HANDBOOK OF MEDICAL AND PSYCHOLOGICAL HYPNOSIS
Gary R. Elkins, PhD, ABPP, ABPH, is the author of Relief From Hot Flashes: The Natural, Drug-Free Program to Reduce Hot Flashes, Improve Sleep, and Ease Stress, and the groundbreaking publication Hypnotic Relaxation Therapy: Principles and Applications, a training manual in hypnosis for health care providers. He is the associate editor of the International Journal of Clinical and Experimental Hypnosis and BCM Complementary and Alternative Medicine, and consulting editor of Psychology of Consciousness: Theory, Research, and Practice. Dr. Elkins is a professor of psychology and neuroscience at Baylor University, where he is the director of the Mind–Body Medicine Research Laboratory. Dr. Elkins is also a clinical professor at the Texas A&M University Health Science Center. He maintains a private practice in clinical psychology with specialization in clinical health psychology, behavioral medicine, and hypnotherapy. Dr. Elkins has board certification from the American Board of Professional Psychology (ABPP) and the American Board of Psychological Hypnosis (ABPH). He is a past president of the American Society of Clinical Hypnosis, Society of Psychological Hypnosis, and the American Board of Psychological Hypnosis. He is the 2014–2017 president of the Society for Clinical and Experimental Hypnosis. With over 40 years of experience in hypnosis and 100 publications, he conducts an ongoing program of research into the use of hypnotherapy and mind–body interventions. He is a nationally and internationally recognized speaker on hypnosis and topics such as complementary and alternative medicine, psychotherapy, pain management, sleep problems, hot flashes, and mind–body interventions in health care.
HANDBOOK OF MEDICAL AND PSYCHOLOGICAL HYPNOSIS
Foundations, Applications, and Professional Issues

Gary R. Elkins, PhD, ABPP, ABPH
In loving memory of my father and mother, Billy Ray Elkins and Jewel Dean Elkins, who gave me everything I needed; I wish I had listened to them more.

In memory of my father-in-law, Zeverino Gutierrez, who taught me to always consult the right book—sometimes the Bible and sometimes Popular Mechanics.

To my wife, Guillerma Gamez Elkins, who is the guiding light of faith and love for our family.
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Foreword

Hypnotherapy is the use of clinical hypnosis to treat medical and psychological disorders and enhance health and well-being. The broad applications of hypnosis in medicine and psychotherapy require clinicians to have a vast amount of knowledge and training in the requisite methods and skills. This *Handbook of Medical and Psychological Hypnosis: Foundations, Applications, and Professional Issues* provides the depth of knowledge needed by a provider of hypnotherapy. It is a book for practitioners—psychologists, physicians, psychotherapists, clinical social workers, marriage and family therapists, mental health counselors, nurses, dentists, chiropractors, and acupuncturists. As competency in hypnotherapy requires lifelong learning, this book fills this role by providing the foundational knowledge needed by the beginner and the depth of clinical wisdom and skills used by experienced clinicians.

*Handbook of Medical and Psychological Hypnosis: Foundations, Applications, and Professional Issues* is destined to become the essential companion to courses and workshops on clinical hypnosis. It begins with thorough coverage of the material typically found in introductory workshops on clinical hypnosis and then moves to more advanced topics such as the theories, approaches, empirical research, and the many hypnotic therapeutic interventions. The reader will learn about both the empirical basis of hypnosis and the practical “how-to” techniques that are necessary to conduct hypnotic inductions, intervene with hypnotic suggestions, and pursue the highest levels of professional practice. The superior quality of this book is not surprising given that Dr. Elkins is internationally known and has served as president of the American Society of Clinical Hypnosis, the Society for Clinical and Experimental Hypnosis, and the Society for Psychological Hypnosis, where he has organized multiple workshops and written on the most widely accepted standards of training in clinical hypnosis.

Every clinician who utilizes hypnosis in his or her practice and every student who is learning hypnosis will want to have this comprehensive desk reference on the bookshelf. The book provides the reader with the major approaches to hypnotherapy—hypnotic relaxation, cognitive, Ericksonian, hypnoanalysis, and ego-state therapy—with each topic written by the leaders in the field. In addition, this book gives physicians, dentists, and therapists a resource to expand and improve their practice with all the major applications of hypnosis in health care. With 75 chapters and contributions from an equally large number of the world’s most expert researchers and hypnotherapists in the field, it represents the largest, most comprehensive, and up-to-date textbook on clinical hypnosis yet to be assembled. This comprehensive reference is an invaluable book for anyone engaged in providing hypnotherapy to his or her patients and clients.

The chapters on medical applications address over 30 topics and problems in which hypnotherapy may be integrated into effective practice. There are chapters on asthma, bone fractures, chronic pain, dental applications, enuresis, fibromyalgia, headaches, hypertension, irritable bowel syndrome, obstetrical care, menopausal symptoms (hot flashes), nail biting, nausea associated with chemotherapy, acute pain management, procedural pain, palliative care, Parkinson’s disease, pediatrics, pre-surgery anesthesia, Raynaud’s syndrome, rehabilitation, skin disorders, warts, spasmodic torticollis, surgery, vocal cord dysfunction, stress, and autoimmune disorders.

Behavioral health professionals, including psychotherapists, psychiatrists, and psychologists, now have a reference for the multiple applications of hypnosis.
hypnosis in psychotherapy and health psychology. Chapters on psychological applications include: addictions and relapse prevention, affect regulation, anger management, anxiety in children and adults, bereavement, conversion disorder, depression, eating disorders, ego strengthening, fear of flying, marital communication, obesity and weight loss, posttraumatic stress disorder, sexual self-image, sleep, smoking cessation, sports performance, and stress management. There are also chapters on forensic interviewing with hypnosis, flow and peak experiences, and mindfulness and hypnosis.

In addition to its wealth of hypnotic information, this book is a tremendous resource for self-study and practice. Each of the chapters on the applications of hypnosis includes a discussion of the empirical clinical trials and the contemporary knowledge about hypnosis, case studies, and transcripts or techniques. The chapters on applications are written to give the reader examples of hypnotic transcripts—what clinicians actually say during hypnotic inductions and hypnotherapy sessions. This provides the reader with the highly useful resource of hypnotic verbalizations and ideas for formulating hypnotic suggestions for treatment of specific problems. The transcripts are provided as examples—not to be applied in cookbook fashion, but as foundations for individualized hypnotic interventions for each patient.

Professional issues are also addressed in this book and include in-depth discussions on certification in clinical hypnosis and ethical considerations. Also incorporated is an extremely useful chapter on the precautions of hypnosis in patient care. It is noteworthy that this one-of-a-kind book clearly integrates relevant research throughout and provides a resource of information on contemporary research in medical and psychological hypnosis.

This book is a perfect companion to clinical workshops and courses in hypnosis. I can speak to this personally, as in my case, after having completed the training in introductory and intermediate clinical hypnosis, I became interested in the use of hypnosis to boost the immune system; increase wound healing; decrease anxiety, stress, or tension; and address specific problems including high blood pressure, insomnia, headaches, and low back pain, as well as help my clients with smoking cessation. However, I quickly became aware of the need for an authoritative text where I could find relevant research and practical guidance on how to best treat these problems. Handbook of Medical and Psychological Hypnosis fills this need and precisely provides this resource.

The credentials of and respect for Dr. Elkins make this book an authoritative contribution to our field. Dr. Elkins is a professor of Psychology and Neuroscience who has become one of the leaders in the field of clinical hypnosis. He is a brilliant scholar and a master clinician who has served as president of several hypnosis organizations, led hundreds of hypnosis workshops, and taught thousands of professionals about clinical hypnosis. Dr. Elkins has made contributions to almost every area of hypnosis—ranging from defining hypnosis, to developing a scale to measure hypnotizability (the Elkins Hypnotizability Scale), to teaching and conducting clinical research into innovative applications of hypnosis such as in the relief of hot flashes and optimization of hypnosis to improve sleep and ease stress. His Mind-Body Medicine Research Laboratory at Baylor University is focused specifically on hypnosis research and has been continually funded by the National Institutes of Health. His clinical knowledge, scientific expertise, and exceptional breadth of knowledge are reflected in this book that is destined to be a classic in the field.

In this book, Dr. Elkins has brought together the finest clinicians and academicians from around the world to contribute their respective expertise and clinical skills. This was a very large undertaking that required many hours of writing, dedication, and a great commitment on the part of Dr. Elkins, as well as the many chapter contributors. We can be grateful for this massive work. The result is that we now have a magnificent resource for the practice of hypnotherapy.

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Preface

Hypnosis has a wide range of uses in the treatment of medical and psychological conditions. Further, there is an increasing body of research that supports hypnotic interventions in psychotherapy and health care. In the United States, the National Institutes of Health has supported numerous clinical trials of psychological interventions that utilize relaxation, suggestion, imagery, and various forms of self-hypnosis. Considerable evidence now exists to show that mind-body interventions, including hypnosis, can be of great benefit in the treatment of disorders ranging from chronic pain, anxiety, and stress to coping with medical procedures, irritable bowel syndrome, menopausal symptoms such as hot flashes, and sleep problems, just to name a few. Given the mounting evidence for hypnosis, health care professionals are increasingly challenged to take a more integrative approach and learn about hypnosis as a primary therapy or as an adjunct to other psychotherapy approaches. This book provides a comprehensive resource for students and professionals in the helping professions to learn about hypnosis and its many applications.

Hypnosis is generally understood as a state of consciousness involving focused attention and reduced peripheral awareness in which there is an enhanced capacity for response to suggestion (Elkins, Barabasz, Council, & Spiegel, 2015). In clinical practice, hypnosis generally involves an induction procedure with suggestions for focusing attention, followed by suggestions for relaxation and a hypnotic state. The hypnotic state is sometimes referred to as a trance state and is characterized by attentive concentration and reduction in judgmental critical thinking. As a result, during a hypnotic state, a person may be more receptive to positive suggestions. While a formal hypnotic induction is often used in hypnotherapy, a hypnotic state may occur naturally, such as becoming absorbed in reading, daydreaming, or becoming engrossed in a fascinating movie. In some ways, a hypnotic state may be compared with meditation or other relaxation-based methods that involve an inward focusing of attention and calmness (Stewart, 2005). Both meditation and hypnosis may be self-guided (self-hypnosis) and a state of meditation may be understood as hypnosis, depending on the state achieved. However, hypnotherapy differs from meditation in that hypnotic suggestions may vary a great deal and are intentionally goal-directed. Hypnotic suggestions may involve mental imagery, direct suggestion, or indirect suggestions using stories or metaphors. Much of the skill in using hypnosis depends upon the ability to achieve a hypnotic state and individualize hypnotic suggestions to achieve a desired effect.

The first section of this book—Foundations of Medical and Psychological Hypnosis—includes much of the information that might be covered in a basic level workshop on hypnosis. While hypnotic methods of inducing a state of consciousness and therapeutic suggestions have been used for centuries, the early history of hypnosis begins with the Austrian physician Franz Anton Mesmer, who developed a thriving practice in Vienna and later in Paris in the late 1700s. The term hypnosis was introduced by a Scottish physician, James Braid, during the early 1800s, in which it was recognized that the hypnotic state is different from sleep but involves concentrated attention and absorption. The rise of scientific research into hypnosis began following World War II, during which time there was a need for effective psychological interventions for pain management and treatment of posttraumatic stress. Ernest Hilgard and his research team at Stanford University conducted numerous studies and developed scales for measurement of hypnotizability. Many of the currently used clinical methods of hypnotic suggestion were introduced by
Milton Erickson, MD (1901–1980). Milton Erickson was a psychiatrist and leading practitioner of hypnotherapy who developed many innovative methods of hypnotic induction and intervention. During the late 1940s and early 1950s, the present day hypnosis societies were established, including the Society for Clinical and Experimental Hypnosis, followed by the American Society of Hypnosis, the European Society of Hypnosis, and the International Society of Hypnosis.

Also covered in the Foundations section are the theories of hypnosis, hypnotizability, neurophysiology, and clinical methods for presenting hypnosis to patients and formulating hypnotic suggestions. While the mechanisms of hypnosis are not yet fully known, the reader should carefully read this section to develop a fuller understanding of hypnosis and hypnotic inductions.

The Foundations section of the book also introduces the major approaches. Hypnosis may be integrated with cognitive behavioral or psychodynamic therapy. In addition, there are several systems that are more specific to hypnotherapy. These include approaches such as Ericksonian therapy (based on the methods of Milton Erickson, MD) and ego-state therapy (based upon the methods of Jack Watkins, PhD). This also includes the theory and principles of hypnotic relaxation therapy, as developed in my clinical practice and the Mind-Body Medicine Research Laboratory at Baylor University. Each of these systems includes some conceptualization of hypnotic inductions and consideration of unconscious processes in the therapeutic process. The reader will find this section to be very useful, as it provides an understanding of the rich and complex nature of hypnotic interventions to change cognitions, facilitate insight, relieve symptoms, change behavior, and develop coping skills.

The second section of the book is the largest, as it covers the Medical Applications. This section provides a ready reference for clinicians to help deal with most problems for which evidence exists on the use of hypnosis in clinical practice. Many chapters in the Medical Applications section are organized with the following components:

- Introduction (description of the problem, prevalence, symptoms, etc.)
- Evidence (relevant research)
- Case example
- Technique or transcript
- Summary or clinical tips, and so on.

Medical Applications are presented in alphabetical order and include 34 chapters covering both adult and child applications. Each chapter provides a review of existing empirical evidence as well as clinical technique. Transcripts are provided as an example of hypnotic intervention; however, it is generally understood that hypnosis is individualized based upon the needs of each patient.

The Psychological Applications section comprises 22 chapters on a range of topics from addictions and relapse prevention to treatment of anxieties and stress management. Most of the chapters in this section include case examples of hypnosis in therapy, transcripts, as well as guidance on how hypnosis can be most effectively used in clinical practice.

The last section of the book covers Professional Issues in the practice of hypnosis. This section is intended for clinical practitioners as well as researchers. Topics include ethical practice, placebo effects, and information on certification and specialty boards in medical and psychological hypnosis (i.e., the American Board of Psychological Hypnosis, American Board of Medical Hypnosis, American Board of Dental Hypnosis, American Hypnosis Board for Clinical Social Work, and American Board of Hypnosis in Nursing). Precautions regarding the use of hypnosis are also presented. Hypnosis can be a very powerful and effective tool when used by a skilled clinician. However, like a scalpel, its effectiveness depends largely upon the expertise of the practitioner. It is important for the skilled clinician to know both when to use hypnosis and when to not use hypnosis.

Finally, research methods in medical and psychological hypnosis are presented. Research into clinical hypnosis and empirical evidence continues to expand. This includes well-designed randomized clinical trials as well as research into the psychological and physiological mechanisms that may be involved in hypnotic responding. Critical evaluation of evidence is important to know how to best use the evolving body of knowledge about hypnosis. Also, researchers must develop sophisticated methods to study hypnosis and related mind–body therapies to determine the effective components and further applications.
HOW TO USE THIS BOOK

This book was written for several purposes. It was written to fill the gap between hypnosis clinical practice and research; provide foundational knowledge about hypnosis theory and practice; and serve as a desk reference on a range of medical and psychological applications as well as professional issues. It is a comprehensive text and may be used in graduate study in training programs for physicians, psychologists, psychotherapists, and other health care providers.

The clinician should use this book to identify the theory and clinical techniques useful in presenting hypnosis, structuring hypnotic inductions, and formulating hypnotic suggestions. Practitioners will find a wealth of information on the theories and techniques of hypnotic interventions, which may be integrated with other therapeutic approaches or, in some cases, used alone.

Learning hypnotherapy is a process that requires practice as well as reading. This book can be used to gain the essential knowledge about hypnosis for development of clinical skills. It is important to refine skills through practice and mentorship. This book may be used in conjunction with workshops, training programs, course work, and clinical supervision. Readers are encouraged to seek out appropriate training with skilled teachers such as may be found in professional organizations. Clinical skill is built through practice and the process of supervision and counsel. The same is true in regard to clinical skill in hypnosis. The use of hypnosis should be consistent with both the needs of the patient and the professional’s area of expertise. It is always the case that one should restrict one’s use of hypnosis to areas in which the individual has expertise and appropriate certification.

As a desk reference, this book can be used as a resource by clinicians who may be treating patients with a variety of presenting problems. It is not uncommon that hypnosis is sometimes considered for especially complex cases. This book provides a reference for most uses of hypnosis such as pain management, psychophysiological symptoms, smoking cessation, weight loss, and stress, as well as rare or challenging problems such as conversion disorder and spasmodic torticollis. Also, innovative uses of hypnosis are identified such as for facilitating marital communication, forensic interviewing, mindfulness, and improvement of slow-wave sleep.

Becoming an expert in clinical and experimental hypnosis requires lifelong learning. This book is designed to be a key resource to facilitate that process.

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REFERENCES


Acknowledgments

The vision for this book has been with me for many years, as I have served as the president of several organizations (American Society of Clinical Hypnosis, Society of Psychological Hypnosis, and Society for Clinical and Experimental Hypnosis) and conducted workshops and research in clinical hypnosis for most of my professional career. I began to envision a work that would be comprehensive, draw upon the most highly recognized experts in hypnosis, integrate research and clinical practice, and provide a much-needed contemporary handbook on medical and psychological hypnosis. I knew that such a book would be a large undertaking and would depend on the contributions of many. It seemed like an overwhelming task. It was through my consultation with Stephanie Drew at Springer Publishing Company that this vision began to become a reality. I want to first thank Ms. Stephanie Drew and Ms. Mindy Chen for their support and guidance throughout this process. I could not imagine a more favorable place to publish than Springer Publishing Company.

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Asthma

Ran D. Anbar

Asthma is considered to be a chronic inflammatory disease of the airways that affects more than 25 million people, including more than 7 million children, in the United States (NHIS, 2011). The airway inflammation predisposes the airways to become hyperreactive, constrict, and develop swelling in reaction to various stimuli. This leads to episodic limitations of air flow and difficulty with breathing that are at least partially reversible (Cohn, Elias, & Chupp, 2004). Patients with allergies are more prone to developing asthma (Huss et al., 2001). Viral infections are among the most common triggers of asthma flare-ups and may even predispose people to the development of asthma (Sigurs, Bjarnason, Sigurbergsson, & Kjellman, 2000). The morbidity of asthma includes missed school days and workdays, in order to undergo evaluation and therapy, and decreased quality of life, as patients may have poor exercise tolerance, poor sleep quality, and the need to avoid certain environments. There is also an increased risk of mortality (Adams et al., 2006; Graham, Blaiss, Bayliss, Espindle, & Ware, 2000; Hallstrand, Curtis, Aitken, & Sullivan, 2003).

Asthma is treated with a combination of anti-inflammatory (“controller”) and bronchodilator (“rescue”) medications that typically are inhaled (O’Byrne & Parameswaran, 2006). It is well recognized that the management of asthma can be complicated by several medical factors such as allergies (Halonen, Stern, Wright, Taussig, & Martinez, 1997), gastroesophageal reflux (Avidan, Sonnenberg, Schnell, & Sontag, 2001; Kiljander, Salomaa, Hietanen, & Terho, 1999), and chronic sinusitis (Guerra, Sherrill, Martinez, & Barbee, 2002). Patients with asthma and their health care providers also are well aware that environmental exposures such as cigarette smoke, air pollution, or other small particulate airborne matter that are irritating to the lungs when they are inhaled can trigger asthma (Malo, Lemière, Gauvin, & Labrecque, 2004; Strachan & Cook, 1998). However, many providers do not address the possibility that asthma can be triggered by emotional factors such as anxiety, depression, anger, and even excitement about a happy event (Busse et al., 1995; Sandberg et al., 2000). The lack of attention paid to the emotional issues that affect patients with asthma may be related to lack of knowledge regarding how to recognize symptoms suggestive of emotional factors at play, or clinicians’ inability to provide patients with appropriate care for their mental health needs (Anbar & Hall, 2012). Ironically, a large proportion of patients who are referred to asthma care specialists because their respiratory symptoms are inadequately controlled with medical therapy suffer from symptoms that are triggered by stress (Anbar & Geisler, 2005; Seear, Wensley, & West, 2005).

Thus, the hallmark symptoms of asthma, including cough, wheeze, and shortness of breath, can all be triggered by psychological stressors. Furthermore, when a patient or even another health care provider reports “wheezing” as a symptom, it is essential to verify that this represents classical wheezing. Classical wheezing can be defined as a high-pitched whistling sound localized to the lower airways that occurs primarily with exhalation (Weinberger & Abu-Hasan, 2007). In contrast, a lower pitched inspiratory sound localized to the upper airway or throat, often mistaken for “wheezing,” actually is characteristic of an upper airway obstruction, which, in a patient with asthma, is most commonly caused by vocal cord dysfunction (VCD). Interestingly, VCD typically is triggered by psychological factors. Sometimes, patients or parents even apply “wheezing” as a descriptor of a noise emanating from the nose, which is not reflective of any lung problem. In this setting, anxiety about the nasal “wheezing” can contribute to the perception that the patient’s asthma is inadequately controlled.
Such anxiety may cause or exacerbate the patient’s asthma symptoms (Baron & Marcotte, 1994; ten Thoren & Petermann, 2000). Finally, it should be kept in mind that a significant number of patients who do not respond to asthma therapy have been misdiagnosed with asthma (Weinberger & Abu-Hasan, 2007). The most common diagnoses in this setting include

1. Anxiety that has led to the development of shortness of breath
2. VCD independent of asthma that causes difficulty in association with inhalation, inspiratory stridor that may be incorrectly termed as “wheezing,” and even occasional coughing
3. Habit cough that presents as a loud, harsh, and disruptive cough that typically resolves once patients are asleep

It is notable that all three of the aforementioned diagnoses are amenable to treatment with hypnosis.

**RESEARCH**

In multiple case reports, hypnosis has been reported to have beneficial effects on the subjective aspects of asthma, which include symptom frequency and severity, coping with asthma-specific fears, managing acute attacks, and frequency of medication use and health visits (Brown, 2007). Hypnosis may also be efficacious for decreasing airway obstruction and stabilizing airway hyper-responsiveness in some individuals (Aronoff, Aronoff, & Peck, 1975; Ben-Zvi, Spohn, Young, & Kattan, 1982; Fernandez, 1993). Some case reports have suggested that the use of hypnosis can be associated with dramatic improvements in asthma symptoms (Anbar, 2003; Anbar & Sachdeva, 2011). Notably, as these observations were made in an uncontrolled context, it cannot be concluded that hypnosis was a key intervention but rather that randomized studies of hypnosis in the treatment of asthma are indicated.

Only a few such studies of hypnosis in patients with asthma have been reported over the past five decades. A randomized study of 25 children with asthma showed no significant effect of four weekly hypnosis sessions on the patients’ forced expiratory volume in one second (FEV₁) or daily symptom scores (Smith & Burns, 1960). In a study of 62 asthma patients who were randomized to receive three different hypnosis protocols or a control intervention at three different sites, patients who were taught to use hypnosis reported less wheezing and bronchodilator use, but no significant changes in pulmonary function were documented (Maher-Loughnan, Mason, Macdonald, & Fry, 1962). However, in a multicenter yearlong trial, 252 children and adults with moderate and severe asthma were randomized to receive monthly hypnosis sessions and daily self-hypnosis or to a control group in which patients used daily relaxation and were taught breathing exercises. Hypnosis was associated with an increase in FEV₁ of 4.3% ($p < 0.05$). There was no significant difference between the groups in their incidence of wheezing or medication use (British Tuberculosis Association, 1968).

In another randomized controlled study of 39 adults with mild-to-moderate asthma, patients who were highly skilled in hypnosis (high hypnotizable) demonstrated a significant reduction in reactivity to methacholine challenge testing ($PC_{20} 9.1$ vs. 15.9, $p < 0.01$) and decreased chronic bronchodilator use (26% reduction, $p < 0.05$), as well as decreased subjective scores for nocturnal symptoms (62%, $p < 0.05$), wheeze (53%, $p < 0.01$), and activity limitation (40%, $p < 0.01$). In contrast, patients who did not use hypnosis well (low hypnotizable) or were in the control group demonstrated no significant changes in these parameters (Ewer & Stewart, 1986).

In the only pediatric controlled trial that has been reported to date, 28 patients were divided into four groups (hypnosis, suggestion only, attention only, and a nonintervention control group). At 1-month, 6-month, and 2-year follow-ups, no significant differences emerged between groups on physiological measures of pulmonary function. Children taught to use self-hypnotic techniques had a significantly larger reduction in wheezing as compared with the control group (52% vs. 35%, $p < 0.05$). Also, these children reported fewer emergency room visits and fewer missed school days relative to the control and suggestion groups but not compared to the attention group (Kohen, 1995). These results should be interpreted with caution due to the small sample size.

As is described in the remainder of this chapter, there are many ways in which hypnosis might be applied in the treatment of asthma (Anbar, 2014). Thus, some of the variability in outcome of the
described studies and reports regarding the use of hypnosis for asthma likely is related in part to the different hypnotic approaches that were offered. Furthermore, when used clinically, hypnosis is most effective when suggestions are made based on the interests, motivation, and abilities of individual patients (Anbar, 2007). Thus, experimental studies that employ uniform protocols for the management of asthma with hypnosis likely underestimate the effectiveness of clinical hypnosis. Given the small number of studies of hypnosis for asthma, more randomized, controlled studies of hypnosis and asthma would be helpful. Such studies would benefit from the use of larger patient populations and flexible hypnosis protocols that allow for individualizing the hypnosis experience. As is true for all medical illnesses for which hypnosis is offered, it is essential that the patient’s illness be managed medically with concurrent application of hypnosis therapy (Anbar & Hall, 2012).

CASE EXAMPLE

A 13-year-old patient reported that his asthma often was triggered when he became angry or sad. For example, he sometimes had to leave the room to use his rescue inhaler during the middle of altercations with his 17-year-old brother who picked on him. He explained that frequently he had been experiencing cough and shortness of breath on mornings when he had an important test at school. Sometimes, he said that he awakened at night as a result of a nightmare and felt as if he could not breathe. In those instances, he would awaken his mother and ask to use his rescue inhaler.

The patient was offered an opportunity to learn how to use hypnosis to become calmer, so that he would have better control of his body’s reactions during stressful situations. The patient was eager to learn such a technique and was provided instructions similar to those presented in the following text (Anbar, Sugarman, & Wester, 2013). The phrasing was delivered in a soft voice with many pauses that allowed the clinician to observe the patient’s physical reactions. A month after he learned to calm himself with hypnosis, the patient reported that he used it on a regular basis and felt much calmer overall. He said that he was able to remain calmer and his asthma no longer was triggered during interactions with his brother or in relation to school tests. He reported that he had had no recent nightmares.

TRANSCRIPT: HYPNOSIS FOR ASTHMA SYMPTOMS

“Imagine a favorite, safe place, which you would enjoy visiting. It can be a place you have been to, would like to go to, or even an imaginary place. Let me know when you have this place in mind. . . . Now, imagine what you might see there. What colors might you see? Are there people there? Are there sights there that make you happy? Now, what might you hear there? Is it silent? Are there sounds of nature? Talking? Music? What might you smell? Fragrance? Perfume? Salty air? Fresh air? If you touch something, what would it feel like? Soft? Smooth? Rough? Wet? And if there is something to eat or drink there, imagine what it might taste like. Is it salty? Sour? Sweet? Notice how the more you imagine your different senses the more relaxed you can become, and the more real the experience can become.”

Now I am going to talk to you about relaxing even more. You can start by relaxing your forehead. That’s right. Now, let that comfortable feeling of relaxation pass into the muscles around your eyes. Your eyes can be open or closed, whichever is more comfortable for you. Now, let the relaxation spread to your cheeks. And jaw. Sometimes, it helps to open the mouth a bit in order to allow the jaw to become very relaxed. Now, let the relaxation spread to your neck. Your shoulders. Your arms. And your hands. Very good. Now, take in a deep breath, and let it out slowly. Notice how your chest relaxes as you do that. Now, take in another deep breath, let it out slowly, and notice how your belly relaxes as you do that. Excellent. Now, let the relaxation spread. To your back. Your legs. And your feet. That’s right. Notice how relaxed you have become. How peaceful, and calm, and content, and serene, and tranquil, and in control, and comfortable you can be. Very relaxed, very calm, and very comfortable. Your breathing can be easy and comfortable. That’s right.
II: MEDICAL APPLICATIONS

This can be a great feeling, right? This is a feeling you can achieve anytime you want to just by imagining returning to your relaxing place. Let me know when you are ready to come back in a few moments by raising your hand, or nodding. Very good. Now, before you come back, you might tell yourself four things. First, congratulate yourself for your excellent imagination and ability to relax. Remind yourself to practice your hypnosis skills every day for at least 2 weeks so that you can become very good with its use. Hypnosis is a mind–body skill. The more you practice it, the better you become. Next, remind yourself that whenever you want to relax, you can go back to your favorite place in your imagination. Finally, right now your mind is open to good suggestions. You can tell yourself good things. And the more you tell these to yourself, the more they come true. For example, you might tell yourself, I like how I feel now and I want to feel this way for the rest of the day. I am going to do well on my tests in school. I am going to remain calm and have fun the next time I interact with my friends. [The clinician can suggest specific affirmations based on the patient’s interests and experiences.] And once you are done telling yourself all the good things you need to hear, once the time is right, and you’ll know exactly when that time is; then come back. Formal example (often useful with adults, and applicable especially to patients who are deeply absorbed in the hypnotic experience): Now I am going to count from 1 to 5. The higher I count the more alert you can become. The more you will be able to feel the chair in which you are sitting, and the floor beneath your feet. That’s right. 1 . . . 2 . . . You can sit up straighter . . . 3 . . . More alert . . . 4 . . . Your eyes can start to open . . . 5 . . . You can open your eyes, and look around you.”

Imagery Specific to Symptoms

Patients can be coached to open their constricted airways through realistic or creative imagery. Especially for patients who are going to use realistic images, it can be helpful to show drawings or photographs of constricted airways in contrast to images of airways that are open.

“When your asthma is bothering you, imagine seeing the airways as constricted, and in your mind’s eye open them. Notice how your body follows that imagery and helps you feel better. Imagine your asthma medication entering your lungs and attaching to the muscles that surround your airways. Imagine that the medication massages the muscles until they relax and allow your airways to open. Imagine the air you inhale to be warm, clean, and humid, just like you might encounter in a tropical rain forest. Notice that as you breathe in that wonderful air, your breathing can become more and more comfortable. If a boa constrictor tightened itself around your lungs, how do you think you might convince it to loosen its grip? Perhaps offer it an enticing meal? Scare it with a more fearsome creature? How does it feel once the boa leaves?”

Breathing Techniques

Breathing retraining can help improve asthma symptoms and pulmonary function (Holloway & Ram, 2004) and thus can be helpful when included within a hypnotic intervention.

Breathing primarily with expansion of the diaphragm as opposed to through the use of thoracic muscles helps expand the lungs better and thus enhances the effectiveness of breathing, which can help patients feel more relaxed (Barker, Jones, O’Connell & Everard, 2013). Such breathing can be taught with the following instructions:

“Imagine a sailboat at the bottom of your sternum. Notice how when you inhale, the rowboat can rise, and when you exhale, the sailboat can fall. Good. Focus on that sailboat as you breathe comfortably, and notice how you can feel better and breathe more easily . . . Inhale slowly through your nose for a count of 4, hold your breath for a count of 5, and exhale slowly through your mouth for a count of 7. Repeat this cycle 10 times. Notice
how much more relaxed you become as your breathing control improves.”

Breathing through the nose helps humidify, warm, and clean the inhaled air and thus is less likely to irritate hyperreactive airways. Holding the breath allows for better expansion of the lungs. Exhaling slowly helps resolve anxiety-associated hyperventilation.

Subconscious Exploration

When asthma symptoms result from psychological stressors that are expressed through somatic symptoms, subconscious exploration with the aid of a clinician can sometimes help patients come to a better self-understanding regarding their psychological triggers (Anbar & Linden, 2010). This can help formulate ways of addressing such stressors more effectively.

Before engaging the subconscious through hypnosis, it is helpful to discuss the patient’s understanding of the role of the subconscious (Anbar, 2008). A clinically useful definition of the subconscious is “The part of your mind of which you are often unaware.” A patient also can be told, “When you do things without thinking about them, this is an example of the subconscious in action. The subconscious shows you dreams while you sleep. Sometimes, when you are about to do something wrong, you may hear a small voice in the back of your head that cautions you. Many people call that ‘the conscience,’ but even this can be thought of as emanating from the subconscious.”

The “inner advisor” technique allows the subconscious to interact with the patient through an imagined figure (Hammond, 1990). For example, “Imagine yourself in your comfortable place. Look around for a house or another structure with a door that you may not have noticed before. Once you find it, let me know. That’s right. Now, knock on the door and when it opens, you will meet your inner advisor. Perhaps it will be a person, animal, or thing. Once you meet your advisor, ask if it would be all right to ask him or her some questions.”

Once the inner advisor is identified, a discussion can ensue with the advisor through questions posed by the clinician or even the patient. An advantage of this technique is that the advisor can answer in full sentences, although oftentimes the answer is short and concrete. A disadvantage is that the patient is aware of the answers since he or she verbalizes them, and therefore the subconscious may choose not to share information that could be upsetting to the patient.

Rehearsal

Some patients benefit from imagined rehearsal of their hypnosis techniques.

“Imagine yourself in a situation during which you often develop your asthma symptoms, such as when you are around something to which you are allergic, or when you are taking a test in school. Now, imagine using your relaxation sign in that situation, and notice how your breathing can remain easy and comfortable.”

Other patients are willing to experience their respiratory symptoms in order to learn the extent of their mastery of their illness (Tal & Miklich, 1976).

“Imagine a situation in which your asthma starts bothering you, and allow yourself to feel your airways constricting. Notice how your breathing can become more labored. Let your breathing worsen as much as you feel comfortable, and when you are ready to help yourself feel better, use your relaxation sign. Notice how rapidly you can feel better. Now you know that you can be in much better charge of your asthma.”

Age Regression

Respiratory symptoms sometimes develop as a result of stressful early life experiences (Yonas, Lange, & Celedón, 2012). For example, psychosocial stress, a near-drowning episode, choking on food during infancy, or an allergic reaction may be related to development of long-term breathing issues. Some clinicians believe that even difficulty with breathing associated with birth experiences can lead to the development of asthma (Dabney Ewin, personal communication). Patients affected by such
events can improve with the use of clinician-guided hypnotic regression techniques (Hammond, 1990). Hypnotic regression may be beneficial even in the absence of an actual triggering event, as learning to deal with an imagined triggering event can serve as a metaphor for mastery of asthma.

Hypnotic regression instructions can be given in many ways including through initially teaching a patient to use a relaxation sign and ideomotor signaling (as in the preceding text).

“Have your subconscious take you back to the very first time when you experienced breathing difficulties. Perhaps this was a time when you were scared for your life because it felt as if you would be unable to breathe again. Your subconscious will signal to me with the ‘yes’ finger when you find yourself at that time again. . . . Very good. Now, teach your younger self to employ the relaxation sign, and tell yourself you can breathe again. You survived and felt good again. Go ahead and exhale, and breathe comfortably. . . . Now, allow your subconscious to bring you back to the present, and it will let you know when you have returned by signaling with the ‘yes’ finger. Very good. You may be surprised by how much better your asthma now has become.”

CONCLUSION

Asthma is one of the most common diseases in the Western world. In the early 20th century, it was considered as one of the “Holy Seven” psychosomatic disorders (Anbar & Hall, 2012) and thus was thought to be amenable to psychological therapy. However, by the late 20th century, medical scientists had characterized it as a chronic inflammatory disease and the focus of its treatment had shifted toward medical therapy directed at the underlying physiological abnormalities. In the early 21st century, we have become more aware that psychological abnormalities can both predispose to and be the result of asthma. Thus, optimal treatment of asthma requires concurrent attention to its physiological and psychological manifestations. As a psychological therapy, hypnosis appears to provide an effective, efficient tool for the treatment of asthma as well as some of its associated common comorbidities including anxiety and VCD.

REFERENCES


Anger Management

E. Thomas Dowd

Anger is a curious phenomenon and an ambiguous psychological state. While it is generally viewed as a negative emotion to be addressed in psychological therapy, it is likewise often seen as a positive emotion. The term righteous anger expresses the latter feeling; many people think they have a right to be angry, are justified in being angry, even that their anger is someone else’s fault (e.g., “I wouldn’t get angry if other people treated me better”), or something others should just learn to handle. Angry individuals are often powerful externalizers, seeing events and other people as responsible for their difficulties. The result is that few clients ever come to treatment for an anger problem; usually it is a side aspect of another issue or because someone else (e.g., a spouse, an employer, the courts) has referred them for therapy for that issue. As a result, perhaps, the Diagnostic and Statistical Manual of Mental Disorder, 4th edition (DSM-IV) contains no anger diagnosis, the closest approximation being intermittent explosive disorder (IED; 312.34). In the International Classification of Diseases (ICD)-9 anger issues are embedded within aggressive behaviors and disorders of conduct. Only in the 2014 ICD-10 does an anger diagnosis actually appear as “irritability and anger” disorder. Thus, until recently, anger and aggression were largely conflated. Emotion theorists for many years have identified anger as a primary emotion exhibited by all humans (Tafrate, Kassinove, & Dundin, 2002).

As Kassinove and Tafrate (2011) note, anger has its origins deep in our evolutionary past, as an outgrowth of the “flight–fight” response. Bodily and neurochemical changes, including adrenalin, oxytocin, and vasopressin, that occurred with and fueled anger supported aggressive behaviors toward outsiders (“the others” who were often dangerous) that enabled individuals and tribal groups to protect and enhance their resources. Anger tends to be seen as, and often is, empowering (DiGiuseppe, 2011; Kassinove & Tafrate, 2011), at least in the short run. It can often coerce and direct other people’s behavior, establish social dominance, and aid in acquiring additional resources. But in the long run, an excessive level of anger can lead to health problems, poorer relationships, and diminished occupational functioning.

Resentment and irritability are closely related to anger (Dowd, 2006); indeed, they can be seen as low-grade forms of anger that occasionally flare into genuine anger. Aggression, however, is a distinct, though related and overlapping, concept and refers to a more behavioral expression of anger. Anger tends to be more verbally expressed. Kassinove and Sukhodolsky (1995) state that anger does not cause aggression, although anger makes aggression much easier to express and more likely to occur. Although they sometimes occur together, we can have either one without the other. According to Tafrate, Kassinove, and Dundin (2002), although the incidence of aggressive behavior is quite low in nonclinical and low-trait angry individuals, it rises significantly in high-trait angry individuals. In addition, behind anger, there is often a profound sense of hurt or humiliation so that anger can be seen as a mask or cover for hurt (Deffenbacher, 2011).

Deffenbacher (2011) has identified a number of themes behind anger, often revolving around a perceived or actual lack of ability to cope with a situation and feeling overwhelmed. These themes include powerlessness, control by others, being taken advantage of, rigid demands for fairness, assumptions that vulnerability and weakness are catastrophic, low frustration tolerance, and a narcissistic feeling that one should not have to put up with this (whatever “this” is). Kassinove and Tafrate (1998) report that anger has been linked to
anxiety and low self-esteem as well as to the rational emotive behavior therapy (REBT) concept of “demandingness” (e.g., others should/must do this or that or treat me better!).

In addition, there are several types of anger. Chronic anger is exhibited by people who always seem to be angry, resentful, and have a constant defensive approach to life. They are always ready to fight—mostly verbal, sometimes physical. Explosive or volatile anger is intermittent in nature and is shown by those who periodically go into rages. When in that state they may become violent, for which they are often remorseful afterward. Avoidant anger is exhibited by those who are afraid to express any form of anger, instead suppressing it and often not even recognizing it. The result is increased tension, often of a somatic nature. Passive-aggressive anger is demonstrated in indirect ways, such as by sarcasm, contempt, ignoring people, deliberately arriving late, or sabotaging. This can be especially difficult to identify and treat because the individual or others may not recognize or accept it as anger. Anger expression toward intimates and others can be considered to be a form of emotional abuse, depending on the frequency and severity.

RESEARCH

Psychological therapy has been shown to be effective in treating anger problems (Glancy & Saini, 2005; Saini, 2009). Glancy and Saini reported that diverse approaches may be effective in reducing anger and aggression, although cognitive-behavioral approaches have more supporting research evidence. In addition, cognitive-behaviorally oriented treatments have been able to be completed in and show results by about eight sessions. Stapleton, Taylor, and Amundson (2006) found prolonged exposure, eye movement desensitization, and relaxation training to be effective—and equally effective—in reducing both trait anger and guilt and trauma-related anger and guilt.

There are few research studies specifically on the use of hypnosis in treating anger. However, anger reduction may occur when hypnosis is targeted toward reduction of anxiety and stress. For example, Sapp (1992) reported a clinical trial in which relaxation therapy was combined with hypnosis in treatment of anxiety and stress in 16 adults. Levels of anxiety were improved and state anger and trait anger as measured by the State-Trait Anger Expression Inventory (STAI; Spielberger, 1988) were significantly reduced. Relaxation therapy combined with hypnosis also significantly increased participants’ levels of self-esteem. Follow-up data demonstrated that the reductions in anxiety and anger were maintained even after treatment sessions ended.

An alternative Buddhist description of anger treatment has recently been presented by Horn (2014). She describes a four-step process. The first step is to recognize the many forms that anger can take—from irritation to resentment to rage. The second step is to nonjudgmentally accept this anger in yourself. The third step is to investigate the nature of your anger by recognizing when it is arising, where it is located in the body, the themes of the anger, and so on, all the while maintaining a nonjudgmental attitude toward it. The fourth step is not to identify with your anger, maintaining a detached attitude toward it as you recognize that the anger may be part of you, an aspect of you, but not you.

Also, Leifer (1999) described a Buddhist conceptualization and treatment of anger that sees anger as a form of suffering because it causes pain to self and others. The fact that everyone suffers is the First Noble Truth of Buddhism. Leifer states that the causes of suffering are the three poisons of passion, aggression, and ignorance. Treatment involves three steps: taking responsibility for one’s anger (not easy for externalizers), becoming aware that anger is the result of our frustrated desires and aversions, and making a decision and commitment not to act out anger but to become aware of it and reflect on it. He suggests asking two questions: “What did I want that I wasn’t getting?” and “What was I getting that I didn’t want?”

The clinical use of hypnosis in combination with a cognitive-behavioral conceptualization and mindfulness have been reported (Dowd, 2006). A combination of cognitive-behavioral therapy and a Buddhist conceptualization of anger in treating anger may involve the hypnotic routines around themes of perceived lack of respect from others as well as early maladaptive schemas of entitlement/grandiosity and insufficient self-control/self-discipline (Young, Klosko, & Weishaar, 2003). The combined intervention includes development
of changes in cognition, emotional regulation, and often new interpersonal skills for expression of feelings.

**CASE EXAMPLE**

“George” (not his real name) came to see me very reluctantly. He had been referred by his wife, who said she could no longer tolerate his explosive outbursts of anger. My usual strategy in cases where a client is referred by a family member is to see both the referring party and the client privately before beginning treatment. In this case, I met with his wife first.

She reported that George had never been physically aggressive but she feared he might be in the future because his angry outbursts were increasing both in frequency and intensity. In addition, his verbal anger was becoming very wearing and upsetting to the whole family, in particular because it was unpredictable and no one knew what might “set him off.” All the family members felt they were constantly “walking on eggshells” and were increasingly avoiding all interactions with him. However, that by itself could arouse his anger because he perceived (correctly) that his family was avoiding him and he felt slighted and disregarded. George’s angry rages had become so great that his wife was considering leaving him with their two children (seven and five).

George admitted that he was easily angered but tended to attribute it to others (in particular, his family) ignoring his wishes and desires and doing whatever they wanted. He reported having little influence in family activities and directions in life. His wife made all the major decisions for him and for the family and often informed him about upcoming family activities (in particular, involving her family of origin) after she had made plans. He did not think he could refuse to go or there would be “hell to pay.” His attempts to express his dislike of being disregarded were either ignored or denigrated and opposed. George said that he sometimes felt angry at work, too, but was afraid to express it for fear of losing his job. He therefore “stuffed it” (his term) and seethed inwardly with resentment.

I conducted an assessment of George’s family of origin. He said that his father was a volatile person as were his uncles and aunts on that side of the family. His mother was rather timid and engaged in numerous attempts to placate his father. Family members on his mother’s side were not particularly volatile although several of them lived in other parts of the country and he rarely had contact with them so he did not know them well. George did admit that he liked his mother more than his father but did admire his father who was quite successful occupationally. He reported that he had attempted to please his father as a child, mostly without success he felt. But he had at least followed his father in one regard: by becoming himself very successful occupationally, although in a different field. It was not clear; however, if this had actually pleased his father, and he reported feeling very frustrated by his inability to seemingly make his father proud of him.

Although George tended to externalize the responsibility for his anger, he did recognize that it caused him difficulties in his family. After some discussion, he could see that it might potentially cause him problems at work if he dared to show it. He could also see that his anger and volatility in both areas of his life were not really getting him what he wanted, which we identified as respect. He could see that he was, to some extent, following family-of-origin behaviors in his own. Accordingly, I pointed out that what he was doing was not helping and was even hurting him in the achievement of his goal of being treated with respect. I asked him if he was willing to try something else and he reluctantly agreed.

**TRANSCRIPTS**

Therapy with George lasted 10 sessions, including the two intakes (with his wife and himself). Most sessions involved a combination of discussion and hypnosis. The following somewhat abbreviated hypnotic routine occurred early in our work together.

“And now, I’d like you to become comfortable—comfortable in your own skin—as you begin to relax and turn your attention inward; inward and downward; becoming aware of the tension points in your body—and as you become aware, allowing them to relax and become more comfortable.
That’s right! Becoming more comfortable and more relaxed as you turn your attention inward and downward—downward and inward. And as you continue to find comfort and peace, you can listen to my words in new ways—earing the meaning behind the words—beginning to find new associations and meanings in ways you never expected to and never thought of—beginning to learn new things, not quite sure what yet. Finding increasing comfort in your mind and in your body—not doing, not forcing but simply allowing it to happen—in its own way and at its own pace. Feeling comfortable with the process—beginning to understand that good things can happen in their own way and at their own speed. Beginning to feel the tremendous power of letting go—letting go of powerful emotionality—beginning to realize that sometimes we can sabotage our own best interests by trying to move too quickly, can’t we?—expecting others to do the same—creating problems and blocks where we really don’t want or need them. And you might begin to discover that you don’t really need to demand respect and admiration from others—you can let respect and admiration come to you by allowing it to do so—beginning to feel comfortable and confident that it will. Beginning to realize that you can and should set limits with others but in a comfortable and confident way. Beginning to understand what that means. Comfortable and confident—confident and comfortable. And you can discover this if you allow it—and you can begin the process of allowing yourself to discover it. It’s all new and exciting, isn’t it? And you can allow yourself to be increasingly excited about learning and discovering new things—and the more you discover the more you can learn; the more you learn the more you can discover and the more you learn and discover the more excited you can become about the whole process. Beginning to feel better about yourself and the tremendous power in letting go, allowing things to happen in their own way, at their own speed. Now let your mind lay flat as it begins to incorporate these new ideas—new learnings—in new and different ways—learning, growing and developing.

During a subsequent session, I created a hypnotic routine to address the early maladaptive schemas described earlier. Here is a somewhat abbreviated transcript.

“In the past you learned many things, didn’t you? And as you continued to grow and develop, you continued to add to those learnings, didn’t you? As you became an adult, perhaps you thought you had learned everything you needed to learn, didn’t you? Many people do and perhaps you did too. It’s normal and natural, isn’t it? Perhaps you think that way now. You may have learned, or thought you did, that some people can’t be trusted sometimes. Many people do. Perhaps you began to wonder if you could ever trust anyone; some people do. Perhaps you wondered, ‘will those big people who are so important to me ever really like me; ever really approve of me?’ So you tried harder—and harder—and it didn’t work—and perhaps you didn’t trust them to be there for you when and how you needed them. It’s easy to constantly look for approval, isn’t it?—and perhaps you did so. Over and over—until it became a habit—and you know of course how difficult it is to break a habit. Perhaps you felt eventually that they owed you approval—and it’s natural to feel that way, isn’t it? Many people do and children are owed many things by those who are important to them; love, caring, affection, respect. We all want—we all need—these things, don’t we? So it’s natural to feel this way and perhaps you do, too. But because things are natural and normal doesn’t always mean the ways of looking for them are always good—are always useful. There are better and worse ways of getting what you need—what you want—aren’t there? And as you continue to learn, grow, and develop you can begin to separate the good from the bad—finding new ways to get what you need—what you want—legitimately.”

After using these routines and discussing their impact, George reported that his anger and its verbal expression had begun to diminish, which his wife confirmed. However, he was still left with his feelings of resentment (a low-grade form of anger) over being left out of family decision making and his wishes being denigrated, disregarded, and ignored. One alternative would have been marital therapy with George and his wife to address these issues and his feelings about them. That might have been advantageous in letting his wife know that the family problems were not completely of George’s making. Instead I chose what I thought might be a shorter and less onerous way of addressing them. Marital therapy would have meant enlisting the
assistance of another therapist because I had a previous therapeutic relationship with George and it would likely have taken much longer. We discussed his feeling of lack of respect from his family and his perceived helplessness in doing anything about it. George was a conflict-avoider and consequently I used the following hypnotic routine to address his resentment.

“You have some resentment . . . about being disrespected by some important others in your life. They don’t seem to care, you feel, what you think about things—that are important to you. You don’t know what to do about it, don’t you, so the resentment and feelings of helplessness just fester and fester and you stuff them. These feelings are normal—natural. No one likes to feel disrespected—to be ignored, do they? What can you do about it? You don’t know, do you? And perhaps it seems the only thing you can do—what you do—is to get angry, hoping they will pay attention to you and to your needs and desires. But it doesn’t work—it hasn’t worked—and all you know to do is more of the same—which doesn’t work any better the second—or third—or fourth time either. So the frustration leads to more anger, which leads to no success and in fact can make things worse, in a sort of a vicious circle of helplessness, anger, frustration, and more anger. And perhaps you can feel your anger rising right now as I talk to you about it—if so, just notice the anger, reflect upon it, and slowly allow it to diminish, becoming less and less. That’s right—you can just allow it to slowly dissolve—becoming less and less without doing anything about it—just allowing it to diminish. Not doing—just allowing it to happen. Now let those thoughts roll around in your mind, slowly allowing them to sink in. . . . [Pause]. Perhaps if you think about it, you may already have discovered the tremendous power of doing nothing, or allowing your negative emotions to gradually fade away—becoming less and less, not by doing but allowing. It can be really quite powerful, isn’t it—in a way perhaps you never thought. . . . [Pause]. Now turn your attention to your wife’s refusal to consider your desires in making family plans. You can’t really force her to consider your desires, can you? And that’s what is so frustrating—leading to anger. You feel blocked, helpless, and angry in that order. What can you do? Let me suggest something different. You can’t force her to consider your wishes—but she can’t force you to accept her wishes either, can she? She can only make you do what she wants if you give her the power—and so far you have. But you can say, ‘No,’ even though she might be irritated and angry if you do. You can stand it because it will eventually go away. And wouldn’t it be interesting—even fun—for her to be angry instead of you! You can take the power back if you say ‘No’ and then she might be the one to feel blocked, helpless, and angry. Kind of a reversal, isn’t it? Remember, you have the power if you choose to exercise it—and if you feel powerful and act powerful you don’t have to get angry because there is nothing to get angry about. Think of that; nothing to get angry about! Let that thought roll around in your mind—the tremendous power in saying ‘No’—knowing ‘No’ can stick if you want it to, if you want to feel the power—feel the power. . . . And the more you let this idea penetrate your unconscious mind, the more at peace you can feel—calm and at peace . . . peaceful and calm.”

In this final transcript, the client’s feelings of powerlessness and helplessness were addressed, as well as his desires to be heard and acknowledged by his family. It may be strange to think of an angry person as feeling helpless because anger is often thought to reflect power, but in many instances, it may reflect attempts to feel more powerful when one doesn’t. This is more apparent if one thinks of anger as arising from frustrated desires and blocked actions. I instead suggested to the client that although he could not force his wife to do what he wanted, neither could she force him to do what she wanted unless he allowed it. In a potentially amusing routine, I suggested that his saying “No” might in turn trigger angry responses on her part, leading perhaps to a role reversal and more empathy from her toward his anger. It has been long noted in intimate relationships that behavioral changes by one partner unbalance the system and can lead to unanticipated changes by others in the system. I also included suggestions for reducing anger by letting go, by allowing it to diminish.

After the 10 sessions for which we had contracted, George reported his anger was much reduced. He was able on a few occasions to disagree with his wife about events that she had planned without consulting him. Once he refused to go, leaving him with a new feeling of power. Although his wife
was irritated by that, she did accept it somewhat gracefully. George and I discussed appropriate ways of handling his resentment and I suggested he have a proactive discussion with his wife when neither was angry and tell her of his resentment at being excluded. I instructed him on the use of self-calming techniques should the discussion become heated. I suggested marital therapy to resolve these issues if they persisted. George and I agreed to terminate with the understanding he could return if his anger resurfaced.

CONCLUSION

This case example nicely illustrates the central themes in anger management by hypnosis: letting go of frustrated desires, allowing things to happen instead of trying to force them, and finding alternative ways of obtaining what one wants and reducing what one doesn’t want. Providing clients with self-calming techniques and often assertion training is crucial. It also illustrates the manner in which I use hypnosis in psychological therapy; cognitive-behavioral or otherwise. That is, hypnotic routines are interspersed within discussions of the client’s psychological difficulties and subsequent discussions of the effects and reactions to the routines. These reactions can often be quite powerful and may require extensive discussion, sometimes requiring attention during the next session as well. Likewise, the initial discussions allow me to understand the major themes in the client’s life, to formulate a case conceptualization, and from that to develop the hypnotic routines to address the themes. I would estimate that approximately one-third of the total client session activity might be devoted to hypnosis on the average. As therapy winds down, the percentage may be less.

REFERENCES


