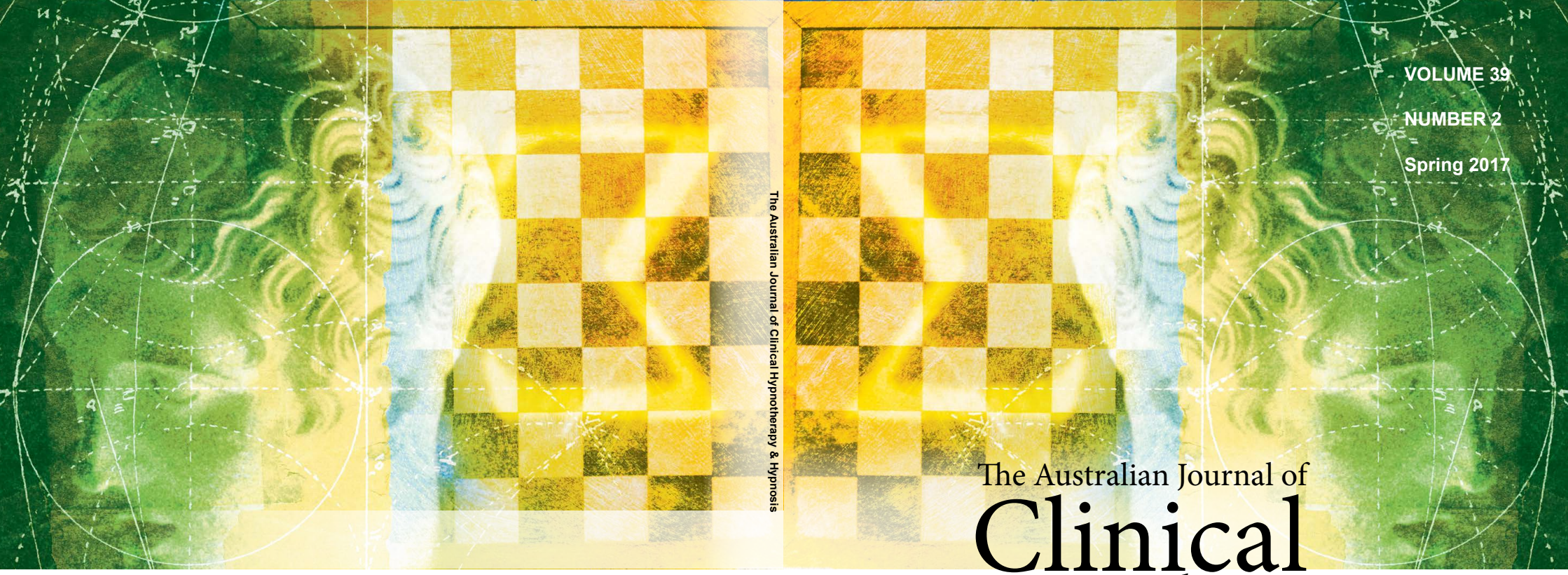

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An interdisciplinary journal dedicated to advancing the art, science and practice of hypnosis

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Editorial

I've always loved learning new things, and this particular issue of the journal has been enlightening to me in that respect. Each of the articles fascinated me for different reasons, and some sent me on a journey through the Google wilderness to learn more about a particular subject or angle. I thought I would pass some of that value-add learning onto you.

After reviewing Richard Hill's wonderful article on enactments, I began to wonder: *Is enactment the same as transference, and is transference the same as projection?* I soon discovered the subtle differences between them, and offer up simple definitions below.

Projection is a defence mechanism, and the act of attributing one's own unacceptable feelings, impulses, qualities, behaviours or thoughts onto another person or persons. For example, an individual may say about another, "She's so selfish".

Transference, however, is the act of directing feelings, impulses, qualities, behaviours, or thoughts about or in relation to a second person onto a third person (usually the therapist) in the therapeutic setting. *Countertransference* is the redirection of the therapist's feelings (often unresolved issues) toward the client. If for example, the client transfers to the therapist the feelings they harbour about an authoritarian figure such as a father or teacher by being unreasonably reactive and aggressive then that is an example of transference. If then the therapist acts defensively or aggressively in response because they were bullied as a child then that is an example of countertransference.

Enactment is a pattern of non-verbal behaviour that emerges between two people as they interact within a therapeutic context. There is often unconscious meaning for both parties. It actually involves subtle, but mutual projection between the therapist and the client.

Richard's article probes the subject of enactments, draws our attention to the idea that this is a natural human process, but one we need to be aware of and manage within the therapeutic setting. In grasping this notion, therapists can become both conscious

of the 'stuff' they bring into the therapeutic alliance and also remain vigilant so they can avoid corrupting the interaction.

On another note, I welcomed reading Sonia Barbara Czernik's article, as it took me back to my management studies when I was just out of high school. While studying managerial psychology I discovered transactional analysis for the first time. I became fascinated with the idea that as humans we are not just one big personality or character, but are made up of a number of ego states or parts. Later on, when I was studying to be a hypnotherapist, I learned that for wholeness and / or healing to occur, these parts need to be in alignment and at peace with each other. Sonia expands on this with her analysis of parts therapy in conjunction with timeline therapy in treating anxiety disorders, amongst the most prevalent neuroses of this modern age, and in the process, demonstrates the potential for permanent relief of these conditions in all their embodiments.

Nick Ramondo's moving article examines the famous book *Man's Search for Meaning* by Dr Viktor E Frankl—the story of how the author and other inmates survived the death camps of World War II. Nick began reading it from an 'everyperson's' perspective, but his training in psychology and hypnotherapy came to the forefront, and he discovered a hidden layer in the book that perhaps was not even Frankl's intent. Nick had a eureka moment and made the connection that the coping strategies the survivors used – some of which are also characterised as defence mechanisms – were akin to self hypnosis techniques. You will undoubtedly find this article fascinating, and I predict it will drive you to order Frankl's book so you can read it alongside Nick's article.

Finally, Jerry Knight presents a case study on treating non-epileptic attack disorder using hypnotherapy, wherein he demonstrates the effectiveness of hypnotherapy in accessing and utilising subconscious resources such as relaxation to aid a serious condition that the majority of medical practitioners would classify as falling into the realm of being untreatable or unmanageable except with medication. Case studies such as this suggest to me that it might be in the best interest of future patients for universities to integrate hypnosis training into medical courses for both doctors and nurses.

Julie Ditrich

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

Is It Me or Is It You? An Introduction to Enactments

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Abstract
The concept of enactment has emerged from the psychoanalytic field and the issue of transference/countertranference. The implicit interaction between two people is as true in therapy as it is in general life. When this occurs between the hypnotherapist (and indeed all therapists) and the client, the therapeutic process can be severely disrupted. Knowing how to deal with an enactment can be very important for the progress of hypnotherapy with that client. Several case studies are presented to show different types of enactments and different ways in which they might be managed.

Introduction

Therapy is, fundamentally, an interaction between two people. The therapist/client dyad is a complex engagement that operates on many levels—both explicit and implicit. The term 'enactment' refers to non-conscious interactions between therapist and client where the client is affected by the therapist's implicit responses. Left unnoticed and unresolved, enactments can become problematic interactions that interfere with, and disrupt, productive therapeutic processes.

The term enactment was introduced in the psychoanalytical field by Theodore Jacobs (1986). His idea emerged from the psychoanalytic concept of transference and countertransference during therapy. The paper was concerned with countertransference, "… not to the more obvious forms of countertransference… but to its subtler ones" (p.289).

1. Transference/Countertransference

In psychoanalysis the therapist presents themselves as a blank canvas, which makes it possible for the patient to project or redirect onto the therapist aspects, characteristics and the characters that are pertinent to their troubles. This is called transference. This might be redirection of current people, feelings and desires, but also those unconsciously retained from earlier times and back into childhood. The act of transference is not uncommon in daily life. Someone at work might remind you of your angry father and so you feel intimidated.

Someone you just met at a party reminds you of an old friend and you talk in a surprisingly familiar way. In many relationships someone has shouted, in a heated moment, "Stop treating me like I'm your mother/father!" Transference can happen everywhere, and is experienced in many therapeutic situations. Psychoanalysis intensifies it because the therapist deliberately creates the blank canvas to invite transference in order to place the transference behaviour under an analytical microscope.

Countertransference is the same form of implicit or non-conscious reaction, but where the therapist projects their own unresolved conflicts onto the client. Freud was the first to discuss the concept. Countertransference can be detrimental to the therapeutic process when it is unexamined, but moreso when it is unnoticed. The therapist might find that they have unusual emotional responses to a particular client. They might feel bored or annoyed or inadequate or uncomfortable in a way that is outside of the obvious things going on in the therapy room. In psychanalytic practice, the therapist is expected to have ongoing analysis in order to work on the unresolved personal issues that are at the base of the countertransference. An example in hypnotherapy is when the therapist may use the words or a form of induction that may be more to do with their own mood state rather than a sensitivity to the client. Equally, using a set induction for every client will result in some clients not being comfortable

Transference/countertransference is likely to be experienced regardless of therapeutic modality because it emerges from a natural human behaviour. It is important, therefore, in hypnotherapy supervision for the supervisor to not only assist with issues relating to the client, but also to look carefully at the therapist and the possibility of unnoticed countertransference.

Counter-transference can be differentiated into four general categories (developed from Machado et al, 2104):

State:

1. Subjective: the therapist's unresolved personal issues implicitly alter the behaviour of the therapist, which can be harmful if not detected and resolved.
2. Objective: the therapist's reaction to the client's maladaptive behaviours causes a disruption that can be beneficial when intentional, e.g. Ericksonian shock technique.

Action:

1. Positive: the therapist is over-supportive, trying too hard to befriend his client, disclosing too much which can damage the therapeutic relationship and create serious boundary issues.
2. Negative: the therapist acts out against uncomfortable feelings in a negative way, including being overly critical, and punishing or rejecting the client.

The 'acting out' that emerges from the transference/countertransference can manifest in a number of ways and at different levels of awareness, intention and affect. These are interesting topics for investigation, but we will now examine the more subtle, implicit and often initially unnoticed acting out that is called an *enactment*.

2. Enactments

It would be an error to be simplistic about the definition of an enactment. Although I suggest that enactments occur at a non-conscious, implicit level, that is not to say that all non-conscious, implicit activity is problematic. There is a great deal of non-conscious mutually interactive regulation between therapist and client that is part of the positive therapeutic process (Beebe & Lachmann, 1998). Allan Schore has previously speculated on this concept (1997) and clarifies it further in recent times (2011). Schore reminds us of the words of Ginot:

> This focus on enactments as communicators of affective building blocks also reflects a growing realization that explicit content, verbal interpretations, and the mere act of uncovering memories are insufficient venues for curative shifts… As intense manifestations of transference—countertransference entanglements, enactments seem to generate interpersonal as well as internal processes eventually capable of promoting integration and growth. (Ginot, 2007, pp.317-318)

This inclines us to see that it is how the enactments are dealt with in the therapeutic dyad and within the inner processing of the client that is the relevant concern. The enactment itself is an emergent quantity from the complex system of the therapeutic process and it is the responses, also both conscious and non-conscious, that enable the promotion of integration and growth.

Marion Solomon (2017) captures the essence of the inevitability and the fragility of enactments:

> The explicit conscious journey pertains to what the therapist believes he or she is doing as a clinician supported by theory and technique… However, inevitably, the implicit selves of therapist and patient communicate beneath the words and even collide in therapeutic enactments. The implicit journey is elusive and unconscious, and although it may feel vaguely familiar, it usually leads relentlessly to outcomes that were not intended or predicted. (p.270)

3. Cases Examples

3.1 *Professional misconduct*

One of the most troubling issues with unnoticed enactments is when the enactment results in professional misconduct. Social worker, Susan Rowan (2002), chose to publish the narrative of her interaction with a client, as an example of how devastating an enactment where professional boundaries were not only blurred, but crossed. She describes how it began:

> I was a well-respected social worker at a venerable psychiatric hospital in the Midwest. I viewed myself as a caring and conscientious professional. Yet, over the course of two years, I progressed from sympathizing with C, to over-sympathizing with her, buying her groceries, paying her rent and, finally, sleeping with her. At first, I did not think I was doing anything harmful—I was going the extra mile, helping C until she could take care of herself. But my previous dedication to all my clients became an obsession with one. (p.39)

Susan did eventually realise that she had to stop the relationship, but C was infuriated and reported her to authorities. Susan lost her job, her clinical reputation was ruined, and her licence to practice revoked. C sued her, which led to bankruptcy. Her career of 20 years was in tatters. She answers the obvious question:

> Why on earth did I do it? I've spent years since then examining the risk factors that led me to destroy my professional career. Part of the explanation lies in personal vulnerabilities my previous training never encouraged me to explore. (I had never been in therapy myself.) My own mother had been seriously ill with rheumatic heart disease throughout my childhood, and had died when I was 19. A sister, 20 years older, had been my surrogate mother… as I stacked C's groceries that day, I rationalized that I was helping her and her children – as my sister had helped me – just until she could function on her own. I was dead wrong. (p.40)

Susan Rowan's story is extreme, but not rare. Her responses to C's needs were triggered by her own unresolved issues. It may seem hard to imagine that Susan could slide so far down the slippery slope, but, the reality is, she did. Her reasoning explains that falling into an enactment is not necessarily protected by a practitioner's professionalism or good heart, but is conditioned by unresolved issues that lie within the implicit space.

3.2 *Just the tiniest slip*

Not all enactments are so obvious to the therapist. The client can be triggered by something so subtle that it may not even be consciously remembered by one or other party. A professional colleague shared one of her enactments. This summarised narrative will leave out some details for privacy, but will clearly show the nature and impact of the enactment.

B is a qualified psychotherapist who often sees clients that are suffering the effects of trauma. Her childhood was also marred by serious trauma which she has worked through in various ways over many years. Her ability to understand and empathise with trauma clients is very high and her reputation is widely known and respected. During a session with D, a female adult trying to resolve childhood trauma, B found that D's mood had changed in an unusual way. They had been working together for a while and had a good, comfortable rapport. Some progress had already been made. D was relating another episode of abuse in her childhood, and B was particularly touched because she had experienced something very similar.

As the session continued, D became more and more emotional in an angry way. B had not seen this before, but continued to hold the space and allow D to express whatever emotions that arose. Suddenly, D stood up grabbed her bag and stormed out of the clinic, shouting angrily that she couldn't bear what B was doing to her. B was totally shocked and was at a loss as to what had disturbed D so much. B followed up as sensitively as she could to try and repair the disruption. Initially, D was unwilling to talk about it. Again, with sensitive and professional care, B kept the lines of communication open, without applying any pressure or expectation on D.

B reflected on the session and her mind turned to the similarity of the event that D was describing, but until D returned to describe what happened from her point-of-view, B was at a loss. Eventually, D chose to return to B's clinic and they began to unravel the problem. D was reluctant, but was finally able to tell B that she saw her expression of disgust while she told her story. B was, of course, surprised and genuinely curious as to what she did to give D the impression she had a negative emotion, let alone disgust. D was now prepared to give B the benefit of the doubt and they worked through their memory of the session to try and find an explanation.

D could clearly remember that an expression had flashed across B's face. It was fleeting, but D was certain it was a look of disgust. D saw it as a look of disgust about her. D's anger built as the session had continued, because B was obviously hiding her disgust and pretending to care. D told how she could stand it no longer and had to get out of the room and away from B's emotional insincerity.

B was able to make sense of this 'fleeting expression'. As B listened to the story, her own memories began to enter her mind. Before she was able to mindfully let them pass, B's own feelings of disgust about what happened to her had enough energy to flash an expression to her face. It would have only been a moment. B was not even able to remember her face moving, but it had and D took it personally, which is exactly what subtle transference/countertransference can create. Even though the 'acting out' of an expression on B's face was fleeting, unintentional, implicit, and passed by unnoticed to B, it was noticed by D and an enactment began.

This situation was able to be resolved due to the careful and professional skills of B to maintain the connection with D. This case is also an example of how it is possible to turn a disruptive enactment into a positive element of therapy. B was able to get a clear sense of just how sensitive D was to the feeling of disgust, and so B was able to shift the therapeutic approach accordingly.

It is important to note that therapeutic change and growth is more likely to occur in times of high activity and/or emotional arousal (Schore, 2009). In systems theory, the period of phase shift is close to the point of change and not in passive states or dissociative states (Hill & Rossi, 2017). As uncomfortable and potentially disastrous that enactments might potentially be, they can also be the best way in which the unspoken and hidden implicit states can rise into conscious awareness where they can be acted on.

3.3 *Noticing at the time*

This case is based on a video example shown at a conference. Most of the details are being withheld for privacy, but the essence of the enactment is presented. F is a somatic therapist who works with trauma patients. H had presented with terrible childhood abuse and had agreed to having this session filmed.

F began by talking through how H had been since the last session. The conversation turned to an incident in the past, which was usual practice for H. F was quietly vigilant as she observed H's body responding to the process of recall. It was not unusual for H to stiffen markedly and even develop local expressions of catatonia, especially in her hands. F was sensitive that H was beginning to build tension in her body. H drew her legs up onto the couch in what may have been a form of foetal position. F wanted to be of some comfort and moved forward a little in her chair in a warm gesture of concern and care. H responded by developing a rigid catatonia in one of her hands. F moved a little closer to be of assistance, but H's fingers became more rigid and began to fan out. F moved a little close and H's other hand began to stiffen.

At that moment, F realised that H was stiffening as she moved closer. F realised that she was creating an enactment. She quietly asked if H felt she was getting too close. With a tense sigh, H told her that F's closeness was, indeed, bothering her. F moved back and asked if that was better. H agreed, but it was not far enough. Because this session was being filmed, they were in a studio that was much larger than the usual therapy room. F decided to stand up and step away. H said this helped her feel better, but asked if F could step away even further. Each time F stepped back, H's hands relaxed a little. This continued until F was some 10-15 steps away. Finally, H's hands relaxed and she was able to sit comfortably in her chair. After a few more minutes H invited F to come closer again. The issue of how much personal space H needed, even when the intention was for care and concern, became an important breakthrough in the treatment.

3.4 *Inescapable enactment*

Sometimes, even when you become aware that you are causing an 'acting out' that is detrimental to the therapeutic process, nothing seems to be able to reverse the situation. Occasionally, the client takes a particular objection to you, perhaps as a transference, and even though you see it happening and try to shift the situation, your efforts are unsuccessful.

A young client in senior high school presented to me for anxiety issues. He was very astute and had been to see a number of practitioners over the years. This certainly concerned me at the start. It seemed to me, based on the previous phone calls and finally meeting the young man and his father, that we would probably end up having only one session. I realised that if I didn't do something different or change something about the first session to what the young man and his father anticipated or indeed were accustomed to then they would simply scratch me off their list. This assessment, which on reflection I still think was correct, shifted my natural practitioner's process. Instead of allowing the therapeutic exchange to emerge as a mutual experience, I tried to push the session to a successful outcome.

About half way through the session I became acutely aware of what I was doing and how it was negatively affecting the client. I suggested utilising a Mirroring Hands therapy and, despite my reasonable assessment that I am an expert in that technique, I made a number of beginner's errors. I failed to follow the fundamental principle of establishing a trusting rapport and a positive therapeutic alliance before offering an intervention. In the end, I believe that I delivered some elements of good therapy, but as we concluded the session, there was no suggestion of booking again. It was one of those situations where you learn that therapy is a difficult task and, even with the best of intentions, a therapist can leave a client dissatisfied.

Even though I was aware of the issue during the session, I still discussed this with my supervisor which allowed me to clear any residual issues that might be the cause of future problems. This situation has not recurred, partly because I have not had a similar client and, also, because I have remained true to the principles of my therapeutic practice. In this case, the enactment revealed an important lesson for me as the therapist.

Discussion

That we are able to consciously control human interactions is, simply, a fallacy. It is now well understood that implicit processes have a very powerful impact on how we interact with others. Neuroscience has shown that mirror neurons react when we observe others in order to give us a sense of their motor capacities, which allows us to form a felt sense of how we might relate to that person and what their intentions might be (Iacoboni, 2009; Sinigaglia & Rizzolatti, 2011). The most important discovery is that mirror neurons are responding before conscious reflection, so it is not something we think about or know in a conscious form, but something we feel and are already responding to before we think. Our mirror neurons are already influencing what we think about another person before they have even sat down and spoken a word.

Stephen Porges (2009) explains the process of 'neuroception', which is another implicit process that scans the environment for signs of safety and security to stir us into a response before the conscious reflection. The reason why we have these implicit, immediate processes is that conscious perception occurs as much as half a second after our senses are vividly aware and guiding us toward safety, comfort and desirable social interaction (Soon et al., 2008). The quality of empathy, which is of such importance to therapeutic work is our ability to share in the emergent property, that we call an emotion, of the client, and they with us (Ginot, 2009). But, our empathy, along with mirror neurons and neuroception, is based on our prediction of the possibilities in the other person and the environment, which is constrained by the experiences and predictive capacities within. Who we are is based on the journey of our life and how we have integrated that journey into both our conscious mind as explicit memory and our non-conscious mind as implicit memory (Squire & Dede, 2015).

In short, there are lots of things transpiring between and within people during human interaction. It is neither a good thing nor a bad thing, but something to be consciously aware of as a possibility. By being sensitive and observant (Hill & Rossi, 2017) of all that occurs within the therapy room we increase the likelihood that enactments will be noticed and utilised for the benefits they bring. We need to continuously work on ourselves in order to understand our own unresolved issues. Therapy is not the only medium in which we can develop and grow as human beings. The important thing is to remain conscious of the fact that much of what we experience is emerging from non-conscious, implicit processes and these 'act out' so that we might notice and respond in the best way we can.

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Tampering with Timelines in Trance: An Integrated Hypnosis Approach for the Permanent Relief of Anxiety Disorders

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Abstract
Anxiety disorders are explored from prevalence to co-existence with depression, to current treatment options, outcomes, and the prevention of symptom relapse. As a result of this exploration, a fresh perspective based on the commonalities of anxiety disorders is provided and a new approach toward their treatment advocated. This, when coupled with pre-hypnotic considerations and the practices and methodologies recognised as effective for anxiety disorders, leads to the integrated approach presented by the author. The aim is to affect lifelong change, free from therapeutic intervention.

Introduction

The aim of this paper is to broaden the clinician's perspective when treating anxiety disorders. We discuss synergistic approaches and embedding interventions within a timeline framework, thus offering a more multi-dimensional approach towards treating anxiety disorders. This, we believe, will affect permanent change. 'Timeline' and other key terms are defined under Key Terms, allowing associations and commonalities between them to become evident.

The multi-dimensional aspect of this approach facilitates the gaining of greater insights in the therapeutic field, requiring a mind shift for some clinicians, particularly those trained and accustomed to following a more linear approach, or set sequence of procedures. Despite the unfamiliarity of the approach presented, we believe it offers greater potential for the permanent relief of anxiety disorders.

We note from our experience that those clients with anxiety disorders tend to feel more nervous than others towards hypnosis itself. We also note that the client-clinician relationship particularly with regard to trust and understanding, supports and drives the therapeutic process, and is often responsible for therapeutic benefits (Sauer-Zavala et al., 2018). We, therefore, dedicate a section to pre-hypnotic induction considerations specifically for anxiety disorders. While many of these considerations are standard practice, the degree and consistency with which they are applied varies widely, therefore a review is warranted.

1. Key Terms

1.1 *Anxiety*

As defined by the *Macquarie Dictionary* (2013), anxiety is "distress or uneasiness of mind caused by apprehension of danger or misfortune".

1.2 *Anxiety disorders*

According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), this group of mental illnesses consists of: separation anxiety disorder, selective mutism, specific phobia, social phobia, panic disorder, agoraphobia, and generalised anxiety disorder (GAD). Each has characteristic symptoms and cognitions associated with them. Anxiety disorders share features of fear and anxiety (American Psychiatric Association, 2013).

1.3 *Fear*

Fear is the emotional response to a real or perceived threat, whereas anxiety is anticipation of a future threat (American Psychiatric Association, 2013). We prefer to say that fear is the emotional *reaction* to a real or perceived threat, whereas anxiety is anticipation, or a *perception* that there will be a future threat. This highlights that fear is an automatic rather than a chosen response and secondly that anticipation of a future threat, as with anxiety disorders, implies a past threat *perceived* as 'real', which no longer exists except as a stored memory in the unconscious. Therefore, we prefer to use 'perception', when speaking of anxiety disorders, as these clients continue to *react* to fear-based beliefs that they will suffer in some way.

1.4 *Timelines*

These are used in hypnosis and are visual internal representations of clients' real or imagined lifetimes with possible links to each other. In hypnosis, clients imagine timelines according to what their unconscious reveals.

1.4.1 *Current life timelines* represent clients' lifetimes from the moment of conception through to the present and into the future. Hypnotic age regression along a current life timeline is used to take a client back to previous ages, where any unresolved emotional injuries resulting in a 'wounded self' are revealed, and healed (Alladin, 2014; Barabasz & Christensen, 2006). Instead of 'self' we may use the term 'part' or 'child' with clients, depending on the context and for reasons given in a later section. Conversely, age progression along a current life timeline is used to direct a client into the future from the present time.

1.4.2 *Previous life timelines*, which are interchangeable with past lives [NOTE: past life timelines are used in similar ways to metaphors, i.e. the clinician or client's lack

of belief in reincarnation does not impact the session outcome (Clark, 1995)]. They represent clients' previous lifetimes, with each lifetime usually perceived as following a linear sequence, in or out of hypnosis. The term 'past life regression' is commonly used for any process, which expands a client's awareness of previous lifetimes.

1.4.3 *Parallel life timelines* represent a client's imaginary lifetimes, which run concurrently to other lifetimes and offer versions of self with other life experiences that reflect potentials expressed through different choices made.

1.4.4 *Generational timelines* represent the lifetimes of the client's parents and past generations, as well as potential timelines of future generations.

1.4.5 *Timeline Therapy* ™ (TLT) is a tool used by practitioners of Neuro-Linguistic Programming (NLP) (James & Woodsmall, 2017; Seysener, 2011). While NLP is an offshoot of hypnosis, TLT (which uses the timeline concept), is taught to practitioners and non-practitioners of hypnosis. The latter often use TLT within a counselling or coaching setting. Perhaps because of this, the focus of TLT has been used for, though not limited to, age regression and future progression along a client's current life timeline, with the client usually awake or in a light hypnotic state. While TLT's value in hypnosis is supported (Moore, 2001), literature comparing TLT, in and out of hypnosis, is challenging to find.

1.5 *Parts Therapy*

With origins in the work of Sigmund Freud and Carl Jung, this therapeutic approach is used in hypnosis to enhance communication with the unconscious by connecting with sub-personalities or 'parts' of the unconscious for conflict resolution. Whilst Freud distinguished between three distinct parts of the psyche (Id, Ego and Super-Ego), Jung referred to parts or aspects of the psyche, as complexes connected to one or more archetypes. He felt that they behaved "like independent beings" (Jung, 1969). The pioneering and massive body of work produced by these forerunners to Parts Therapy, laid a solid foundation for further research and development of therapies involving parts of the psyche— therapies, which are facilitated by the client being in hypnosis. These include: Voice Dialogue (Stone & Stone, 1988), Chairwork within Gestalt Therapy (Perls, Hefferline & Goodman, 1951), and Inner-Child work (Bradshaw, 1990) to name a few.

Perhaps the therapies most aligned with the term Parts Therapy are Client Centred Parts Therapy (Hunter, 2007) based on Charles Tebbetts' teachings, as well as Resource Therapy (Emmerson, 2014) and Ego State Therapy (Watkins & Watkins, 1993) based on Ego State Theory developed by Eric Berne through Transactional Analysis (Berne, 1961). Whilst these are powerful hypnotherapeutic tools, the applications for Ego State Theory, which underpins Resource Therapy and Ego State Therapy, are more diverse, supporting its use within personal, social and cultural settings. Other contributors to the development of Ego State Theory and Therapy include Paul Federn, Edoardo Weiss, Gordon Emmerson and Jan Sky, to name a few (refer to Section 4.6).

1.6 *Nested Loops*

Originally a mathematical term, in hypnosis circles this term has become associated with the mesmerising way in which Milton Erickson would use story-telling therapeutically. He would layer stories and metaphors, nesting them within each other. This nesting effect increases the unconscious imprinting of suggestions, strategies, solutions etc. Richard Bandler, himself a mathematician and co-founder of NLP (Bandler, 2008), referred to this strategy as *nested loops*. (refer to Section 4).

2. Current Approaches and Outcomes

Anxiety disorders are often treated with a combination of pharmacotherapy and psychological interventions, frequently cognitive behavioural-based (Bystritsky, Khalsa, Cameron, & Schiffman, 2013). This seems appropriate considering how common it is for a client to present with more than one anxiety disorder, such as specific fears or phobias coupled with GAD. In addition, anxiety disorders are the single biggest clinical risk for developing depression (Hirschfeld, 2001), and can lead to suicide.

2.1 *Co-existence of depression and anxiety disorders*

In the US, more than 75% of patients diagnosed with depression in a primary care setting were found to be suffering from a current anxiety disorder (Olfson et al., 1997). There was also a strong likelihood that a patient diagnosed with an anxiety disorder would develop major depression within the following year (Olfson et al., 1997). Similar figures have been found in later studies looking at anxiety disorders co-existing with a depressive disorder (Kessler et al., 2005).

2.1.1 *Treatment options* for anxiety disorders, co-existing with depressive disorders, entail a combination of psychotherapy, anxiolytic drugs and anti-depressants, depending on the specifics of the anxiety and depression. While this combination can be very effective in containing symptoms, they often fail to provide permanent relief (Bruce et al., 2008). This is reflected, for example, in the US figure of almost 30% for the lifetime prevalence of anxiety disorders (Kessler et al., 2005) and the long-term use of pharmaceuticals for these disorders. Despite studies which support the continuation of pharmacotherapy for as long as possible with anxiety disorders in order to prevent symptom relapse (Mochcovitch, da Rocha Freire, Garcia, & Nardi, 2017), a reliance on medication feeds disempowerment and a 'sufferer' mentality, so exploring pharmaceutical-free permanent solutions is desirable.

2.2 *Prevalence of anxiety disorders*

Anxiety disorders afflict 12-18% of adults in the US annually (Kessler et al., 2005; Mochcovitch et al., 2017). Similar figures are found for Australia, where these disorders afflict around one in seven (14%) of the adult population (16-85 years), making it the most prevalent of mental disorders within Australia (Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). Also, whilst Attention Deficit Hyperactivity Disorder (ADHD) was found to be the most common mental disorder in children and adolescents up to 16 years (over 7%) within Australia,

anxiety disorders came a close second with nearly 7% afflicted (Lawrence et al., 2015). In addition, while appreciating society's tendency to lump *anxiety* in with *anxiety disorders*, growing concern over these disorders is reflected by Internet surfing behaviour. Using Google Trends worldwide to compare the average search interest for health conditions in a given timeframe indexed to 'doctor', the term 'anxiety' was listed in third position after diabetes and depression (Sheridan, 2017).

2.3 *The societal impact of anxiety disorders*

Impairments associated with anxiety disorders range from limitations in role functioning to severe disabilities such as being unable to leave home. The resulting impact on society, including the enormous and growing burden for health budgets (Wittchen et al., 2011), compels us to explore alternatives.

Acknowledging that the current approach for treating anxiety disorders, namely pharmacotherapy and psychological interventions, is more effective than a single approach we offer a combined approach.

2.4 *Suggested patient groups for best outcomes*

This combined approach is designed to lead the client into recognising that a permanent solution has been affected thus feeling empowered to request the discontinuation of medication, if it has been prescribed. For this reason, this approach is most suitable for clients who have a desire to be medication-free. As Parts Therapy is an element of this approach, it is not recommended with clients diagnosed as having Dissociative Identity Disorder. Along similar lines, if the client is under psychiatric care, we recommend the appropriateness of this approach be discussed with their psychiatrist.

3. Pre-hypnotic Considerations

We review considerations specific to anxiety disorders, which eliminate anxious feelings toward experiencing hypnosis, thereby enhancing clients' confidence and trust in the process and clinician.

Using hypnoanalytical techniques, emphasis is placed in the first session on history taking, specifically noting the words and phraseology used by clients both on their intake form and verbally. Also noted in the client's responses, is their voice tone and body language to determine where there is emotional charge. This allows insights to be gained from both non-verbal and verbal reactions evoked by questions, as well as insights from their answers to questions, which do not evoke a reaction where one might be anticipated. We particularly value contingent suggestions (Erickson & Rossi, 1979) for anxiety disorders, linking what clients can expect from their hypnosis experience with behaviours we want to affect.

3.1 *The client's perception of hypnosis*

Determining clients' perception of hypnosis, expectations and concerns, is particularly relevant. Whether clients fear the unknown or have had a previous less than favourable experience with hypnosis, we identify and alleviate areas of apprehension. If the apprehension is due to a previous experience, identifying what happened and promptly making distinctions between that experience and what they can look forward to in the upcoming session is crucial.

3.2 *Motivation for change*

We find it useful to note from the client's speech pattern whether they are more motivated by 'move-toward' (pleasure) or 'move-away' (pain) suggestions. Then the client's positive words are fed back to them, using 'move-toward' motivators and negative words fed back using 'move-away' motivators. With inadequate research on the benefits of 'move-toward' vis-à-vis 'move-away' suggestions, we use both, emphasising 'move-toward' motivators. This emphasis is because 'move-toward' motivators are outcome driven, offering a complete resolution. In contrast, with 'move-away' motivators we cannot determine how far away the client has to be for them to know an issue has been resolved. Therefore, we ask clients pre-hypnosis to 'picture' their 'future self', identifying numerous 'move-toward' motivators to be used in hypnosis. For example, ""You now choose to experience a *calmness and stillness* inside of you each time you see a… [THERAPIST TO INSERT THE APPROPRIATE ANXIETY TRIGGER WORD/S FOR EACH SITUATION] … just as you are experiencing now"—where 'calmness' and 'stillness' are words the clinician has elicited from the client.

3.3 *Other misconceptions*

Other misconceptions that may fuel the client's anxiety and impact on the outcome of the session include: losing control, behaving against their will, saying things they never meant to, and not going into hypnosis because their mind is too strong. These misconceptions require correction at the outset. As well as dispelling myths, we remove anxiety by reassuring clients on what to expect such as an increased focussed awareness, offering a quick demonstration of how their focus can trigger their unconscious. As anxiety disorders are usually associated with a lack of self-belief, any demonstration that can boost this while allowing clients to realise that their unconscious cannot distinguish between 'real' and 'imagined' is beneficial. We favour a multisensory experience whereby clients are asked to close their eyes and imagine picking up, looking at and smelling a lemon before cutting it, observing the trickling juice, licking the lemon, etc. Their increased saliva production is pointed out, as is the ease with which they imagined aspects of the scene.

3.4 *Seeding the idea of deep relaxation*

Although hypnosis is not by definition relaxation (Elkins, Barabasz, Council, & Spiegel, 2015), we know that it can be profoundly relaxing. Ensuring that this is the case for clients is in itself of enormous benefit. Therefore, it seems prudent to

pre-hypnotically seed the idea of becoming deeply relaxed. We do this through the synergy of direct with indirect suggestions (Fricton & Roth, 1985), integrating metaphors and analogies with present tense embedded commands. These are reinforced in hypnosis to further encourage feelings of safety and install confidence in clients' ability to relax deeply into the process (i.e. "You can *now experience those waves of wellness*…").

3.5 *Shifting the client's perception of their anxiety disorder*

Clients with anxiety disorders tend to use *associative* language (i.e. "*I am* obsessed with…"). Then there are those who say that the issue has always been with them. For these reasons, we empower clients through reframing (Bandler, Grinder, & Andreas, 1982), shifting their perception of their thoughts and feelings, and the subsequent symptoms, enabling clients to view symptoms as aspects of self that have not always been with them. Clients are reassured that as fears were 'picked up' they can also be 'released'.

3.6 *Introducing clients to aspects of their unconscious mind*

3.6.1 *Ideomotor Signals*

Prior to a hypnotic induction, formal or otherwise, ideomotor signals (Wikipedia, 2017) are established. When dealing with anxiety disorders we prefer this non-verbal communication to immediately alleviate concerns about saying things in hypnosis, which were never intended. While already mentioned, it is repeated here because ideomotor signals allow clients to relax more readily into hypnosis, knowing that little or no verbal communication is expected from them.

Another reason for favouring ideomotor signals is due to their multiple uses, which includes assisting clients to go into a deep trance. In this regard, Dabney M Ewin MD, the foremost proponent of ideomotor signals, encourages using an eye-roll induction and the suggestion "each breath you take, you will go deeper and deeper, and when you are deep enough to solve this problem, your 'yes' finger will rise". He goes on to say that patience is required as it can take two to three minutes of silence before the 'yes' finger rises, and the client is in such a deep trance that he or she is unaware that it has risen (Ewin & Elmer, 2006).

We remind clinicians that ideomotor movements arise from the pre-verbal, unconscious parts of the mind, and that traumatic memories associated with anxiety disorders, often become stored in those parts of the brain (amygdala, thalamus, hippocampus, hypothalamus and brain stem), as well as the body. Greater recognition of the latter over the years has given rise to many body-centred approaches for releasing stored emotions under-pinning anxiety disorders. Body psychotherapy is one of the earlier and more established of these approaches (Kurtz & Prestera, 1977; Thielen, 2014). As stored traumatic memories may be inaccessible to the reasoning performed by the frontal lobes, ideomotor signalling offers highly effective communication with those parts of the client's brain and body for releasing emotions within traumatic memories (Ewin & Elmer, 2006).

3.6.2 *Working with the emotions*

We find it useful to prime clients to work with emotions in hypnosis by translating 'emotion' to 'E-motion', where 'E' represents 'energy' designed to be in motion. We also establish that over time, negative emotions that are not released through tears, vocalisation or another form of expression, can become 'frozen' in the body (Bordoni & Marelli, 2017). This imagery allows metaphors related to *melting frozen emotions* to be used in hypnosis. Another aspect which when conceptualised supports the client's hypnotic experience and the outcome, is that the most entrenched memories are those 'frozen with fear'.

Attention to the emotion, a physical bodily reaction (which can be measured when experienced) allows one to identify feelings associated with the emotional experience. Awareness/perception of feelings originates in the brain's neocortex where mental associations are made (cognition). Compare this to emotions which arise from the brain's subcortical regions such as the amygdala and muscle memory, triggered by outside stimuli.

3.7 *Introducing clients to mindfulness and meditation*

Since anxiety disorders take clients out of the present moment into the immediate projection of past fears, routinely recommending they take up practices such as mindfulness and meditation, which focus on 'being in the now', is an enormous aid (Clarke, 2012; Otani, 2016). This empowers clients, while complementing the approach taken here. Over the last 20 years, the number of studies showing the value of these practices in anxiety disorders has grown rapidly, shifting the topic of mindfulness and meditation from fringe to fashionable (Goldin & Gross, 2010; Hofmann & Gómez, 2017; Miller, Fletcher, & Kabat-Zinn, 1995). Specific meditation-based (Peterson & Pbert, 1992) and mindfulness-based (Goldin & Gross, 2010) programs have reinforced this.

4. Integrating Approaches

We focus on recognised methods and techniques, which when integrated, offer greater potential for the permanent relief of anxiety disorders. This integration includes the merging of synergistic therapies and the embedding of such interventions within the framework of timelines, similar to the use of embedded commands in 'nested loops' (refer to Section 1.6), which features in the Milton Model of NLP (Bandler, 2008).

4.1 *Using timelines*

We assert that *anxiety* within anxiety disorders is a symptom of fears originating in the past. Therefore, fears can be perceived as following a linear time sequence (i.e. their rapid passage from the past into the *present* through projection of the *past* into the *future*). Underlying fears associated with the *anxiety* will have arisen from a point in the past, so a timeline approach seems appropriate. Clarity on the types of 'past' associated with timelines is provided under Key Terms. The approaches discussed for clearing fears beneath the anxiety disorder require trust that the

unconscious has been holding onto those fears in the belief that it must. One of those approaches is the use of parts therapy where beliefs can be personified as specific parts of the client, for example, the part who believes that (*client's name*) would be safe and protected if they (*unwanted behaviour*). Working with beliefs, which may have served a purpose in the past and determining in hypnosis whether they still serve a purpose in the now or can be dissolved, is crucial for the permanent relief from those fears and by extension the anxiety disorder.

4.2 *Timelines versus other time-orientated approaches*

For many years, clinicians were trained to use hypnosis as a tool to explore the past, with numerous studies documenting its use to induce age regression and uncover traumatic memories including those associated with anxiety disorders (Alladin, 2016; Godoy, 1999). Hypnotic regression to previous lifetimes, however, is met with mixed feelings among clinicians. Nevertheless, as previously stated, therapeutic outcomes are independent of the client's and clinician's belief in reincarnation. What is relevant is that past-life regression has been shown to be effective across an extensive range of issues including anxiety disorders (Freedman, 2002; Hunter & Eimer, 2012) and more specifically phobias (Spiegel, 2014; Tripathi, 2013).

A timeline framework can open up a client's awareness to timelines other than their current life timeline where their anxiety disorder, or aspects of it, may have existed and even originated. Clients can be guided in hypnosis to explore and work with timelines in ways outlined in this paper. We feel that using a timeline framework, wherein hypnosis methodologies are integrated, will affect greater change. This is due to the enhanced imagery that occurs in hypnosis (Liggett, 2000), which in turn amplifies / enhances communication with the unconscious and allows greater flexibility to explore aspects of the anxiety disorder, or lack, on multiple timelines.

4.3 *Introducing timelines to clients*

Clients are familiarised with the concepts of current life and generational timelines. This familiarisation occurs while determining the client's awareness of their anxiety disorder (i.e. its origin and links to 'peak' experiences). The client's knowledge of circumstances surrounding their mother's pregnancy and the birth itself, such as "my parents were disappointed that I was not a boy", can be particularly useful, providing an opportunity for age regression within hypnosis to the appropriate point along their timeline if required (Zimberoff & Hartman, 1998). Similarly, the client's knowledge of fears and anxieties that their parents and past generations may have experienced, present potentials for exploration in hypnosis, on timelines other than their own. These generational timelines may be perceived as linking up to the client's current life, indicating traumas of past generations responsible for anxiety disorders in the current generation (Eley et al., 2015; Yehuda, Halligan, & Bierer, 2001). We find that referring to these timelines as being *familiar* to the client, when they are in hypnosis, assists in their recognition. Clearing generational timelines could be the missing link to the permanent relief from such disorders.

4.4 *Regression therapy*

Supportive to our approach is determining whether the client has had any form of regression therapy and details noted, especially if the client experienced being in their mother's womb, where emotions are experienced, yet not understood. We recognise that deep unconscious pre-birth memories, real or imagined, can shed enormous light on the transfer of anxieties (Fodor, 1949; Olivetti, 2015) and the development of anxiety disorders (Talge, Neal, & Glover, 2007). Such information is useful when melting 'frozen' emotions from the client's timeline. It is worth noting that therapies involving regression to the womb, range from various Rebirthing Breath Work practices (Manné, 2003) to the lesser known Pre-birth Analysis Matrix (PAM) within Whole-Self Pre-birth Psychology (Turner & Turner, 1993). Knowledge of such practices is unnecessary for working with the integrated approach, presented here.

4.5 *Introducing patterns to clients*

Occasionally, clients say they sense, even know, that their anxiety disorder stems from a previous lifetime. Here, it seems appropriate to prime clients with the suggestion that in hypnosis their unconscious can recognise similar signature patterns of fears and anxieties, originating in other lifetimes. Referring to 'patterns' as part of the unconscious' language, assists in working with them metaphorically in hypnosis (i.e. tracing patterns along a current life timeline to earlier memories associated with the anxiety disorder). The possibility of symptoms being linked to previous lifetimes, or generations, can then be worded as repeating patterns spreading along and across timelines up to the present time. This allows patterns to be disrupted or modified appropriately, with further details provided in sections 4.6.1, 4.7 and 4.9.

4.6 *Parts Therapy within timelines*

With numerous effective psychological approaches used to treat anxiety disorders, we have selected complementary ones that can be readily incorporated into our timeline framework for the greatest outcomes. Parts Therapy is one of these and a key component of our integrative approach.

We prepare clients to accept the word 'part' within hypnosis, by referring to a figure of speech (i.e. "you may have heard someone say: there is a part of me that knows I should… but there's another part of me that cannot..."). In hypnosis, various 'parts' are guided to specific actions, with ideomotor signals indicating task completion. We acknowledge the many versions and names for therapies that communicate with parts of a client (refer to Section 1.5). The Part therapies, which appear to be the most flexible when working within a framework of timelines, are Client Centred Parts Therapy (Hunter, 2007) and Resource Therapy (Emmerson, 2014) so elements of both are adopted in our integrated approach.

4.6.1 *The Observer Part*

While many parts therapies have overlapping methodologies, in our approach the Observer is the first part to be identified within hypnosis and invited to take

responsibility for witnessing different parts stepping forward to assist with the issue. Suggestions on how the Observer might appear are given, using multi-sensory language. In particular, we favour the image of a replica of the client's body formed of light, as the Observer is instructed to float up above all timelines. Since this can be powerful, clinicians are reminded to reunite the Observer with all parts, back into the Whole Self at the appropriate stage, and before the client is brought out of trance. With a bird's eye view of timelines, the Observer can identify and trace current anxieties and fears along timelines, to earlier or similar points on other timelines. From this higher perspective, teachings from past events (i.e. resilience, compassion, forgiveness etc.), can be recognised and then integrated into the Present and Future Self. Metaphorical suggestions are used throughout (i.e. a *spotlight* highlighting timeline sections, offering clarity on the situation; *disturbing* or fearful events marked on timelines as distortions such as crossed wires, indentations, knots or breaks). The Observer can notice which timelines these appear on, and how emotional charges held in past traumas may appear. As referred to in Section 4.5 above, the Observer can survey patterns spreading along or across timelines from distortion points up to the present time. For example, the 'pebble-pond-ripple pattern' metaphor has pebbles representing *disturbing* events and more pebbles creating *intersecting* ripples. Combining generic with client-centred metaphors supports our multi-layered approach, with the Observer directed to view versions of the client on parallel timelines, including a version completely free of the issue, and how that version goes about their day.

Suggestions given in hypnosis often warrant a proviso that the client's Creative Part may create better alternatives to those already provided, defining *better* to the 'part' according to the desired outcome. At some point, the Observer observes a Future Self on a future timeline, who is free of the anxiety disorder and can relay their wisdom to the Present Self for implementation. Depending on the outcome of this action, other parts may be involved (i.e. a Creative Part to create the client's Future Self).

4.6.2 *The Child Part*

We acknowledge aspects of the approaches discussed, which when used within stand-alone regression practices, can precipitate abreactions. In our approach, abreactions are unnecessary for a therapeutic outcome. Instead, the Observer is directed to observe timeline sections, including childhood. Then, with or without the client's conscious awareness of specific childhood traumas, anxieties or fears, the Observer is directed to notice from above a Fearful Part below. When identified as a child, we integrate parts therapy with inner child work. Since the Observer is dissociated, observing the fearful Child Part from above, offers a gentler approach to releasing stored emotions thereby reducing the likelihood of abreactions.

With many anxiety disorders originating in childhood, the Fearful Part is often identified as a Child Part. Here we recommend integrating both parts because in the evolution of the anxiety disorder, the client has resisted and so rejected, this fearful part of themselves. As no one wants to reject a child, especially his or her own child, working with a part of the client, the frightened child, removes resistance. A nurturing Parent Part is invited forward to provide the Child Part with whatever allows them to feel safe and loved—a determining factor for dissolving fears underlying anxiety disorders. If the client did not have nurturing parents, it can be explained to them that regardless of how their parents behaved towards them, they know that every child deserves love and nurturing and that the Parent Part of them knows how to do that.

4.7 *Fears underlying anxiety disorders*

Clinicians may see clients who can connect their fears to their symptoms, while unconscious of others, as in the case of Lucinda. With an upcoming plane trip, Lucinda's fear of flying was prominent in her mind with little recognition of other fears besides being in an enclosed space. Strategic questioning revealed various fears and triggers, with their root in the fear of embarrassing herself and others, as well as being considered stupid. The client declared, "I died with embarrassment," and then described how she felt responsible for people vomiting on a plane flight after she had vomited. Her earliest recollection of embarrassment was when she was five years old, "embarrassing her parents" for feeling sick on a car-trip. They told her not to be stupid. Lucinda promptly vomited and then recalled being ignored by her parents, though was unable to access the rest of that memory. A realisation of the connection between that memory and the fear of vomiting on a flight provided the client with a sense of relief and a perceptual shift. Our timeline approach left Lucinda confident after her first session that the fears were gone. A second session reinforced the previous work and included dissolving triggers. In each session, and with different emphases, the Observer invited a Parent Part to provide the Child Part with the reassurance required. The emotional charge within the embarrassing memories and subsequent fear triggers were filtered out along all timelines. Tools used with Lucinda included: reframing, imaginal desensitisation and anchoring positive feelings.

Clinicians know that multi-sensory information, picked up unconsciously from the environment at the point of origin of a fear, can trigger offshoots of that fear, as in the above case. (Therapeutically, clinicians recognise post-hypnotic suggestions as unconscious triggers deliberately imprinted). Therefore, we identify fear triggers and underlying fears associated with the disorder, pre-hypnosis and in hypnosis.

We appreciate that fear accompanying the self-preservation instinct has many branches or expressions such as anxiety disorders, often as a displacement activity (McNaughton & Corr, 2008). Considering this viewpoint of one root fear and its expression (Hawkins, 2015), the Observer is guided to detect branching patterns of fear along and possibly across timelines, tracing them back to their origin. Respective parts can then clear unhelpful patterns, even creating and installing more appealing ones.

4.8 *Psychotherapeutic interventions with timelines*

In addition to NLP referred to earlier, other psychological interventions which we feel will provide improved outcomes and permanent relief when used in hypnosis within the timeline framework include: Eye Movement Desensitisation and Reprocessing (EMDR), Emotional Freedom Technique (EFT), and Thought Field Therapy (TFT). These have each been shown independently, as effective for anxiety disorders (McNally, 2001) and can be combined in the open-eye trance state.

4.9 *Timeline distortions*

Designing and strategically using metaphors (Kopp, 2013) encourages the clients' awareness of: timelines and their distortions, various 'parts', signature patterns of fears and anxieties, and negative stored emotions on timelines. Metaphors also offer gentle ways to clear all aspects of the anxiety disorder, represented as timeline distortions. With distortions identified metaphorically, Expert Parts are directed to clear or adjust timelines. Collapsing timelines disintegrates distortions irrespective of their timeline position. Similarly, we might guide the Observer to notice a split in the current timeline and use the 'fork-in-the-road' metaphor to ensure the 'right' fork or 'right' choice is made and the 'left fork' is 'left' behind. This frees the client to step onto the smooth road on the right path, free of distortions.

As a source for imagination (Rossman et al., 2016), insights (Yu, 2008), intuition (Clark, 1973) and creative problem solving (Proctor, 1989), we incorporate metaphors whenever we can. These aspects of the psyche are cultivated in the clinician and client, as both are exposed to metaphors, increasing the probability of creating permanent solutions.

We link metaphors by directing the Observer to detect the appearance of timelines and distortions while suggesting what distortions represent (i.e. "That timeline may appear as a rope, with fears and anxieties tied up in knots along it, or perhaps a hose with kinks in it, or something else"). Following the clearing of distortions on all timelines using parts, a compelling Future Self is installed into the present.

Conclusion

We explored the why, what and how of treating anxiety disorders. We began by exploring their prevalence and the issue of permanent relief, which answered: 'Why is a fresh perspective on the treatment of anxiety disorders required?' We proceeded to the 'What'—'What do these clients have in common?' While anxiety disorders share features of anxiety and fear, a less noted commonality is that such clients appear to skip the present moment, projecting past fears onto their future self. Thus, working with timelines, as a container for past, present and future moments, is pertinent. The third aspect of this triad is 'How'—'How to engage all commonalities of anxiety disorders to achieve permanent relief?' The answer was provided in two steps. Firstly, we reviewed pre-hypnotic considerations and recommendations specific to these clients. Secondly, we discussed practices, processes and methodologies, recognised as effective for anxiety disorders, integrating them within a timeline framework. Both steps involved identifying branching roots of anxieties and fears—analogous to the good gardener who removes weeds. Success is assured if soil around the weeds is loosened before the roots and their branches are removed with the right weeding tools, referencing pre-hypnosis tools, to dig deeper into the presenting disorder. We have given considerable attention to preparation in our integrative approach, therefore, we conclude with a quote supposedly by Benjamin Franklin: "By failing to prepare, you are preparing to fail".

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Man's Search for Meaning: Viewed Through Another Lens

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Abstract
Man's Search for Meaning by Dr Viktor E Frankl is widely regarded as a classic text. In it, Dr Frankl recounts his experiences in some of the most infamous death camps of World War II. This narrative not only outlines how Dr Frankl and his fellow inmates coped with their traumatic experiences, but it is used by him to illustrate the principles of Logotherapy. As I began reading this story, however, I was surprised to view this famous work from another perspective—that of hypnosis. Beginning with context drawn from Dr Frankl's personal history, this paper orients the reader to hypnosis and self hypnosis before moving on to interpret Dr Frankl's experiences as hypnotic phenomena, with examples drawn from the text. The final excerpt is Dr Frankl's impromptu speech to his fellow prisoners, which not only highlights key notions of Logotherapy, but implicitly illustrates common ideas and practices shared across different psychotherapies. This paper concludes by returning briefly to Dr Frankl's history and to the final observation that we have inherent, self hypnotic capacities, which potentially protect us from the most horrific of trauma.

Introduction
"He who has a why to live for can bear almost any how." Frederick Nietzsche

Dr Viktor E Frankl is a former Austrian psychiatrist and neurologist who developed Logotherapy, often referred to as the third Viennese school of psychotherapy (after Freud and Adler's psychotherapy schools)[1]. In 1942, at the age of 37, Dr Frankl and his family were deported and imprisoned in the Theresienstadt ghetto, a concentration camp in German-occupied Czechoslovakia. In 1944, he was transferred briefly to the Auschwitz-Birkenau concentration camp in Poland before being moved onto other labour camps[2]. After six months of incarceration, working mostly as a slave labourer and briefly as a doctor, Dr Frankl and the surviving inmates were liberated by American soldiers on 27 April 1945[3]. Tragically, his wife, father, mother and brother did not survive their ordeal.

In 1946, an intensely grief stricken, some feared suicidal, Dr Frankl published his widely acclaimed book From *Death-Camp to Existentialism*, which in 1963, he re-titled *Man's Search for Meaning*. This is considered to be a classic text in both the Holocaust and psychotherapy literatures. It not only contains an account of his experiences in Auschwitz-Birkenau and, subsequently, the Kaufering (connected to Dachau) and Turkheim death camps, but it contains his observations of imprisonment that furthered his development of Logotherapy, which he had begun before the war[4].

Upon opening the cover of *Man's Search for Meaning*, I was aware of feeling some ambivalence. Having read and watched many stories about the Holocaust (e.g. *The Pianist, Schindler's List* and *Life Is Beautiful*), I braced myself for the imagined horrors that were contained within. However, I was also aware of a sense of anticipation as it is a story of survival. As I wondered how Wladyslaw Szpilman, Oskar Schindler and Guido Orefice's[5] moving and inspirational stories would resonate with Dr Frankl's own narrative, I could almost hear Szpilman's achingly beautiful rendition of Chopin's Nocturne, playing somewhere in the distance.

As I commenced Dr Frankl's narrative, I was not prepared for the surprising discovery that lay waiting. While the book embodies Dr Frankl's central thesis that, even in the most horrific of circumstances, striving to find meaning in one's life is the primary motivational force for all human beings, I was not expecting to discover that *Man's Search for Meaning* contains countless examples of hypnosis—specifically self hypnosis.

Dr Frankl's account as seen through the lens of hypnosis is not a perspective that has, to my knowledge, been commonly applied to his work[6]. It is highly unlikely that such a view is unique, however, a brief survey of the literature has yielded only one paper by Durbin (2002) who makes a broad connection between Dr Frankl and hypnosis.

Prior to his imprisonment by Hitler's SS, Dr Frankl was an accomplished psychiatrist pioneering, among other things, innovative work with youth counselling and techniques for the management of severely depressed and suicidal patients. However, his interest in medicine and in mental health had started many years earlier[7]. Having taught himself how to use hypnosis "correctly" (Frankl, 2000, p.53) by the age of 15, it is likely that he would have been further exposed to hypnosis during his medical or psychiatric training, though Dr Frankl never referred to hypnosis in *Man's Search for Meaning*. Furthermore, aside from two clinical vignettes where he used hypnosis (one performed as an intern with a patient requiring anaesthesia and the other as a young doctor with a patient having trouble with insomnia)[8] there is little, if any, reference to hypnosis in his other publications.

Before presenting an interpretation of Dr Frankl's experiences through the lens of hypnosis, I will present an overview of the definition of clinical hypnosis and self hypnosis, which will be followed by a brief outline of hypnotic phenomena used by Dr Frankl, with illustrative examples drawn from the text. Finally, this paper will conclude with Dr Frankl's impromptu speech to his fellow prisoners which, considering the extreme conditions that he was under, is not only one of the most moving of speeches, but it captures the essence and heart of Logotherapy.

Clinical Hypnosis, Self Hypnosis and Hypnotic Phenomena

Clinical hypnosis is not generally considered a treatment or type of psychotherapy per se, but it is an approach that is used to enhance whatever psychotherapy model a clinician may choose to use (Kirsch, Lynn & Rhue, 1993)[9].

Yapko (2012) defined hypnosis as:

> …a focused experience of attentional absorption that invites people to respond experientially on multiple levels to amplify and utilize their personal resources in a goal-directed fashion. Employed in the clinical context, hypnosis involves paying greater attention to the essential skills of using words and gestures in particular ways to achieve specific therapeutic outcomes, acknowledging and utilizing the many complex personal, interpersonal and contextual factors that combine in varying degrees to influence client responsiveness (p.7).

Implied in Yapko's definition is the traditional and common view of hypnosis, as an intervention performed by a clinician with a client, also referred to as hetero hypnosis.

According to Robertson (2013), in 1846, James Braid first coined the term self hypnosis. Braid discovered that hypnosis does not require the use of an "exotic" induction delivered by a practitioner in order to be effective. Later, renowned hypnosis researchers such as Hilgard (1965) argued that hypnosis depends more on the subject's own abilities and efforts than that of the hypnotist. Referring to other prominent figures in the field, Araoz (1985) stated that Theodore Barber "is echoing the words attributed to Bernheim by Boudin (1922), 'There is no hypnotism, there is only suggestion', and Coué's later statement 'There is no suggestion, there is only self-suggestion'" (p.3). These views have led to the common clinical saying—all hypnosis is self hypnosis.

Clarke and Jackson (1983), drawing on the work of Erika Fromm, make the distinction between self directed responses and self initiated responses. The former involve the client utilising hypnotic phenomena taught to him or her by the clinician, while the latter involve the client freely choosing whatever suggestions, imagery or fantasies he or she cares to utilise. As will be seen below, it is the self initiated type of hypnotic phenomena that Dr Frankl and his fellow inmates mostly used.

Hypnotic phenomena are found in the experiences of everyday life, although the average person would not view them as such. By way of analogy, Barber, Spanos & Chaves (1974) talk about reading an interesting novel or watching a motion picture. Through the process of such activities, "a person thinks and imagines with the communications from the printed page" (p.11) or "thinks with the communications from the screen" (p.12). To the extent that the person becomes engrossed or involved

in the imaginings, identifying with the experiences of the central characters in a "living with" fashion, contradictory thoughts that this is just a novel or just a movie do not occur. Barber et al argue that a person responding in a clinical situation to hypnotic suggestions resembles the person imagining the story through the words of the text or the words/images on the screen because each person has 'capabilities and potentialities' for hypnotic phenomena. They state:

> (a) the phenomena are elicited when an individual thinks and imagines with the themes that are suggested and (b) a large proportion of individuals have the potential to think and imagine with the themes of suggestions. However, (c) the potential often remains dormant until the individual has positive attitudes, motivations and expectancies toward the situation (p.119).

The various hypnotic phenomena that are used by clinicians, therefore, represent untapped human resources, and clinical application only differs from everyday occurrence in terms of degree (Yapko, 2012). Classical hypnotic phenomena include: age progression, age regression, amnesia, anaesthesia, analgesia, catalepsy, dissociation, hallucinations, ideodynamic responses, sensory alterations and time distortion. While only a selection of these hypnotic phenomena will be reviewed here, namely those used by Dr Frankl and fellow inmates (presented in the sequence as they unfold in the narrative), readers are directed to numerous resources for more information on hypnotic phenomena (e.g. Barber et al, 1974; Hilgard, 1965; Lynn & Kirsch, 2006; Nash & Barnier, 2008; Robertson 2013; Yapko, 2012).

1.1 *Dissociation*

This phenomenon refers to the ability to separate a part of one's experience from conscious awareness. Dissociation occurs naturally in one's life many times per day, such as getting lost in the memories associated with a particular song or photograph, or managing pain by distancing oneself from the immediate experience. Dissociation is considered to be an adaptive coping mechanism for people experiencing trauma. A dissociative experience is, in fact, the essence of hypnosis as it facilitates unconscious processing and responding (Hilgard, 1986; Yapko, 2012). All hypnotic phenomena, at some level, involve a process of dissociation.

Not surprisingly, Dr Frankl's narrative is replete with examples of dissociation. The first example in the text begin with instances of humour and curiosity as a means by which the prisoners could detach from the grimness of their circumstances, before moving onto more familiar examples of dissociation.

> After a time we again heard the lashings of the strap, and the screams of tortured men. This time it lasted for quite a while.
>
> Thus the illusions some of us still held were destroyed one by one, and then, quite unexpectedly, most of us were overcome by a grim sense of humour [10].We knew that we had nothing to lose except our so ridiculously naked lives. When the showers started to run, we all tried very hard to make fun, both about ourselves and about each other. After all, real water did flow from the sprays!
>
> Apart from that strange kind of humour, another sensation seized us: curiosity. I have experienced this kind of curiosity before, as a fundamental reaction toward certain strange circumstances. When my life was once endangered by a climbing accident, I felt only one sensation at the critical moment; curiosity as to whether I should come out of it alive or with a fractured skull or some other injuries.
>
> Cold curiosity predominated even in Auschwitz, somehow detaching the mind from its surroundings, which came to be regarded with a kind of objectivity. At that time, one cultivated this state of mind as a means of protection[11].

And a little further on…

> The man with the corpse approached the steps. Wearily he dragged himself up. Then the body; first the feet, then the trunk, and finally – with an uncanny rattling noise – the head of the corpse bumped up the steps.
>
> My place was on the opposite side of the hut, next to the small, sole window, which was built near the floor. While my cold hands clasped a bowl of hot soup from which I sipped greedily, I happened to look out the window. The corpse which had just been removed stared in at me with glazed eyes. Two hours before I had spoken to that man. Now I continued sipping my soup.
>
> If my lack of emotion had not surprised me from the standpoint of professional interest, I would not remember this incident now, because there was so little feeling involved in it.
>
> Apathy, the blunting of the emotions and the feeling that one could not care any more, were the symptoms arising during the second stage of the prisoner's psychological reactions, and which eventually made him insensitive to daily and hourly beatings. By means of this insensibility the prisoner soon surrounded himself with a very necessary protective shell[12].

And a final example of dissociation….

> In spite of all the enforced physical and mental primitiveness of the life in a concentration camp, it was possible for spiritual life to deepen. Sensitive people who were used to a rich intellectual life may have suffered much pain (they were often of a delicate constitution), but the damage to their inner selves was less. They were able to retreat from their terrible surroundings to a life of inner riches and spiritual freedom. Only in this way one can explain the apparent paradox that some prisoners of a less hardy make-up often seemed to survive camp life better than did those of a robust nature[13].

1.2 *Age Progression*

This phenomenon refers to the ability to project into or engage with an experience in the future as if it is happening now, such that an individual can imagine themselves experiencing positive (or negative) gains from having certain thoughts, behaving in certain ways or making particular choices. Clinical tasks such as goal directed imagining or goal directed fantasies capitalise on the phenomenon of age progression (Spanos & Barber, 1972).

> Because of the high degree of undernourishment which the prisoners suffered, it was natural that the desire for food was the major primitive instinct around which mental life centred. Let us observe the majority of prisoners when they happened to work near each other and were, for once, not closely watched. They would immediately start discussing food. One fellow would ask another working next to him in the ditch what his favourite dishes were. Then they would exchange recipes and plan the menu for the day when they would have a reunion—the day in the distant future when they would be liberated and returned home. They would go on and on, picturing it all in detail, until suddenly a warning passed down the trench…"The guard is coming".[14]

And another example further on…

> I became disgusted with the state of affairs which compelled me, daily and hourly, to think of only such trivial things. I forced my thoughts to turn to another subject. Suddenly I saw myself standing on the platform of a well-lit, warm and pleasant lecture room. In front of me sat an attentive audience on comfortable upholstered seats. I was giving a lecture on the psychology of the concentration camp! All that oppressed me at that moment became objective, seen and described from the remote viewpoint of science. By this method I succeeded somehow in rising above the situation, above the sufferings of the moment, and I observed them as if they were already of the past.[15]

1.3 *Age Regression*

This phenomenon involves a person becoming intensely absorbed in the experience of a past memory. According to Yapko (2012), there are two types of age regression techniques: *revivification* (i.e. clients are encouraged to go back in time to re-experience an event as if it were happening now) and *hypermnesia* (i.e. clients are encouraged to remember an experience as vividly as possible). Yapko states that "age regression is one of the most widely used hypnotic patterns in therapeutic work" (p.346). An example of hypermnesia as used by Dr Frankl follows.

> This intensification of inner life helped the prisoner find a refuge from the emptiness, desolation and spiritual poverty of his existence, by letting him escape into the past. When given free reign, his imagination played with past events, often not important ones, but minor happenings and trifling things. His nostalgic memory glorified them and they assumed a strange character. Their world and their existence seemed very distant and the spirit reached out for them longingly: In my mind I took bus rides, unlocked the front door of my apartment, answered my telephone, switched on the electric lights. Our thoughts often centred on such details, and these memories could move one to tears[16].

1.4 *Hallucinations*

This hypnotic phenomenon involves a suggested sensory experience that a person can have which does not arise from their current, objective reality. Many everyday, guided visualisations where a person is asked to imagine 'walking through a rainforest, seeing the trees and plants with their infinite shapes, shades of green and other colours, hearing the sounds of the birds and the crunching of the leaves underfoot while feeling the moisture in the air...' tap into a process of fantasising or hallucinating. Spanos et al (1972), performing research on hallucinations, found that the vast majority of their subjects were able to see or at least vaguely imagine a suggested object, with only 5-10% subjects not being able to see anything at all. Yapko (2012) made the distinction between positive hallucinations (as exemplified in the visualisation) and negative hallucinations which involve not having a sensory experience that is objectively present in the person's current experience (e.g. not feeling pain in one's body or hearing sounds that are in the room). Some examples of positive hallucinations used by Dr Frankl are provided below.

> That brought thoughts of my own wife to mind. And as we stumbled on for miles, slipping on icy spots, supporting each other time and again, dragging one another up and onward, nothing was said, but we both knew: each of us was thinking of his wife. Occasionally I looked at the sky, where the stars were fading and the pink light of the morning was beginning to spread behind a dark bank of clouds. But my mind clung to my wife's image, imagining it with an uncanny acuteness. I heard her answering me, saw her smile, her frank and encouraging look. Real or not, her look was then more luminous than the sun which was beginning to rise.
>
> A thought transfixed me: for the first time in my life I saw the truth… The salvation of man is through love and in love. I understood how a man who has nothing left in this world may still know bliss, be it only for a brief moment, in the contemplation of his beloved. In a position of utter desolation, when man cannot express himself in positive action, when his only achievement may consist in enduring sufferings in the right way – an honourable way – in such a position man can, through loving contemplation of the image he carries of his beloved, achieve fulfilment[17].

And a little further on…

> Another time we were at work in a trench… I was again conversing silently with my wife, or perhaps I was struggling to find the reason for my sufferings, my slow dying. In a last violent protest against the hopelessness of imminent death, I sensed my spirit piercing through the enveloping gloom. I felt it transcend that hopeless, meaningless world, and

> from somewhere I heard a victorious "Yes" in answer to my question of the existence of an ultimate purpose. At that moment, a light was lit in a distant farmhouse, which stood on the horizon as if painted there, in the midst of the miserable grey of a dawning morning in Bavaria… For hours I stood hacking at the icy ground. The guard passed me, insulting me, and once again I communed with my beloved. More and more I felt that she was present, that she was with me: I had the feeling that I was able to touch her, able to stretch out my hand and grasp hers. The feeling was very strong: she was there. Then, at that very moment, a bird flew down silently and perched just in front of me, on the heap of soil which I dug up from the ditch, and looked steadily at me[18].

2. Logotherapy: Principles and Reframing

In Prisoners of Our Thoughts, Pattakos and Dundon list seven core principles of Logotherapy[19]. Attempting to connect a person with these principles is clearly a goal of Logotherapy. The clinical technique that Frankl often used to achieve this was reframing. Reframing "means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby chang(ing) its entire meaning" (Watzlawick, Weakland & Fisch, 1974, p.95). Utilising Logotherapy principles, Dr Frankl helped his patients put a new frame around an old picture, so to speak, thereby transforming its appearance and meaning. While reframing is not specifically a Logotherapy technique, it is a technique that has been used in many forms of psychotherapy and is often used within hypnosis. Like all effective psychotherapists, Dr Frankl knew the therapeutic value of reframing, though this is not a term he typically used.

In many of Dr Frankl's clinical vignettes, he provided a frame for an event that a patient was struggling to come to terms with, either because the patient had no frame or because they had an unhelpful frame. For example, he consulted with an elderly doctor who was very depressed for some time following the death of his wife. After listening to his story, Dr Frankl asked what would have happened if he had died before his wife? The elderly doctor replied, without a moment's hesitation, that his wife would have suffered terribly had he died first. Dr Frankl then explained that by surviving his wife, she had been spared a great deal of suffering and that by outliving her he had spared her this suffering. The price for this was a suffering that the doctor now had to bare. After listening attentively, and without speaking a word, the doctor stood up, shook Dr Frankl's hand then left the office calmly.

Let me introduce the final excerpt taken from Dr Frankl's narrative, by setting the scene. With starvation an everyday occurrence, one of the prisoners stole some potatoes. The other inmates were then threatened to give him up or they would miss out on their food ration for an entire day, as meagre as it was. The 2,500 inmates did not give up the man as they knew that he would have been hung immediately. To add further insult, the lights went out early and they all sat in darkness. The mood of the group was sombre, they were cold and hungry, irritable and exhausted. In this state, Dr Frankl, who himself was struggling, was asked to speak to the men in his hut.

> So I began by mentioning the most trivial of comforts first. I said that even in this Europe in the sixth winter of the Second World War, our situation was not the most terrible we could think of. I said that each of us had to ask himself what irreplaceable losses he had suffered up to then. I speculated that for most of them these losses had really been few. Whoever was still alive had reason for hope. Health, family, happiness, professional abilities, fortune, position in society—all these things that could be achieved again or restored. After all, we still had all our bones intact. Whatever we had gone through could still be an asset to us in the future. And I quoted Nietzsche: "That which does not kill me, makes me stronger".
>
> Then I spoke about the future. I said that to the impartial the future must seem hopeless. I agreed… But I also told them that, in spite of this, I had no intention of losing hope and giving up. For no man knew what the future would bring, much less the next hour. Even if we could not expect any sensational military events in the next few days, who knew better than we, with our experience of camps, how great chances sometimes opened up, quite suddenly, at least for the individual…
>
> But I did not only talk of the future and the veil which was drawn over it. I also mentioned the past: all its joys, and how its light shone even in the present darkness. Again I quoted a poet—"What you have experienced, no power on earth can take from you". Not only our experiences, but all we have done, whatever great thoughts we may have had, and all we have suffered, all this is not lost, though it is past: we have brought it into being. Having been is also a kind of being, and perhaps the surest kind.
>
> Then I spoke of the many opportunities of giving life a meaning. I told my comrades… that human life, under any circumstances, never ceases to have meaning, and that this infinite meaning of life includes suffering and dying, privation and death. I asked the poor creatures who listened to me attentively in the darkness of the hut to face up to the seriousness of our position. They must not lose hope, but should keep their courage in the certainty that the hopelessness of our struggle did not detract from its dignity and its meaning…
>
> And finally I spoke of our sacrifice, which had meaning in every case. It was in the nature of this sacrifice that it should appear to be pointless in the normal world… But in reality our sacrifice did have meaning…
>
> The purpose of my words was to find a full meaning in our life, then and there, in that hut and in that practically hopeless situation. I saw that my

efforts had been successful. When the electric light bulb flared up again, I saw the miserable figures of my friends limping toward me to thank me with tears in their eyes…[20]

While the above text provides a summary of the key points of Dr Frankl's speech, one can easily imagine that his communication of these ideas in the hut, using words and gestures, would have been in a more conversational manner. As such, this would parallel what Clarke & Jackson (1983) called a self directed hypnotic intervention, containing elements of age progression and age regression, punctuated by a number of impressive reframes[21]

Coda

In 1946, a year after his liberation, Dr Frankl became director of the Vienna Neurological Policlinic, a position he went on to hold for 25 years. He continued to develop, teach and write about Logotherapy, publishing 40 books in total. Dr Frankl held guest professorship positions in a number of overseas universities. He went on to lecture at 209 universities across all five continents, and was conferred 29 honorary doctoral degrees by these various institutions[22]. He passed away peacefully in 1997, at the age of 92, leaving the legacy of a most humanistic form of psychotherapy. And what of *Man's Search for Meaning*? In 1991, the Library of Congress in the United States listed it as one of the Top 10 most influential books in America[23].

Man's Search for Meaning, as seen through the lens of hypnosis, is an impressive story of how professional and untrained people alike exposed to ongoing trauma can draw on their inherent capacities to dissociate. In doing so, they can distance themselves from the unspeakable by focusing on internal experiences that can bring joy through revisiting their past, create positive and powerful emotions in the present or give hope for one's future.

Footnotes

[1] In *Logotherapy in a Nutshell*, Dr Frankl states that the name Logotherapy is based on the word *'logos'*, which is Greek for 'the meaning'. He theorised that man's search for meaning is the primary motivational force of life (as distinct to Freud's pleasure or Adler's power principles). Man's will to seek meaning can be frustrated, resulting in an 'existential frustration'. This frustration can lead to '*noögenic* neuroses' ('*noos*' is Greek for 'the mind'), which differ from other neuroses in that they emerge from existential problems rather than conflicts between inner drives and instincts. Dr Frankl believed that Western society was in an 'existential vacuum'. He argued that man should not ask 'what is the meaning of life?', but should recognise that he is questioned by life to take responsibility to find his own unique meaning. This lead to his famed maxim (and a great example of age progression) "live as if you were living already for the second time and if you had acted the first time as wrongly as you are about to act now" (p.114).

[2] Based on information obtained from the Viktor Frankl Institut: http://www.viktorfrankl.org

[3] In *Viktor Frankl Recollections: An autobiography* Dr Frankl tells the story that when the mayor of Austin, Texas wanted to make him an honorary citizen of Austin, he told the mayor that it is he who should make the mayor an honorary Logotherapist for if it were not for the brave and many Texan soldiers who liberated him from Turkheim concentration camp, there would be no Logotherapy.

[4] Ibid.

[5] While the character Orefice is fictional, the movie was inspired by the true story of Rubino Romeo Salmoni's Holocaust survival as portrayed in his book *In the End, I Beat Hitler*. As Sulmoni's title suggests, the purpose and meaning of his experience was to defy the plans of the most infamous of dictators. To paraphrase Dr Frankl, Sulmoni exercised his freedom to choose an attitude which ultimately helped him survive his incarceration.

[6] Even in the impressive analysis text *Viktor Frankl's Search for Meaning: An Emblematic 20th Century Life*, Timothy Pytell does not recognise the role that self hypnosis played in Frankl's capacity to cope with his ordeal, attributing his coping more broadly to his 'professional training'.

[7] In *Viktor Frankl Recollections: An autobiography*, Dr Frankl's account suggests that he was a very precocious child and teenager. At age three, he told his mother he wanted to become a doctor; at four, he expressed interest in researching medicines and, not much later, he started to wonder about the meaning of life! After teaching himself hypnosis at 15, a little later he gave a public lecture entitled 'The Meaning of Life'. And while still in high school, he was exploring psychoanalysis not only talking to fellow students and completing assignments on the subject, but corresponding with Freud himself! At 19, at Freud's request, Dr Frankl published

his first article containing core Logotherapy principles in the *International Journal of Psychoanalysis*.

[8] See *Viktor Frankl Recollections: An Autobiography*, pp.53-55, for details about these two cases.

[9] Interestingly, Dr Frankl also talked about the use of Logotherapy either as a stand-alone treatment or one that can be used adjunctively with other treatments (e.g. in *Logotherapy in a Nutshell* and *The Will to Meaning*).

[10] One of Dr Frankl's famous techniques which has been adopted by the broader therapeutic community is Paradoxical Intention (or Prescribing the Symptom). He stated that Paradoxical Intention should always be delivered in as humorous a manner as possible. "…humour allows a man to create perspective, to put distance between himself and whatever may confront him. By the same token, humour allows man to detach himself from himself and thereby attain the fullest possible control over himself. To make use of the human capacity of self detachment is what paradoxical intention basically achieves". (Frankl, 2000, pp.81-82). I am sure readers will notice the similarities between self detachment, as achieved through Paradoxical Intention, hypnosis and other treatment approaches such as Mindfulness.

[11] *Man's Search for Meaning*, p.29.

[12] Ibid, p.35.

[13] Ibid, p.47.

[14] Ibid, p.41.

[15] Ibid, p.82. In *Viktor Frankl Recollections: An Autobiography*, Dr Frankl uses the same quote as an example of what he calls 'self-distancing'.

[16] Ibid, p.50.

[17] Ibid, pp.48-49.

[18] Ibid, pp.51-52.

[19] Seven core principles: 1. Exercise the freedom to choose your attitude. 2. Realize your will to meaning. 3. Detect the meaning of life's moments. 4. Don't work against yourself. 5. Look at yourself from a distance. 6. Shift your focus of attention. 7. Extend beyond yourself.

[20] *Man's Search for Meaning*, pp.89-91.

[21] I am indebted to a colleague, Nichola Forster, who in reviewing an earlier draft of this article highlighted the self-directed potential of this speech.

[22] Viktor Frankl Institut: http://www.viktorfrankl.org

[23] Ibid.

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There NEADS to Be Another Way: Treating Non-Epileptic Attack Disorder Using Hypnotherapy

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Abstract
Many different words are used for Non-Epileptic Attacks (NEAs). The more commonly used terms include non-epileptic seizures, non-epileptic events, dissociative seizures, pseudo seizures, pseudo epileptic seizures, psychogenic seizures, functional seizures, and conversion seizures. For the purpose of this paper, I will refer to the condition as Non-Epileptic Attack Disorder (NEAD).

This paper explores using hypnotherapy to treat a female patient with NEAD in her early 20s who had recently become pregnant. Her GP withdrew the medication for her NEAD condition, while at the same time her very loving and supportive parents sought an alternative treatment option.

Emma, as she is referred to in this paper, experienced between six to eight seizures a week on average. She also suffered from high levels of anxiety and stress, coupled with low self-esteem and confidence due to many years of bullying at school.

Emma had six sessions of hypnotherapy and during that time her seizures reduced in number and intensity to the point where she had had no seizures in nearly five weeks. Additionally, Emma and her parents saw a significant reduction in her anxiety and stress levels. She also saw major improvement in her sleep, confidence and self-esteem.

Emma's parents were keen to use hypnotherapy with her through childbirth as well. However, Emma had to have an emergency caesarean section before this could eventuate and she gave birth in early 2018.

This paper explores the patient's background medical history, the hypnotherapy approach, and how she responded to the treatment she received.

Introduction

NEAD can often be misdiagnosed as epilepsy. NEAD is a condition that is not caused by abnormal electrical activity in the brain (like epileptic seizures). It is instead caused by the brain unconsciously shutting down in response to psychological trauma including anxiety and stress. People who suffer from NEAD often lose consciousness as a result of the seizure and a loss of bladder control (Non-Epileptic Attacks, 2018).

Having so many different names for the same condition can be confusing. However, all names describe the same thing—attacks, which mimic epileptic seizures, but are not caused by abnormal electrical activity in the brain (epileptic activity).

It is estimated that between 10,000 and 15,000 people experience NEAD in the UK (Non Epileptic Attack Disorder, 2018). The number of people who experience NEAD in Australia is unknown.

1. *Current Methods of Treatment for NEAD*

Anti-epileptic medication will not work unless the patient also has epilepsy (Non-Epileptic Attacks, 2018). Most often patients will be referred for psychotherapy, usually Cognitive Behavioural Therapy (CBT) (Non-Epileptic Attacks, 2018). If anxiety or depression are present then the patient will be offered medication to help with those conditions. On some occasions, once the patient has a definite diagnosis and also gains an understanding about what is going on, the non-epileptic attacks can occur less often and may stop altogether.

2. *Background*

Emma's parents discovered at her birth that she had a cut on her face, which almost penetrated through the thickness of her lip and part of her right cheek. After investigating the issue, they found out this would most likely to have occurred just prior to Emma being born when her mother was subjected to an amniocentesis procedure to check the maturity of her lungs.

When Emma was born, her Apgar score (Kids Health, 2018) appeared normal. An Apgar score is a test given to newborns soon after birth. This test checks a baby's heart rate, muscle tone, and other signs to see if extra medical care or emergency care is needed. Five minutes after her birth Emma's Apgar score fell from 7 out of 10 to 4 out of 10. Emma was born by caesarean section.

At four months old, her parents noticed that Emma was only using one side of her body to reach for things and her GP referred Emma to a paediatrician. The paediatrician saw Emma when she was six months old. Emma underwent a Magnetic Resonance Imaging (MRI) scan to determine if she had any brain damage. The paediatrician advised Emma's parents that she had had a stroke—most likely on the morning she was born. The damage had caused left side hemiplegia, a paralysis of one side of the body, as the right brain had been affected. It is unclear if the amniocentesis procedure was a contributing factor. At six months, Emma was also diagnosed with cerebral palsy.

At one year of age, Emma had an Encephalogram (EEG) where it was determined that she would have severe epilepsy some time later in life and was immediately placed on anticonvulsant drugs. At that stage Emma was prescribed a low dosage of Epilim (News Medical Life Sciences, 2018), an epileptic preventative treatment. By the time she was four years of age it was noticed that the drug also assisted in calming her down and reduced the mood swings that she had been experiencing.

When Emma was 10 years old, she saw a neurologist who determined that while she did indeed have cerebral palsy, she did not have epilepsy, and would need to see a psychiatric neurologist as she had NEAD. Emma only began experiencing seizures when she was around 16 years old. Over the next five years she experienced between six to eight seizures a week. She was unaware when a seizure struck and only comprehended it after the attack had occurred when it felt like she had suffered severe cramping throughout her body.

The seizures affected Emma's quality of life to the point that everyday functioning became difficult. Emma needed some level of support in her life and had some learning difficulties.

When she was 20, Emma found a partner and subsequently fell pregnant. Her doctor immediately took her off her medication out of concern it could potentially harm the foetus.

The doctors suggested that Emma's seizures would most likely increase as a consequence of her pregnancy, as well as being taken off the drugs. An alternative treatment option was sought and her parents agreed to Emma seeing a hypnotherapist because a nurse suggested hypnotherapy, mentioning how it had helped other patients with an array of issues.

3. *Method*

Emma's first appointment focused on information gathering and exchange, and lasted approximately 30 minutes. Emma's parents were present in the room to discover if hypnotherapy could potentially help her.

After our initial chat, Emma's parents were keen for Emma to proceed. I then conducted a private 10-minute conversation with Emma so I could gauge if and how she could be treated using hypnosis. During this time, I utilised a gentle waking hypnosis technique (Yapko, 2012, p.41) with her. Emma found it difficult in this initial session to chat or make herself clearly understood, generally giving only short answers or shrugging her shoulders. This was likely to her being alone with someone she did not know. However, I assessed that it was possible to treat her with hypnosis as she has a very creative side to her.

In the first session Emma's parents also mentioned that she had been bullied at school and as a consequence had suffered throughout most of her life from anxiety, stress, low confidence and low self-esteem. This became the focus of the hypnosis treatment with the aim of reducing Emma's levels of anxiety and stress and at the same time to help her improve her sense of self-worth.

4. *Treatment and Results*

Emma's parents suggested keeping language to short simple sentences. I utilised these in order to induce a trance-like state in a way that would suit her based around discussions with Emma and her parents, as well as the types of things Emma liked such as art and music. She appeared very receptive to hypnosis and went into trance quite easily after a slightly longer induction. I constructed and used simple childlike fairy-tale type metaphor approaches. During each trance session, Emma remained still with the occasional Rapid Eye Movement (REM).

Emma has difficulty with communication and was not very forthcoming with information in a waking state. When answering questions, she tended to shrug her shoulders, occasionally smile and was not very expressive. I gleaned sufficient information from her to discover more about her creativity—she painted and liked to sing. Her parents offered further guidance so I could develop appropriate treatment strategies. I used this information to customise a style of hypnosis and types of suggestions specifically for her in order to narrow the focus of each session and improve her situation, reduce anxiety and increase her confidence as each session progressed. A priority for the first session was in the application of amnesia (Yapko, 2012, p.220) to assist Emma in letting go of past trauma. Amnesia was also utilised in the second and third sessions to further reduce past trauma.

Emma was unaware of what had taken place throughout each trance session. However, some of the positive changes she experienced related directly to the suggestions given while she was in hypnosis. Furthermore, the outcomes sought during hypnosis were observed by her parents after the sessions. This was mostly prevalent in what Emma said during full waking consciousness on a day-to-day basis in between sessions, which were out of character for her. While she was under hypnosis during the second session, Emma had a seizure which was treated as an abreaction (Yapko, 2012, p.362). Emma was aware after the trance session that she had had a seizure due to residual tension in her body. However, after further discussion with Emma's parents, it appeared that utilising Yapko's abreaction approach had reduced the usual length of the seizure from eight to ten minutes to approximately three minutes.

Throughout treatment, conversation with Emma was limited. Most of the feedback and input came from her parents. Occasionally, I received feedback from Emma in the form of an expression on her face such as a smile which suggested she was pleased with herself.

Interaction with Emma did improve as the hypnosis sessions progressed and she felt more comfortable with the therapy and more aware of positive developments, resulting from the treatment. During subsequent visits, Emma's confidence levels

had increased and she said things to her parents that indicated she was feeling bolder than she had previously been. Additionally, Emma noticed a reduction in her anxiety levels. Her parents remarked on that as well.

Prior to therapy Emma had problems sleeping, experiencing poor quality sleep for short periods, waking up frequently and wandering around the house and disturbing the rest of the family. As her treatment progressed her quality of sleep improved after the sessions to the extent that she went to bed of her own accord between 8.00pm and 9:30pm and went straight to sleep. Emma still continued to experience some broken sleep patterns, however, she found it possible to return to sleep in contrast to her situation prior to hypnotherapy.

As her treatment progressed, it was noted that when Emma attended her Mai-Wel (The Mai-Wel Group, 2018) – a Creative Arts Program, which provides an avenue for self-awareness and creative expression through participation and skills development in singing, dancing, drama, performance, arts and craft – that the art teacher commented repeatedly over a number of weeks that Emma appeared to be more focussed and relaxed when painting. Emma's parents also noted considerable improvement in this behaviour.

Emma's parents also saw enormous improvements in her self-esteem, confidence, and an increase in her ability to cope with the seizures, as well as a significant reduction in her anxiety levels.

Emma's seizures reduced to one a week after the first session, but returned again to four to six times a week, albeit with a reduced level of intensity, after the second session. From the third to sixth session, Emma experienced occasional seizures, followed by a period of five weeks with no seizures at all. After the sixth session, the seizures returned, increasing in number and severity than before. During this time, she would fall and so needed to be more closely supervised.

The hypnotherapy treatment stopped after Session 6 in order to focus on keeping Emma safe and so she could be closely monitored by medical staff. After frequent visits to the hospital over a two-week period, the doctors suggested the huge hormonal changes in Emma's body due to her pregnancy, as well as her withdrawal from the medication she has been on for so long, were the likely causes of the increase in seizures.

Because Emma's parents had reported witnessing a continued improvement in her confidence and a reduction in her anxiety levels during the hypnotherapy sessions, they were keen to use hypnotherapy for Emma through childbirth as well. However, Emma had an emergency caesarean section before this could eventuate and she gave birth early in 2018.

In the three months after the birth of her baby, Emma had three further hypnotherapy sessions, resulting in no seizures during that time and only minor twitching around her eyes.

Conclusion

Treating NEAD using hypnosis was a challenge in that it required a very flexible approach and innovative ways to deliver the right treatment options using simple, yet creative sentences and metaphors, crafted specifically for this client. Secondly, it was important to find different ways to measure the effectiveness of the treatment, especially as Emma was not very communicative. This was made easier in this particular case with such loving and supportive parents who wanted the best for their daughter. Their guidance and my own observations made the task easier.

As mentioned previously, between March and May 2018 Emma had three further hypnotherapy sessions and has had no seizures in that time, except for minor twitching around the eyes, and appears to be an overall more confident and more relaxed young woman.

During and since that time, Emma's parents have reported the following positive changes in Emma: a significant reduction in her overall anxiety levels, an improvement in her ability to cope with everyday stress, better confidence, improved sleep, and an almost elimination of the seizures three months after the birth of the baby, which they have attributed to the hypnotherapy sessions.

I look forward to seeing Emma return in the near future for more hypnosis in order to keep her anxiety and stress levels down, as well as to continue building her confidence and self-esteem now that she has a baby to look after.

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About the Contributors

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Sonia is a clinical hypnotherapist and qualified pharmacist with 40-years' experience in the health care industry. Sonia has an Honours Degree in Pharmacy from the University of Manchester, UK, as well as an Undergraduate Bachelor of Hypnosis (B Hyp) and a Diploma of Advanced Hypnosis (Dip Adv Hyp) from The Australian Academy of Hypnosis (AAH). She also has an Advanced Practitioner's Certificate in Clinical Hypnotherapy (APCCH) from the AAH, with units accredited by the Royal Australian College of General Practitioners (RACGP).

Sonia's last engagement with pharmacy was as a pharmacology lecturer at the Australian College of Natural Medicine (ACNM). Having founded the Hypnosis and Health Practice in 2004, Sonia's practice focuses on education for self-awareness, with hypnotherapy as a key tool to engender this and healing in her clients, along with meditation and mindfulness.

Of the many training courses that Sonia has participated in, and facilitated, the ones she considers pivotal in moving her onto the hypnotherapy path have been: weekly workshops with Dr. Francesca Rossetti (author of *Psycho-Regression*), Gestalt Group Workshops with Clinical Hypnotherapist and Psychologist Rick Cunnington (London, Tuscany, Cape Town and Johannesburg), lectures and workshops on Whole-Self Pre-birth Psychology with Dr. Ellis Snitcher (Endocrinologist and Principal Lecturer for the complementary medicine degree course at the University of Middlesex, London), and seminars and workshops with medical intuitive Paul Anthony Jenkins (throughout UK, Sydney).

Sonia has held various positions on the Australian Hypnotherapists Association (AHA) committee over several years, having also presented several workshops to members. Sonia's next significant presentation will be to GPs at the National RACGP Annual Conference in October 2018 (GP18) on 'Mindfulness and Hypnosis for Anxiety Disorders'.

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Richard Hill, MA, MEd, MBMSc, is a practicing psychotherapist/counsellor, author, educator, and professional supervisor. He is acknowledged internationally as an expert in human dynamics, communications, the brain. and the mind. He is a regular speaker on the topics of neuroscience and psychosocial genomics, has developed special training courses for suicide prevention and is the originator of the Curiosity Oriented Approach. His work with Ernest Rossi, PhD, has led to the publication of *The Practitioner's Guide to Mirroring Hands*, which is not only about a particular technique, first developed by Rossi, but also a complete approach to therapeutic practice. They describe this as Client-Responsive Therapy which includes Richard's Curiosity Approach. He is President of the Global Association of Interpersonal Neurobiology Studies (GAINS), a select member of the International Psychosocial Genomics Research Group, director of the Mindscience Institute and, Managing Editor of *The Neuropsychotherapist*. He holds Masters degrees in Arts; Education; and Mind and Brain Sciences. His other books include, *Choose Hope* and *How the 'real world' Is Driving Us Crazy!* as well as numerous articles, journal papers and book chapters, including *Perspectives on Coping and Resilience* and *Strengths Based Social Work Practice in Mental Health*, published worldwide.

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Jerry has had an extensive career in the UK military (Royal Navy) and Australian Defence Force (ADF). Jerry has travelled throughout his life and estimates that he has visited over 100 countries and has lived in eight—Germany, USA, Yemen, Norway, England, Wales, Scotland and now Australia.

Jerry saw combat in five conflicts—the Falklands War, Kosovo, Macedonia, Sierra Leone and Iraq.

Jerry was invited to join the Royal Australian Navy (RAN), arriving in Australia in 2009. As part of his role he served in Southern Lebanon, Israel and the Sinai desert in Egypt.

Jerry then fulfilled a long-term ambition and trained as a hypnotherapist in 2013 at the Australian College of Hypnotherapy (ACH) in Sydney. He has a key focus on Post Traumatic Stress Disorder (PTSD), anxiety, depression, stress, phobias, sport and works with a wide range of patients such as military personnel, domestic violence survivors, rape victims, and children, and on presenting problems such as bullying, body image, confidence, and self-esteem issues.

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Nick Ramondo is a clinical psychologist in private practice. Graduating in 1981, he has worked as a clinician for 36 years consulting with children, adults, couples, families and organisations. Nick is a relatively late comer to the field of hypnosis, undertaking training in 2014. However, he was so impressed by the therapeutic potential of hypnosis that he enrolled in a PhD program at the University of WA where he is researching the adjunctive benefits of hypnosis with cognitive behaviour therapy.

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The Australian Journal of Clinical Hypnotherapy & Hypnosis (AJCHH) is published twice each year in the Australian Spring and Autumn. Its focus is on the professional application of hypnosis and hypnotherapy, covering aspects of original clinical research, theoretical, historical and related reports, and book reviews.

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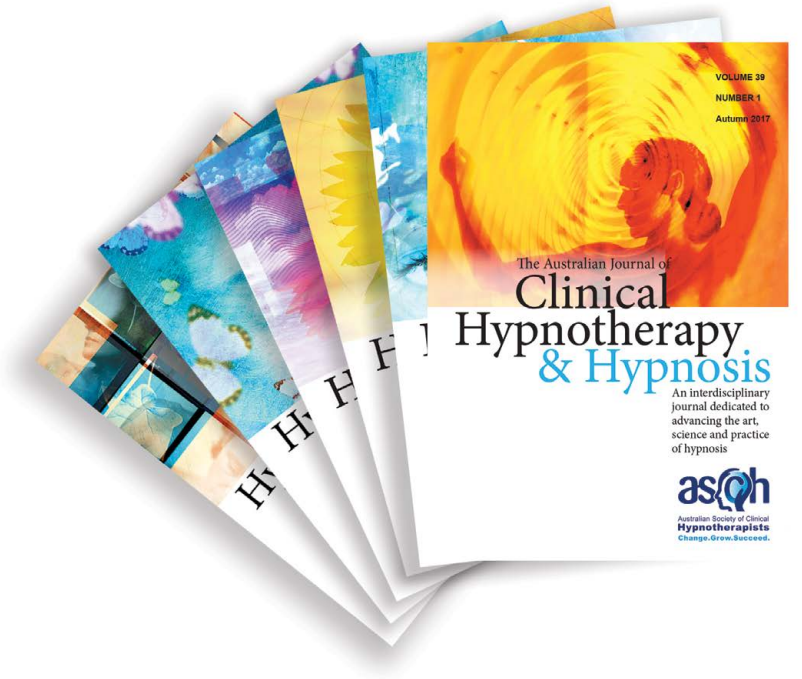

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