physiological effects, they can use hypnosis to achieve emotional and physiological effects that will help solve their problem.

7. When the client is in a hypnotic state, the client will be alert, awake, thinking his or her own thoughts about what is happening, and even thinking the thought, "I wonder if I'm really hypnotized."

8. There is never any problem about "getting out of" a hypnotic state.

It is rare that, after such preparation, a client will have trouble entering into a hypnotic state.

Like most hypnotherapists, when I craft a hypnotic suggestion I attempt to combine images of the desired behavioral change with direct suggestions for behavioral change, as in the driving example cited above. All my hypnotic suggestions begin with *a generalized suggestion for rapid change*:

> Sometimes the psychological changes we experience in our lives happen slowly and gradually. For example, as we grow older we gradually become more mature and wiser...or as we get to know someone over time we realize that we like them more and more. But some psychological changes, sometimes big ones, can happen very quickly, almost instantly. Some of these very rapid psychological changes are unpleasant, like [in the case of a post-traumatic phobia] what you experienced some time ago. But some of these very rapid and very big changes are pleasant ones...they are changes we very much want. Falling in love is one of those pleasant changes that many people experience almost instantaneously. That's why we have the phrase, "love at first sight." Religious conversion is another huge psychological change that can happen to people in an instant. Something touches you and suddenly the whole world looks different...And the interesting thing is that we don't really do anything to make these big and pleasant changes happen to us....they just happen...and it's hard to say why...So if in these next weeks or even days or even hours you find yourself feeling much better than you have, you might wonder why...but it doesn't really matter...Was

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> it this hypnosis, this tape? Maybe, maybe not...it really doesn't matter...all that really matters is that you feel better...and it really doesn't matter why because big positive changes like this happen all the time...they just happen.

Usually, I do not prepare the rest of the hypnotic suggestion in detail in advance. I have a general idea of what I am going to do; and I have notes, usually that the patient has written him/herself, outlining the major images and statements I will use. From there, I improvise.

Case 1, presented below, is unique in my practice because I wrote out the hypnotic suggestion in advance. I did so because the suggestion was a bit complicated, involving multiple components, and I did not want to make a mistake in delivering it. I am glad that I have an annotated verbatim transcript to present in this article.

4A – 8A. THE CASE OF LAWRENCE

4A. Assessment of the Client's Problems, Goals, Strengths, And History

One of nature's kindnesses to human beings is that -- unless we are Kierkegaard, or Woody Allen, or depressed, which all amount to about the same thing -- we don't think about our own death very much. The deaths that surround us all the time, that we hear about, that are reported on the news, that we see portrayed in grisly detail in movies, even the deaths of loved ones, leave us remarkably unfazed. They are remote, abstract; they are happening to someone else. We blithely look forward to the future, sometimes even with impatience -- to the party next weekend, to having a better golf swing next time we play because we have been practicing. Ordinarily this furniture of our quotidian life blocks our view just enough so that we don't have to see the unmarked door at the end of the hallway. But every once in a while, some malign hand sweeps the furniture away, and we see it. We have an immediate and urgent sense of our own mortality, and our blood runs cold. It may be in the form of a visual image -- our dog looking around the house for us, but we're not there because we're dead -- or it may be a non-visual realization, e.g., "In the year 2080, when the Zeus space probe leaves the solar system, history will be going on, but I won't be around to know what's happening." For a brief moment we glimpse our own death, we have a powerful visceral response to what we see -- and then we go back to what we were doing.

There have been many religious thinkers, and even some secular ones, who have claimed that it is not good to be as unmindful of death as we ordinarily are; that we would be better off spiritually and emotionally if we paid more attention to it. Spinoza, on the other hand, thought that it is life, not death, that is the worthy subject matter for the philosopher and for the rest of us. My own attitude toward my mortality is like Hamlet's toward his mother's sex life, "Let me not think on it."

This was Lawrence's view too, but nature had not been so kind to him. While as mentioned above, Lawrence presented as a healthy-looking, 40-year-old-man with no apparent job or family problems, almost his first words to me were, "I have a fear of my own mortality."

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The experiences that most of us have only occasionally and shake off, Lawrence was having almost every day, casting a pall of dread over his life. He reported that he first remembered being troubled by the fear of his mortality at least since age 15 or 16 when a friend of his died in a fire. He also remembered that, when he first saw a dead body, at a wake when he was age four or five, the thought occurred to him that if he touched the body he would be dead too. He sought treatment with me now because over the past few months the fear had become "more and more with me....more pervasive." It had even invaded his sleep in the form of a dream he had been having about once a week: He is on his deathbed surrounded by his children. He looks at the grief-stricken face of his eight year-old daughter and he feels a tear welling up in his eye.

With this kind of chronic and pervasive symptom, there is much to assess before you can have a clear enough idea of what you are confronted with so that you can think of a treatment. Were there any precipitants for the recent increase in the frequency and intensity of his fears? In fact there was one that was plausible to Lawrence. A coworker had died suddenly of a heart attack just a few weeks before at age 46. Lawrence had been shaken by that, he readily admitted. In addition, his mother had died five months before at age 76, and his mother-in-law three months before that. Lawrence, though, denied being greatly affected by either of these losses. His mother, he said, had been well-prepared to die. He said that even though he loved her, he hadn't shed a tear over her death. This sounded peculiar to me because Lawrence struck me as a sensitive and warm, expressive person, and I entertained the possibility that his problem might be, at least in part, a complicated grief response.

Of course, when there is a fear of death, the client's current state of health and personal assessment of his or her own health are important questions. It turned out that Lawrence had intriguing answers to them. Since his teens he had suffered from asthma. There were periods in his life, although not in the recent past, when it had been "a lot of trouble," but not recently. He was able to carry on a normal life, including an intensive schedule of competitive softball. On the other hand, Lawrence's sister had died of an acute asthma attack about ten years before. And he reported that he would panic if he ever found that he had left home without his inhaler.

Likewise, when there is a fear of death, the state of the client's religious faith is of relevance. Lawrence said that he considered himself religious but was not involved with any church. He said that he could be not sure of immortality and that he didn't know "what death is like." But the many similarities, including asthma, between his sister and his younger daughter who was born shortly after the sister's death, made him think that reincarnation may exist. He also said that he believed he had "a guardian angel," whom he felt had protected him from dying in a couple of situations that should have killed him. For some reason, I didn't follow up on this intriguing revelation in the initial interview. But I did note it for further investigation in the second session.

Did he have any other related fears? It turned out he did. He was afraid of driving in adverse weather conditions, especially in snow. He was afraid of accidents like two he had seen on interstate highways in recent years. In one, he had seen an Isuzu Trooper roll over; in another, he had seen a Chevy Chevette plow into the back of a tractor trailer and get stuck under

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it. He never felt quite at ease driving, although he drove every day. Sometimes he worried about being hit by a softball, but this did not affect his game. He was afraid of heights and was afraid of going up ladders. I decided to probe this fear in vivo, I stuck my torso out my thirteenth floor window and then, resting the weight of my body on the two-foot wide ledge outside it, raised my feet off the floor. Lawrence reported that he started to get a little nervous only when I lifted my feet. Was he afraid of flying? No. Did he have any signs of agoraphobia? No.

Because Lawrence was African-American, and because the lives of African-American men are lived in much closer proximity to danger than those of many other people, I asked him about his personal sense of danger. He said that he did not feel in imminent danger. He had a good, non-dangerous, professional job in a high-tech environment. He lived in a nice neighborhood and denied any fear of being the victim of criminal or random violence.

Did he have any other life problems or psychological problems? It looked like the answer to that was no too. He lived in a nice neighborhood and denied any fear of being the victim of criminal or random violence; and he said that his marriage and family were fine. As mentioned above, he lived with his 20-year-old son and 14-year-old daughter from his first marriage and with his second wife, along with a daughter and 6-year-old son from the current marriage. His only other complaint was suffering from middle insomnia, as mentioned above, but he denied all other symptoms of major depression. Also, he was only a light, infrequent drinker.

Finally, what exactly was it about death that he was afraid of -- the process of dying, pain, not having any more experiences? For Lawrence it was definitely the latter. However, he said that he was not completely sure that he would have no sensations after death and was undecided about the immortality of the soul. And he even expressed some fear about what it might feel like to have his body buried or burned after he died. These speculations notwithstanding, Lawrence's fear of his own mortality was premised on the conviction that after he died he would have no more experiences, that there would be nothing.

5A. Formulation and Treatment Plan

By the end of the first session, my working hypothesis was that Lawrence's fear of his own mortality was indeed some kind of anxiety disorder, with multiple factors, at different stages of his life, contributing to its etiology. I did not at that point have a definite plan for treating it. One idea I entertained was that we might desensitize his fear of heights in vivo and see if that had any more general effect. I shared all this with Lawrence and suggested that he read my copy of *Anxiety and its Treatment* (Greist, Jefferson, & Marks, 1989). I wanted him both to get an idea of the general approach we might be using and also to see what he might most identify with as read about the varieties of anxiety disorder.

As I wrote up my notes to the initial interview, I had a brief episode of panic myself. I recalled that the employee assistance program (EAP) counselor who had referred Lawrence had characterized his problem as an obsession with death, and then I was seized by doubt. Maybe

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Lawrence's problem was actually some variant of obsessive compulsive disorder (OCD), and I had spent most of the first session barking up the wrong tree. I couldn't wait to see Lawrence again to find out.

In fact, I had to wait three weeks because Lawrence cancelled one of the next two appointments I made for him and didn't show for the other. Ordinarily I would not persist in reappointing someone who had behaved like that, but in the case of Lawrence: a) I was somehow convinced that he was generally a good and decent person and dealing with me in good faith, and; b) I was too interested in his case to just let go of it. When we finally met for the second time I did not discuss his missed appointments beyond asking him what came up (as it turned out, a work emergency, and then an opportunity to do advance planning for the Million Man March).

The first questions I asked Lawrence were about his sister's death: Exactly what happened and what was his reaction? His sister had died suddenly at night. Her asthma was worse than his had ever been and required oral medication in addition to an inhaler. She had an asthma attack, evidently found that she had run out of medication, and died on the stairs outside her house as she left to get help. Lawrence's first reaction, when a family member phoned him, was disbelief. He did not, though, draw any personal implication from her death, because at that point in his life, and in fact during the entire period from age 17 to 36, he'd been free of asthmatic problems.

It was only after his own asthma returned, within the past year, that he started to think about what his sister's death implied for him. Currently, though, he did not feel a sense of personal danger stemming from her death. His asthma was less severe than hers, and he identified himself as a much more careful person than his sister. Even though he occasionally forgot his inhaler, he thought of himself as the kind of person who would never let himself run out of medication as his sister had. "I feel like I have a lot of control in my life right now," he said. Nevertheless, the recent recurrence of his own asthma, in my view, had to have something to do with his current death fears.

Lawrence's sister died on a Memorial Day. Over the Labor Day weekend just three months later Lawrence's brother died suddenly of a brain aneurism at the age of 42. Lawrence and everyone else in the family were shaken by this, and as the Veterans Day weekend approached they waited apprehensively to see who would be next. But no one died then, and in fact there wasn't another death in the family for almost ten years, until Lawrence's mother died. Lawrence mentioned that he made occasional visits to his sister's grave, lingering there for about 15 minutes, but that he had never cried over her death or over any of the losses he had experienced. I told him I thought this was significant and raised the possibility that his mortality fears were a manifestation of unresolved grief.

There seemed nowhere else to go with regard to the sister, so I shifted my inquiry to the guardian angel. The angel had intervened three times. Lawrence explained that at five he had fallen out of a moving taxi and survived. It had been one of those big old Checker cabs with the

little, round, fold-down, kiddie seats in the back, in which Lawrence was sitting. The taxi rounded a corner, possibly faster than it should have. The inertia of the turn forced open the back door of the cab and pitched Lawrence out. A truck following the taxi rolled right over Lawrence and, as Lawrence would have it, would have killed him had not the guardian angel kept him from raising his head.

Then, more than 25 years later, within the space of a year, he got into two serious automobile accidents which he felt should have at least caused him serious injury or even killed him. In the first, Lawrence was driving when another car ran a red light "at 80 miles per hour" and broadsided his car. Lawrence's brother and nephew, who were passengers in his car, lost teeth in the crash. Lawrence suffered only a stiff shoulder. In the second accident, Lawrence was driving on a busy urban highway to the airport when suddenly his car slipped on a patch of ice. The car turned full circle and finally crashed into the divider. Lawrence, though, "walked away" from that accident, too, "unscathed." He felt that in both instances there had been a "higher power...somebody looking out for me." I asked him if he could recall seeing that power in physical form. He said he hadn't.

Finally, I asked him a series of questions about OCD, all of which he answered negatively; he didn't, in any sense, regard his death fears as protective. He added that he didn't even like getting into ordinary routines. So that was that for the OCD hypothesis.

Having eliminated OCD as a diagnosis, I settled on hypnosis as the treatment. In part, and perhaps paradoxically, I opted for hypnosis instead of a straightforward psychotherapy approach expressly because there was so much material for psychotherapy in Lawrence's case -- too much. His fear of mortality was the result of such a variety of causal factors, probably none of them decisive but all of them together interacting in such dizzying complexity, that the prospect of psychotherapy to understand it all was overwhelming to me. Better to acknowledge my uncertainty about exactly why and how Lawrence developed his particular problem and what, if anything, it meant about how he really felt about himself and his life, and just try to eliminate the problem in the simplest way possible.

I must confess that part of my rationale for using hypnosis was based on a mistake I made in recollecting what Lawrence had told me in the first session three weeks before. Despite the fact that my notes, which I read just before the second session, clearly said that Lawrence's image of himself on his deathbed was a dream image, I misremembered it as being the core of his waking experience of his mortality. (I also misremembered the teardrop as welling up in his daughter's eye and then running down her cheek.) Accordingly, I reasoned -- and actually said this to Lawrence -- that if a visual image was central to his experience of mortality, we could use visual imagery to counter it. He didn't react with puzzlement when I said that, or maybe I didn't notice it. In fact, when I mentioned hypnosis as the vehicle for the imagery he responded enthusiastically, explaining that several years before, one session of hypnosis had instantly and lastingly cured him of his longstanding addiction to cigarette smoking. While my own clinical view is that I do not expect hypnosis to be effective in smoking cessation, I didn't give voice to my skepticism. I just said something like, "Oh gee, that's great," and wondered silently about

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why hypnosis had worked for him. I suggested that, for the next session, Lawrence think of imagery that might be useful in countering his mortality fear. I also asked him to do something that I should have recommended the first time we met, to keep a record of the occurrences to the fear -- when they happened and some estimate of their intensity.

When Lawrence returned for the third session, he reported that he had experienced only one fleeting thought about his mortality in the past week. He attributed this very low frequency of attacks to the fact that he had been too preoccupied with a toothache he had for three days of the week to worry about his mortality. I thought that was very interesting, and intuitively, in a way I couldn't quite articulate to myself , I felt it made a great deal of sense. The one episode of fear had occurred when he'd heard about a tragic collision between a commuter train and a school bus at a railroad crossing. When he mentioned the stimulus for this episode of fear, I mentally slapped my forehead with my hand, and asked myself how I could be so stupid. Up until that moment, I had made the completely unjustified presumption that Lawrence's mortality episodes, like mine, came seemingly out of nowhere, in the absence of any environmental stimulus, and so I had not asked him the obvious question of whether any particular kinds of situations were more likely to provoke them. So I asked the question and Lawrence indeed enumerated the likely suspects: hearses; funeral homes; funeral processions; driving in bad weather; the sight of a car overturned in a ditch, a tractor trailer coming towards him on the other side of the road; and doctor shows on television, especially when the doctors said that the patient's condition was hopeless and it looked like they were giving up. He added emphatically that he would never want life support withdrawn from him, if he were ever in that situation, because you could never tell when someone might come up with a cure to what had put you in a coma.

Hearing all this at once rendered Lawrence's problem less mysterious and easier to treat. The fear was indeed provoked, at least some of the time, by specific external stimulation. I could use a hypnotic suggestion in which Lawrence visualized himself in those situations and having a non-phobic reaction to them. In short, I could desensitize it through imaginal exposure.

I then asked Lawrence what represented an image of life to him. What I had in mind was some actual situation but evidently this is not how Lawrence interpreted it because he answered that, for him, such an image was a particular photograph taken a few years before of his wife and children. I rephrased the question and asked in what situations did he feel particularly alive. He responded with the following list: playing with his kids; when his 6 year old son crawls into his lap and snuggles; fishing; and playing softball. I now had enough information to formulate a hypnotic suggestion.

6A. Course of Therapy: The Hypnotic Intervention

As mentioned above in the section on Guiding Conception, usually when I do hypnosis, the suggestion I use is simple enough in its general outlines so that I can improvise upon it as I go along, relying on only sketchy notes or no notes at all. In this case, there were too many small details I wanted to include, and I was not confident that, improvising, I could get them all

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in and in the right order. So I composed the hypnotic suggestion in advance. When Lawrence came in to be hypnotized at our fourth session I told him that the suggestion I had prepared was based mostly on things he had told me, his own ideas. The following, with only minor ad lib elaborations, is exactly what I said:

1. I'm going to talk to you about how your mind works and what's really important in life.

2. I'm also going to talk about change and how it happens [and then the rest of the *generalized suggestion for rapid change* I presented above in the Guiding Conception section].

3. You know that you have many blessings: you are alive, married, have beautiful and happy children, general good health. You know other people don't have the blessings you have: they have died young, some of them, and you wonder. . . .

4. You think that maybe your blessings are some kind of good luck. You have told me that you believe that you have a guardian angel who has protected you in a couple of life threatening situations, and maybe you do. But I think it's more than that. I think a big part of your guardian angel is you. It wasn't just that your guardian angel protected you: you protected you. When you rolled out of that taxi, maybe you didn't consciously keep your head down, but your innate survival instinct, your unconscious mind, kept your head down. And in the car accidents you had, when you skidded on the ice and when that other car plowed into you, things happened very fast. Things may have happened so fast that you weren't aware of the instantaneous protective actions you took to prevent those accidents from becoming major disasters. You may not have been aware of it at the time, but your unconscious mind was in control, you were in control. You are a very rational and plan-full man and that's another way that you maintain control. You have been rational and careful about the kinds of cars you buy. **You** wouldn't ride around in a tiny sports car. **You** are careful about your health in ways you have to be. **You** wear your knee braces. [Lawrence, like many of us middle-aged athletes, had to resort to knee braces if he wanted to participate in sports.] **You** always carry your inhaler. **You** would never run out of your asthma medications.

   So it's not just luck, it's not just your guardian angel that keeps you alive. So when you are driving in bad weather, you are a little nervous. Of course you are, because you are going to be alert to any possibly dangerous situation and you will avoid it. When you are driving and you see a big truck approaching in the opposite direction, of course you are nervous because consciously and unconsciously you are preparing for the worst case so that whatever happens to the truck you will be in control and you will protect yourself and everyone else in your car. Other people may not be so careful. But **you** are very careful and that makes up for their lack of care. **You** are careful and you are in control, and that makes the difference between you and other people.

5. So if other people get hurt and if other people die that has nothing to do with you. That's them. They are someone else and you have other things to worry about. You have better things to do.

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During the day you are exposed to all sorts of things that could remind you of death, but I wouldn't be surprised if in these next days, weeks and months you feel strangely *detached* from them. It's not you. It's someone else. And you have better things to do. **You** have more important things to do. Driving around, you may see a hearse or even a funeral procession. You may even catch a glimpse of the casket or of some of the relatives of the deceased. And you may even feel sympathy for them, for their loss. But they are someone else, and you are you and **you** have better things to do and more important things to do, and **you** are in control.

You have important things to think about, like your kids, and you can see so clearly in your mind's eye that photo you told me about of them. And it feels so warm and comforting to just visualize that picture at any time because that's what's really happening. And even when you see a funeral procession you realize that the funeral is someone else and you are you and you have more important things and you visualize your kids and it's so warm and comforting. And you might even get preoccupied with something about the kids. Maybe one of them has a cavity or maybe one of them needs some special supplies for school. Because that's what's really happening.

6. Likewise when you watch doctor shows on TV, you watch them with a different kind of attitude, a special kind of *detachment.* You are in control and you put yourself in the position of the doctors. You feel bad for the patient but they are the patient and **you** are not. You are like one of the doctors and you worry about the patient and you try your best, but you are not the patient and so what happens to them happens to someone else. And that's too bad. But you have your own concerns and those are different, and **you** are *alive* and **you** are *in control* and **you** have better things to do.

7. Now, as time goes by, you will have occasion to attend a funeral or wake of some kind or even go to a cemetery. And again this special sense of *detachment* will go with you. And this sense of detachment will protect you as if it were an invisible shield, an invisible dome protecting you. And the special sense of detachment is the thought that: You are you and they are someone else and you feel bad for them, but you are in control so they really have nothing to do with you. And you might visit your sister's grave and you might even find yourself crying and that's just fine because she is your sister and you love her. But she's someone else, and she lived a different way. And her problems are not your problems. So your invisible shield protects you. Because though you feel sad for her, you feel thankful for your blessings. And you think about your kids and you think about fishing and you think about softball, and that is so comforting and that's really what's happening in your life.

8. And of course you think about the future and there's so much good stuff to look forward to, and when you think about the future what you think about is the good stuff: It gives you pleasure to think of your kids growing up, becoming good and strong and responsible people. And of course you're curious to see exactly what they will make of their lives. Almost like a mystery story: You want to see how it turns out. You look forward to that. And you look forward to having grandchildren and having them cuddle up in your lap, just like your son does now. When you think of it, even though you are 40, there is so much more of your life in front of you. There is more than you can even imagine. And you know how bad any of us is at predicting the future. So when you

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> look forward towards the future of your life, it's like looking out at the ocean: You can't see to the other side. And as the days and weeks and months go by, you will be curious to see what comes next, and you'll look forward to the coming time with a sense of pleasant anticipation because you know that every day there is something good that you can look forward to.

This transcript needs little explication. It contains the same interlacing of images and direct suggestions for cognitive change that are characteristic of all my hypnotic suggestions -- just more of them than usual. Paragraph 2 is an abbreviation of the *generalized suggestion for rapid change*, which, of course, I delivered to Lawrence in its entirety. Paragraph 4 takes off from Lawrence's statement about feeling in control, and develops the theme that he is his own guardian angel by virtue of his faculty of control. It also positively reframes part of his driving anxiety into an aspect of this faculty.

Paragraph 5 marks the beginning of the development of a theme that continues for most of the rest of the suggestion: that Lawrence is detached from people who die, that they are someone else. This paragraph also contains the first desensitization image: seeing a funeral procession, thinking about his kids instead, and feeling good. The desensitization continues in paragraphs 7 and 8.

Paragraph 7 also contains a direct suggestion that Lawrence cry when visiting his sister's grave. This suggestion was based on an hypothesis I had developed that Lawrence's inability to cry could be due to his over-identification with people who had died. If he could think of his sister as someone else, he might be free to cry over her. I was also hoping that crying, in turn, might help with his fears if indeed they were partly a manifestation of unresolved grief. Paragraph 8 is a direct suggestion to anticipate the future the way most people do most of the time. The hypnotic suggestion ends with a metaphor that concretizes the idea of death as remote.

I brought Lawrence out of the trance state in the usual way, by counting from one to five, and then asked him the usual debriefing question, "What did you experience?" He looked at me with a puzzled expression, paused for a second, and said, "Nothing." Then he looked at his watch and literally jumped out of his chair -- this rather large man looked like he had been levitated -- in his surprise that 45 minutes had elapsed without his awareness. Lawrence had experienced an amnesic trance, something that happens only to a very small percentage of hypnotic subjects, and only to those who have the greatest talent for entering a deep hypnotic state. Now I understood why hypnosis had worked for Lawrence's smoking. If it was going to work for anyone, it would be for someone like him.

Lawrence said that he felt very good after this hypnosis and noted that he was now breathing more easily than he had been during the hours before it. I told him to listen to a tape of the above-listed hypnotic suggestion daily for two weeks and we made an appointment to meet again.

7A. Therapy Monitoring and Use of Feedback Information

No formal monitoring of the therapy was conducted other than the processes described in the above section.

8A. Concluding Evaluation of the Therapy's Process and Outcome

After the hypnotic suggestion session, Lawrence cancelled his next appointment -- another work emergency. I couldn't resist asking him, on the phone, how he was doing. He said he was doing very well. Two weeks later, the day before his next scheduled appointment, he called and cancelled it. This time, on his phone message, he said that he was not sure he even needed another appointment because he was doing so well. I phoned Lawrence four weeks to the day after the hypnosis. I told him I was thrilled he was doing so well and asked him the details. He reported that he was listening to the tape at least every other day and had experienced no recurrence of mortality fears. "I feel great," were his words. When I told him I wanted to write up his case, he said, "I'm honored."

I tried to do a long-term follow-up on him for this report. But when I called the number I was told that he didn't live there and had not for a long time. I would like to think that Lawrence is doing well still, for reasons that I provide in the last section of this report.

4B – 8B. THE CASE OF BETTY

4B. Assessment the Client's Problems, Goals, Strengths, and History

As mentioned earlier Betty was 36 when I met her. Generally happily married for 16 years with a nine-year-old son, who was doing well, she had a mid-level management job in a large corporation and had been referred by its medical department.

As mentioned earlier, Betty's presenting problem was an obsessive fear that she or her husband or son would be struck by fatal cancer. This obsession interfered in her life every day and manifested itself in a variety of ways. Anytime she or her husband or son had any physical symptom—e.g., an ache or pain, something unusual on their skin -- Betty would jump to the conclusion that this was a sign they had cancer and that they would surely die from it. She would seek out stories about cancer on television and in newspapers and magazines and read them. She would also scan the newspaper obituaries, calculating the age at which people died; and for anyone who died relatively young, if the cause of death was not specified, she would conclude that it was cancer and would be afraid. Her fears of cancer would be particularly intense in the days preceding her yearly gynecology exam.

On the face of it, Betty's obsession seemed to have a clear precipitant. Her sister, older by about 10 years, had died of a recurrence of breast cancer just a half-year earlier. Betty explained that for her cancer was worse than anything else because it was, as her mother had said

to her many years before, "the silent killer. . . . By the time you feel pain, it's too late." Heart disease, for example, was far less dreadful because it was more easily detectible and controllable.

Betty regarded her obsession with cancer as simply the most recent version of an obsessive fear of death that had haunted her since childhood, specifically from age eight when she nearly died in a car accident. Her understanding was that she had been given last rites in the hospital because she was not expected to live and that her father prayed on his knees through that entire first night. Betty remained in a coma for two weeks after the accident before retaining consciousness. Her family had told her that as child she had been very afraid of dying and that they would have to rock her to comfort her. She had also been afraid of her sisters or parents being killed in an accident. Betty recalled two periods of her life when she was relatively free of mortality fears: at age 17 when she and her husband started going out together, and for a period after she got married at age 20.

Betty's fear of death was not an isolated item of psychopathology; it was embedded in a matrix of other emotional problems. At some point prior to seeing me -- I imagine less than a year -- she had been diagnosed with depression and prescribed Prozac by her family physician. She was still taking it when she began treatment with me, although she did not quite meet diagnostic criteria for major depressive disorder at that time. Betty had a prior history of depression: a post-partum episode, about nine years before. It is noteworthy that both of Betty's parents had histories of chronic depression, and her father had a history of alcohol abuse. In addition, one of Betty's sisters had suffered from panic disorder and been treated with medication.

Betty was also significantly overweight, weighing about 90 pounds more than she had 16 years before, at the time of her marriage. Most of that weight had been gained in the last seven years, that is, starting two years after the birth of her son. Betty said that she felt "addicted" to carbohydrates and chocolate, which she would eat when she felt particularly depressed. She had tried a variety of weight loss strategies over the years but, like most people, found that even if they worked the weight loss was only temporary.

There was also evidence of obsessive rituals. If she did not put her makeup on in a certain order -- blush before mascara -- something bad might happen. She remembered obsessive rituals in childhood: putting her clothing on in a particular order; and worrying, when her parents were out, that if she didn't put her shoes in a particular spot when she took them off, her parents might not come back. Finally, about half-way through the treatment Betty began to complain of deficits in assertiveness, which frustrated her both in her work and in her personal life. In sum, Betty, like many of our clients (and in stark contrast to the relatively untroubled Lawrence), presented a complex and confusing picture of mixed and chronic psychopathology -- in Betty's case, in an individual with a probable genetic vulnerablity to both depressive and anxiety disorders.

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5B. Formulation & Treatment Plan, and 6B. Course of Therapy

All of Betty's presenting problems were addressed in different ways at various points in the therapy, which consisted of 17 sessions taking place over about seven months. The key session was the fourteenth, in which I did a hypnotic age regression. I considered hypnosis from the start, but Betty was resistant to it, saying that she was afraid she couldn't be hypnotized. (I believe she was simply afraid of hypnosis itself, despite my various attempts at explanation and reassurance.) It was only after other interventions didn't work that she became desperate and finally agreed to it.

Sessions 1-12

First I will outline the treatment up to the 14th session, based on what is in my notes of the case. The initial interview consisted primarily of history taking. In the second session Betty reported that her doctor told her that a mole on her ear, which she was convinced was cancer, was in fact "nothing." I used that as the basis for deriving some rational thoughts and procedures next time she detected a worrisome change in her body, e.g. remind yourself that you are not a doctor and can't diagnose, and remind yourself of this most recent false alarm. Betty's hypochondria extended to her mental states: She thought that her grief over her recently deceased sister was "pathological." I told her it wasn't.

In the third session Betty talked about her obsessive reading and TV watching on the subject of cancer. I instructed her to discontinue all that sort of behavior, and to stop reading obituaries. In the fourth session Betty admitted that she hadn't entirely avoided reading the obituaries, but had avoided the cancer-related media material. She reported that she'd had no cancer scares that week. I had her leaf through that day's paper in the session and pass right over the obituaries.

In the fifth session Betty reported that she had only looked at the Sunday obituaries to see if anybody famous had died. She also reported that she'd heard that the daughter of someone she knew had been diagnosed with a tumor in her eye, but that she dealt with it rationally, reminding herself that she wasn't a physician. Consequently, it "upset me for a split second but I was able to let it go." In this session, I also taught Betty a simple meditation technique to help her deal with her middle insomnia. I had previously given her a set of insomnia instructions -- don't look at the clock after you retire – which she had been able to follow.

In the sixth session Betty reported that she was doing a bit better. She was struggling against her impulse to read obituaries and mostly winning. I decided it would be informative to see how she responded to exposure to morbid stimuli, after having tried to avoid them, in line with an "ABA" single-subject research design in the applied behavior analysis tradition. I therefore suggested that she expose herself to them ad lib between then and the next session. Then we would evaluate whether she felt better or worse as a result. Unfortunately, during that interval, she ran out of her Prozac, so in the next (seventh) session it was difficult to determine

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what exactly had been the effect of re-exposing herself to morbid stimuli. Attempts at cognitive restructuring continued in the sixth session. I had Betty generate a short list of true propositions about her health, which if she believed them, would be reassuring to her. The sixth session also marked the beginning of our efforts to modify Betty's eating. I gave her directives to track her food intake, and to eat more slowly by taking less food into her mouth at a time.

Given Betty's deteriorated state at the seventh session, and the possibility that this was due to re-exposing herself to morbid media stimuli, I directed her to go back to avoiding them. (During the preceding week she had also seen the new movie *Phenomenon* -- about a man who develops extraordinary powers due to a brain tumor which ultimately kills him -- and so had gotten an extra powerful dose of media exposure to cancer.) In this session Betty finally agreed to try hypnosis. I hypnotized her, using the permissive procedure I usually do, and indeed Betty was able to move into a hypnotic state. Not surprisingly, she found it relaxing, so I gave her an audiotape of the procedure that she could use at home for relaxation.

In the eighth session, 11 days later, Betty was in even a worse condition, despite her Prozac having been increased by her physician to 80 mg. She had found a lump in her neck that triggered her fear, and then just that morning had found out about a 32-year-old man who had just died of cancer. She was in a state of panic, utterly convinced that there was cancer somewhere in her body. When I asked about the hypnosis tape given to her in the seventh session to help her relax, she said that she had not listened to it even once. My response was to tell her that statistically it was more likely that she would die of heart disease than of cancer, especially considering that her grandmother had died of it, and her mother currently had it. I wrote this down on a card and gave it to her. Then I had Betty close her eyes and imagine herself on her deathbed in a hospital's cardiac care unit. She reported that she found this image to be "profoundly comforting." I instructed her to evoke this image any time she found herself being frightened by thoughts of cancer. (The rationale for this paradoxical intervention had its roots in Ericksonian hypnosis: The client is not confronted with a head-on directive to give up her symptom, which she could not be expected to do -- otherwise she would not be in my office -- but rather nudged to shift the symptom in the direction of less distress. Betty's fear of death, especially her horror of the process of dying, was bound up with cancer; heart disease was, for her, comparatively benign.)

The end of the eighth session was devoted to Betty's eating. (As mentioned above, during the sixth session I had asked her to track her food intake, and to eat more slowly by taking less food into her mouth at a time.) She reported that keeping a food diary in itself caused some decreases in her eating, that she was taking smaller forkfuls, and that she was trying to substitute healthier foods, e.g., peas instead of French fries at lunch. I gave her two more directives: "Don't work while you eat. Concentrate on the act of eating so that you don't 'grieve' after the meal is over." I also asked her to make one more little but positive change, of her choice, in her diet for next time.

Two weeks later, in the ninth session, Betty presented a mixed picture. She managed to not work while eating lunch about half the time, and she saw the advantage in that. She also

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"started working in more fruits and vegetables." She now weighed eight pounds less than she had three months earlier, and she felt she was getting better at eating slowly. On the other hand, she had "pigged out" over Easter weekend, eating pizza and cream-filled chocolate eggs. She said that the idea that fats cause cancer didn't help because she thought of them as also causing heart attacks, and that was okay. I asked her to evoke the image of her sister who died of cancer whenever tempted by sweets. Betty reported that she had been listening to the hypnosis tape at bedtime and it seemed to help her relax. She hadn't had any cancer panics about her husband or son, and she saw that as improvement. She also reported that she could stop herself from reading obituaries and didn't feel as terrible as she used to when reading the obituary of somebody who had died young.

At the end of the ninth session Betty complained of assertiveness problems and over-concern about what others thought of her. In response to that, I lent her a copy of *I Can If I Want To* (Lazarus & Fay, 1975) and asked her to rank the cognitive mistakes described in the book according to their relevance to her. I also asked her to think about purposely buying something at a store in order to return it. At the very end of the session Betty told me she was afraid of spiders. I explained exposure treatment to her.

At the tenth session, two weeks later, Betty complained that she "went back 10 steps" in the past week, having heard about three different people who had been diagnosed with cancer. Also it had been her dead sister's birthday anniversary just a few days before, the first since her death, and it made Betty feel "melancholy." On the other hand, she thought her sleep was a little better and that her anxiety level was "much improved." She had not finished *I Can If I Want To,* but she identified with a lot of what she had read. She then talked more about her problems with assertiveness.

Assertiveness was the major theme in the eleventh session, about a week later, specifically with respect to her job. She complained that her boss didn't listen to her, and that he responded to her requests with double talk, which made her very angry. And she had "been horrible" with her diet because of her anger over her job problems. She reported that her cancer fear was more under control, although an article she'd read about a young mother with breast cancer greatly upset her.

The themes were the same in the twelfth session a week later: assertiveness, her boss, cancer fear. Betty expressed guilt that she and the rest of her family had not been assertive enough in assuring that her sister got optimal treatment for her cancer. Betty didn't think that everything that could have been done for her sister had been done. Because of her grief and guilt, Betty reported, she "didn't care" about her diet the past couple of weeks. But then she said that she had resumed keeping her food diary. I suggested to Betty that she think about writing a letter to her dead sister, a cathartic task that had been helpful to several of my clients experiencing grief.

If this description of the first 12 sessions sounds plodding and scattered, that is because that is how the therapy was, or at least how I was experiencing it. I was coming to the conclusion

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that the therapy was not progressing well. There was improvement, then regression, then improvement, then the introduction of a new complaint, and an attempt to address it -- all finally yielding the sense that we were running in place.

Session 13

Finally, in the thirteenth session Betty requested hypnosis to help find out "if her cancer fear stemmed from the accident." I had long before decided on what I would do hypnotically with Betty, if given the opportunity by her initiating a request. I would employ an age regression, but starting from her earliest memory and then moving forward in time, rather than the reverse. And then, after finding out whatever she told me about her memories, I would have her imagine herself as the adult reassuring herself as the child that everything was going to turn out fine -- that she would indeed survive into adulthood and live a full adult life.

The idea for this reassurance scene came from something I remembered having read in Haley's (1973) *Uncommon Therapy* a story that Milton Erickson told about crafting a hypnotic suggestion along those lines. (The actual case is reprinted in Appendix 1 at the end of this article.) I cannot now say why I thought, back then, that having her imagine such a scene would be helpful -- maybe just an intuitive sense that a little reassurance couldn't be bad, especially since reassurance was generally part of the hypnotic suggestion when I treated anxiety cases.

Session 14

The fourteenth session was devoted entirely to the hypnosis. I believe that before I hypnotized Betty I told her, in broad outline, what I was going to do. That is my standard practice. Hypnotic suggestions are not made more powerful by being kept secret from the client until they are delivered; and telling the client in advance exactly what you are going to do decreases their anxiety (and therefore their resistance) and fosters a collaborative mindset. I used a brief induction, since Betty had in fact used the hypnosis tape I'd made for her several times, and I expected she would let herself slip into a hypnotic state with minimal prompting. That was indeed what happened.

On a few occasions prior to my treatment of Betty, I had used hypnosis to help clients recount traumatic experiences which they said they had forgotten, including:

1. a woman with a driving phobia who had no memory of the accident that had caused it;

2. a woman who had developed psychosomatic abdominal pain after successful treatment for breast cancer, and who had no memory for the period between the cancer diagnosis and her surgery; and

3. a young Guatemalan man who, just before he was to testify at his asylum hearing, developed complete amnesia for the torture experiences that he had recounted to me before.

For the two women clients, recalling the traumatic events while under hypnosis, which

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was fraught with intense, negative emotionality followed by reassuring suggestions, was sufficient for symptom removal. The young man under hypnosis recounted his torture experiences in much more detail and with much more horror than he had in a non-hypnotic state. Based on these cases, I expected that something of interest would happen when I hypnotized Betty, but I didn't know what. (As I like to say to my patients, especially when I feel stumped by some awful problem they present to me, "That's what I love about this business -- learn while you earn!?") The memories I was about to ask her to recall not only were much more remote in time than in these other cases (almost 30 years, versus 10 years for the man and only a few months for the women), but also processed through the cognitive structure of a child.

Once I had assured myself that Betty was in a hypnotic state, I gave her the usual instruction about being able to speak to me without disturbing the state she was in. Then I said something like this to her:

> Our memory is kind of like a videotape library. Each of our memories is on a separate videotape. All the tapes are there in the library. The only problem is they are all jumbled up, not arranged in any particular order. But our unconscious mind has a way of using special searching and sorting procedures to find videotapes that we wouldn't be able to find otherwise. So now I'd like you to find the videotape that is labeled "My Earliest Memory."

There was a pause and then Betty described a view of her mother's lower legs and feet as seen from the level of the kitchen floor.

Whether or not this was actually an accurate memory, it was clear that Betty was willing to at least speculate about her past while in a hypnotic state, so I moved forward in time: "Now I'd like you to find the videotape labeled 'My First Day At School.'" Betty produced some image in response to this but I don't now remember what; likewise for her next response, to the stimulus "I Learn to Read and Write." Next, I used a stimulus that would bring her to the approximate time of the accident: "I Learn Arithmetic -- Addition and Subtraction." To this, Betty gave a response describing a workbook in which you would do subtraction by crossing out one or more of a row of coins. I remembered my younger brother having used such a workbook.

Now we were up to the time of her traumatic car accident at age eight. As I described above:

> Betty regarded her obsession with cancer as simply the most recent version of an obsessive fear of death that had haunted her since childhood, specifically from age 8 when she nearly died in a car accident. Her understanding was that she had been given last rites in the hospital because she was not expected to live and that her father prayed on his knees through that entire first night. Betty remained in a coma for two weeks after the accident before retaining consciousness. Her family had told her that as child she had been very afraid of dying and that they would have to rock her to comfort her. She had also been afraid of her sisters or parents being killed in an accident.

I asked Betty to find the videotape of the accident. After a pause she started to respond. She

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responded that after the moment of impact she was wondering if her little friend in the seat next to her was okay. This was clearly not a plausible memory because Betty would have lost consciousness at the point of impact. There was some emotionality in her response, but no where near the emotionality of woman #1 mentioned above who recalled a much more recent collision. Of course, there may not have been much for Betty to remember since she was the passenger, not the driver, and it all may have happened before she was aware of anything being amiss.

Betty did become emotional in response to the next stimulus: "I Wake Up From My Coma." She began to cry. What she saw in her response was her parents standing at the foot of her bed whispering to each other and crying. I asked her what they were talking about. Betty said that they were talking about how she was going to die. Betty was so distraught in response to this image that I remember thinking that I had to get her out of there right away and put her into something more pleasant -- so I asked her to find the tape labeled "I Come Home From the Hospital." Betty gave a more highly elaborated response to this stimulus than to any of the previous ones. She said she remembered being brought home in the car, being carried from the car to the front door by her father, and her father then placing her into an easy chair in the living room. She said that various family members were standing around the living room talking with each other. I asked her what they were talking about. Betty said they were all talking about how she was going to die -- or so she had thought; or, more precisely, or so she now thought she had thought.

In any case, the illogicality of the thought was evident. If she had been allowed to leave the hospital that meant she was out of danger. But Betty's memory, or guess about her memory-- or whatever in between -- was that she had been terrified of dying for at least a period of weeks when she was around eight years old. One would imagine that as soon as she came out of the coma, and repeatedly afterwards, her family would have been telling her that she was going to be okay. If that speculation is factually accurate, then one would have to conclude that the reassurance she received was not powerful enough to quell the fright that her near-death experience had caused her, and she remained terrified.

Betty was very emotional describing this last image, just as she had been in response to the previous stimulus, continuing to sob. Now was the time for the hypnotic reassurance that I had prepared in advance. I said to her:

> I'd like you to imagine that it is later in the evening of the day you came back from the hospital. Your parents have carried you up to your bedroom, and put you into bed. You are on your back under the blankets, which are pulled up to your chin, and your head is on the pillow. Now I'd like you to imagine that the adult you -- you as you are right now -- walks into the bedroom, and you sit on the edge of the bed next to the child you, and you begin stroking her hair. And you tell her that everything is going to be okay. You tell her that in fact she is going to survive into adulthood. She is going to fall in love, and get married, and have a child of her own.

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I supplemented this image with direct suggestions about the child responding to all this with relief, and I included some direct suggestions about her being free from obsessive thoughts about cancer and death.

When I brought Betty out of her hypnotic state, her mood seemed to be good. She certainly did not seem to be traumatized by the experience. Since this hypnotic session involved Betty's talking to me, I did not tape it for home use, since such a tape would have not been appropriate for her to listen to at home. (For the clinical record, I now wish I had recorded this session, of course.)

Sessions 15-17

The next session, the fifteenth, took place a little more than two weeks later. Betty said that she was doing "amazingly well." My notes at the time for this session include the following:

> Very calm in response to one of mentors' telling her about cancer. would have cried and obsessed. More assertive: stood up to snobby older sister. Stood up to boss in front of coworkers. Now boss is giving her everything she wants. Told parents for the first time about her depression and treatment. No more memories [about her life before the accident] have come up. Tape [of the first hypnosis that I'd made for her] puts her to sleep. [Her control of her] eating up and down. No clear pattern except eats more during PMS. Much less preoccupied with illness. Looks at obits but "not with the fervor" [that she had before]. Parents remember patient's chronic childhood mortality fear/preoccupation.

Clearly, in the two weeks since the hypnosis, Betty had made progress not just with respect to her fear, but also with her assertiveness.

The sixteenth session didn't take place until a month later. I believe that it had originally been scheduled for a two week interval but that Betty had cancelled. My notes at the time for this session are as follows:

> [Exactly two weeks after the last session,] the birthmark on son's back looked darker to her. Had about 10 days of worry about that, but then calmed down. Doctor said she was giving her the name of a dermatologist to calm her, [and] patient realized she had nothing to worry about. Level of concern about son is now 15-20 out of 100 [on a Subject Units of Distress (SUDS) scale].
>
> Went to visit her mentor after his prostate cancer surgery. Since he was in . . . [the same hospital as her sister], it brought back memories of her sister. Has been thinking of sister more and talking to her more. [Over my years of practice I have found that it is not uncommon for bereaved people, especially if they have religious faith, to converse with their lost loved ones, and I do not regard it as pathological.] I told her to expect even more of that between now and the anniversary of sister's death [coming up in two months time]. . . . But situation of mentor himself didn't freak her out. Hasn't listened to tape because it puts her into deep sleep for a couple of hours. . . . Has noticed small but real changes in her eating habits: has craved sweets and carbohydrates less. Eats only 5 "Good 'n Plenty" [candy] pieces instead of entire box.

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Of course, the most striking feature of this note is the fact that Betty actually visited her mentor after his surgery for prostate cancer, and in the same hospital in which her sister had suffered her terminal cancer. Betty would have never been able to do that before the hypnosis.

The seventeenth (and last session) took place a month later. Betty opened the session saying, "I'm doing wonderful; I have my life back." The rest of my notes for that session are as follows:

> Obsessive thinking isn't there. Fine with mentor's cancer. Reads only the big obits and isn't bothered. Hasn't talked with family about ritual [for the anniversary of her sister's death; I had suggested she do that]. Will be particularly careful re her own diet on . . . [the anniversary of her sister's death] because that would have made her sister happy. Did ask boss for a raise and will ask again. Lost about 15 lbs. No attraction to snack foods; fruit for dessert. Next session is last.

But Betty canceled that session, and I never saw her again.

7B. Therapy Monitoring and Use of Feedback Information

As with the case of Lawrence, no formal monitoring of Betty's therapy was conducted other than the processes described in the above section.

8B. Concluding Evaluation of the Therapy's Process and Outcome

Thirteen months after the seventeenth session, Betty phoned me, to tell me that she was continuing to do well and to thank me for giving to her her "life back" (the same turn of phrase that she had used in our last session). It is rare, for me, to get a spontaneous thank-you call from a client more than a year after termination. I was surprised to hear that she was doing so well.

Seven years after termination, in preparation for writing this report, I wrote Betty a letter to ask for her permission to write up her case and to ask how she was. About two weeks later I received the following email:

> Dear Sam,
>
> I am responding to the note you sent me last month. I apologize for my late response. I was on vacation for 2 weeks and am now catching up on mail.
>
> First let me say, of course, I remember you. You helped me in a way that no one else could have.
>
> I am doing really well. I continue to take a daily antidepressant (Lexapro) and will need to for the rest of my life. As you are aware, depression runs on both sides of my family so this is not to be unexpected. Since our hypnotherapy session, however, I have not had to take a separate medication for my anxiety. My obsessive compulsive thinking about cancer

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has dissipated. I do get a little anxious during the time of my annual mammogram; however, it's nowhere near the debilitating thoughts I used to have weeks before the mammogram and while waiting for the results. I would be consumed with thoughts of "what might be" and literally couldn't function at work or home.

The raging anger that ran through me occasionally has disappeared. My husband and I have a great relationship, going on 25 years. I believe I have developed more patience with things that used to set me off.

When you first suggested hypnotherapy to me, I thought it was an interesting concept and at that point I was mentally was willing to try anything.

I never would have believed the results.

Anyway, thank you again for restoring my mental health.

If possible, I would like to get a copy of the article. Please feel free to email at the address below.

Happy Holidays,

Betty

8C. CASE COMPARISON AND CONCLUDING THOUGHTS

I would like to think that Lawrence is doing well still. The long-term outcome of Betty encourages that thought. Moreover, in a number of ways, Betty's case was more challenging than Lawrence's. Most importantly, unlike Lawrence, Betty had never been hypnotized before and, due to her misconceptions about hypnosis, was afraid of it. She accepted it only as a last resort, after variety of cognitive-behavioral and experiential tactics, tried over a number of months, had failed. Second, unlike Lawrence, Betty's problem, while maintained by a number of recent and current factors, seemed to have its origin in a specific, traumatic, early-life event, although one about which the client was largely amnesic. Finally, unlike Lawrence, Betty's core problem fear of dying was accompanied by significant other psychological difficulties, including problems of depression, lack of assertiveness, overweight, and obsessive rituals.

As far as explanatory mechanisms for the changes the hypnotic suggestions created, there are a variety of candidates. From a very broad point of view, in both cases the suggestions were designed to provide a substantial cognitive reworking of each client's view of themselves and the world from three time perspectives: the past, the present, and the future. Such cognitive reprocessing (e.g., Calhoun & Resick, 1993), reframing (Persons, 1989), and/or constructivist re-narration (Messer & Wachtel, 1997) has been found to be an important change process in both cognitive-behavioral and constructivist therapy models.

In Lawrence's case, the positive effect of the hypnosis can be interpreted in terms of anxiety desensitization. Betty's case does not fall as easily into this explanation. As one alternative, it could be that for all those years Betty had been lacking some crucial emotional support from her parents which, because of their own chronic depressions (and consequent pessimism), they had been unable to supply. The hypnotic image I had created – that of the adult Betty comforting the child Betty -- somehow filled that need. Alternatively, it could be that the hypnotic self-reassurance allowed Betty to let go of her anger at her parents for not having effectively reassured her and, as a result of the resolution of that conflict, enabled her to let go of her cancer-phobic symptoms. But Betty never evidenced any anger against her parents for not having reassured her, and so this explanation is not that persuasive. Another alternative is that because Betty considered the hypnosis to be a vivid, intensive intervention -- something on the order of surgery, psychologically speaking -- she could feel that something curative had finally been done. This explanation hinges on Betty's understanding about what was being done to her, rather than on the direct effects of hypnotic imagery per se. Perhaps it was the *combination* of Betty's positive expectations of hypnosis working together with the direct effects of the hypnotic imagery that created the dramatic improvement. Certainly, the effects of the hypnotherapy were strikingly superior to the results of her therapy that was conducted during the first 13 sessions.

In closing, it is worth noting that Betty's case is an example of how one therapist's clinical knowledge, transmitted via case report, is used by a subsequent therapist. By the time I met Betty, I had read through *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* (Haley, 1973) twice: once some time before 1983, and then again some time after 1986, the time when I had my first formal training in hypnosis, but certainly a good number of years before I treated Betty. What I remembered by then of the case was partial and schematic. In it, Milton Erickson introduced an adult figure called the "February Man" to a hypnotized, age-regressed client in order to provide her with comfort and reassurance. (The actual case is reprinted in Appendix 1 at the end of this article.). That was all I remembered, yet that was enough to serve as a template for my hypnotic suggestion to Betty – namely, having the adult Betty comforting the child Betty. What Erickson did was a complicated, virtuoso performance. My adaptation of it was simple and workmanlike, but sufficient. Case reports by master therapists give the rest of us a glimpse of what is possible in psychotherapy, and the inspiration and encouragement to generate novel solutions of our own.

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APPENDIX 1.
MILTON ERICKSON'S "FEBRUARY MAN" CASE

(from Haley, 1973, pp. 179-182; reprinted with the permission of W.W. Norton and Company)

[Milton Erickson speaking] In 1943 the wife of one of my medical students approached me stating the following:

> I have a very difficult problem confronting me and my husband. We are very much in love, and he is in the military service studying medicine and will graduate in 1945. We hope by then that the war will be over. After he completes his service, we hope to have a family, but I am afraid about that. My husband has siblings and comes from a well-adjusted family. I'm an only child. My father is very rich and has offices in Chicago, New York, and Miami. He comes home now and then to visit me.

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> My mother is a socialite. She is always attending social affairs in New York or London or Paris or Italy.
>
> I grew up under the care of various governesses. They took care of me from the very beginning because my mother could not have her child interfere with her social life. Besides, she insisted that a governess could handle a child much better than she could because governesses were trained. I did not see my mother very often. Before I went to school, whenever my mother came home she would have a big party and I would be trotted out to display my good manners and to recite nursery rhymes for the approval of my mother's guests, and then I would be hurried off the scene. Mother always bought me presents, sometimes a beautiful doll that had to be kept on display on a shelf somewhere, but she never brought me anything that I could really play with. I was just a display object for my mother when she happened to be home.
>
> My father was different. When he came home, he tried to make it at times when he could give me a good time. He took me to the circus, to the state and county fairs, to Christmas parties, and he often was home long enough to take me out to dinner at various restaurants, where he let me order anything that struck my fancy. I really loved my father, but his goodness to me made me lonesome for him.
>
> As soon as I was old enough, I was sent to boarding schools, and in the summer I was sent to the proper summer camp. Everything was so proper. I was finally sent to finishing school, where I learned how to toss the conversational ball and say all the right things. The finishing school allowed the class I was in to attend a junior prom at a college. That is where I met my husband. We corresponded and managed to see each other with more and more frequency, and finally my father agreed to our marriage, but my mother looked up my husband's pedigree before she consented to the marriage. She planned a very elaborate wedding and was outraged when my husband and I eloped. I knew I couldn't stand the kind of social affair that my mother would make out of the wedding. She punished me for the elopement by taking off for Paris. My father said, "Bully for you, kids." He never really approved of my mother's high-society life. My problem now is that I am very afraid to have children. I really don't know anything good about childhood, and I want children, so does my husband, and we both want to be happy. My husband has sent me to you to see if you can hypnotize me and allay my fears.

I thought this problem over for several days and then undertook to use hypnosis in a manner I thought would be helpful. The procedure I developed was, first, to test the young woman for her competence as a hypnotic subject. She proved to be a somnambulistic subject and very responsive to all manner of suggestions. In accord with the discovery of her competency as a subject, she was hypnotized and regressed to the age of "somewhere around the age of four or five years." She was given the instruction that upon regression to that age, she would come "downstairs to the parlor," where she would "see a strange man" who would talk to her.

She regressed in a satisfactory fashion and looked at me with the open-eyed wonder of a child and asked, "Who are you?" I answered, "I am the February Man. I am a friend of your father's. I am waiting here for him to come home, because I have some business with him. While I am waiting, would you be willing to talk to me?" She accepted the invitation and told

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me that her birthday was in February. She said her father would probably send her some nice presents or maybe bring them. She talked quite freely at the level of a four- or five-year-old girl who was rather lonesome, and she manifested a definite liking for the "February Man."

After about a half-hour visit, I said that her father was arriving and that I would see him first while she went upstairs. After I had left, she would be sure to come down and visit her father. She asked if the February Man would return, and I assured her that he would, and I added that I didn't think he could come until June. However, the February Man appeared in April, in June, and a little before Thanksgiving and Christmas. Between each of these appearances of the February Man, the patient was awakened, and casual waking-state conversations were held.

This therapy continued over a period of several months, sometimes twice a week. She had spontaneous amnesia for the trance events, but in the regressive hypnotic states she was allowed to remember previous visits with the February Man. In the original interview with the patient, I had taken care to make certain of important dates in her life so that the February Man would never accidentally intrude upon some important memory. As therapy continued with her, she was regressed from year to year and there were longer and longer intervals between the February Man's visits, so when she reached the age of fourteen it was possible to meet by "accident" in actual places where she had been at various times in her life. This was frequently done by appearing just a few days before some real memory in her life. As she approached her late teens, she continued her visits with the February Man, evincing a definite pleasure in seeing him again and again and talking about teen-age interests.

As I came to learn more about her, I was able, when some new childhood memory was discovered, to regress her back to that age and appear a few days before some really important event of her life and join in her anticipation of it. Or perhaps I would join her a few days later to reminisce.

With this method, it was possible to interject into her memories a feeling of being accepted and a feeling of sharing with a real person many things in her life. She would ask the February Man how soon she would next see him, and when she requested presents, things were offered to her that were very transient in character. Thus, she was given the feeling that she had just eaten some candy or that she had just been walking with the February Man past a flower garden. By doing all these various things, I felt that I was successfully extrapolating into her memories of the past the feelings of an emotionally satisfying childhood.

As this therapy continued, the patient in the ordinary waking state began showing less and less concern about her possible inadequacy as a mother. She repeatedly asked what I was doing with her in the trance state to give her a feeling of confidence that she would know how to share things properly with children of any age. She was always told, in the waking state and also in the trance state, not to remember consciously anything that had occurred in the trance state so far as its verbal meaning was concerned. But she was to keep the emotional values, to enjoy them, and, eventually, to share them with any possible children she might have. Many years later I learned that she had three children and was enjoying their growth and development.