

HYPNOSIS IN POST-ABORTION DISTRESS: AN EXPERIMENTAL CASE STUDY

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Abstract

The present case study of a 23-year-old woman begins by exploring post-abortion distress in context with hypnosis and identifies particular themes across symptoms that indicate that hypnosis may be an appropriate adjunct to therapy for this problem. For treatment a three-phase framework was used, as proposed by Brown (1995) for post-traumatic stress disorder (PTSD). Symptom changes were monitored throughout the course of therapy in a multiple-baseline study design. The client, S, also completed pre- and post-therapy questionnaires. The therapeutic outcome is described with reference to data collected from weekly monitoring and from written feedback regarding her own feelings about the therapy. The results indicate that the therapeutic interventions improved specific symptoms as well as general mental health and it is concluded that hypnosis may be a particularly appropriate adjunct to therapy for post-abortion distress.

Key word: case study, hypnosis, post-abortion distress, post-traumatic stress disorder, therapy

Introduction

There is some evidence that severe distress after termination of pregnancy can lead to post-traumatic stress disorder (PTSD; Spekhard and Rue, 1992) and there is general agreement among researchers that a minority of women will suffer long-term disturbance following termination (Paintin, 1997). However, the diagnosis of PTSD for severe post-abortion distress is controversial and the problem receives little coverage in therapeutic training or PTSD handbooks. As a result, women who experience a termination as a traumatic event and who are unable subsequently to resolve their cognitions and feelings are at risk of having their PTSD symptoms unrecognized by health professionals. If problems are not diagnosed accurately this is likely to prevent women from receiving appropriate psychological treatment.

From our own experience of clients with post-abortion distress, three particular themes may be identified across symptoms which indicate that hypnosis may be a useful adjunct to therapy for this problem. First, clients in this group display a tendency to dissociation or depersonalization, for example 'switching off' when being around babies and young children. Second, they commonly show high levels of absorption in fantasizing and report episodes in which they may be intensely involved, for example, in imagery of the baby's continued existence and that it is at the age it would have been if the termination had not taken place. Third, they appear to be disposed towards increased suggestibility — 'a heightened responsiveness to social cues' (Spiegel, 1997)

— these clients respond with intense emotions, in particular guilt, on hearing opinions expressed about abortion or when exposed to stimuli associated with the termination. These themes closely resemble the three components of hypnosis identified by Spiegel (1997) as being analogous to aspects of PTSD (that is, dissociation, absorption and suggestibility).

A further consideration that indicates the use of hypnosis in therapy for post-abortion problems is that women displaying such symptoms frequently appear to have become absorbed in what has been called 'negative self-hypnosis'. Negative self-hypnosis may be evident in the distorted and self-damning cognitions that result in negative affects, such as guilt, shame and regret. Araoz (1981) believes that the post-hypnotic suggestion element of negative self-hypnosis leads to powerful negative self-statements that are resistant to change.

The therapeutic framework investigated here is based on the considerations outlined above. It integrates both cognitive and psychodynamic approaches and also uses ego-state techniques (Watkins and Watkins, 1997). The framework has also been informed by Dolan's (1991) therapeutic techniques for resolving sexual abuse. Although there are numerous clinical reports citing the efficacy of the use of hypnosis as an adjunct to the treatment of PTSD (Spiegel, 1997), there is a need to conduct more systematic studies, both group and single case (Cardena, 2000), in order to substantiate these claims. The present paper begins to address this need.

The therapeutic framework

The therapeutic framework comprises three phases, as proposed by Brown (1995) to treat PTSD. The first phase concentrates on building resources (Brende and Benedict, 1980). The second confronts unresolved issues in order to facilitate emotional processing (Foa and Kozak, 1986) and the third focuses on personal growth and the future (Dolan, 1991) (see Appendix I for a more detailed account of the three phases of treatment as they apply to the present case study).

Study design

A multiple baseline study design was used. Psychometric tests were used before and after therapy in order to measure overall change. Specific target symptoms were identified and were measured weekly. Anxiety, anger/hostility, somatization and depression were also measured weekly. Nightmares were monitored three times a week. Three sets of baseline measures were taken at weekly intervals before therapy. The same sets of measures were taken three times after therapy, at one week, three months and 12 months.

Materials

A pre-therapy questionnaire was designed for the study, based on clinical experience, and informed by the literature on abortion (Meuller and Major, 1989; Major, Cozzarelli, Sciacchitano, Cooper, Testa and Mueller, 1990; Major and Cozzarelli, 1992; Brien and Fairbairn, 1996) specifically to assess cognitions, behaviours and beliefs relating to the pregnancy termination.

The Creative Imagination Scale (Barber and Wilson, 1978) and the Vividness of Imagery Questionnaire (Marks, 1973; Johnson and Puddifoot, 1998) were given before therapy to evaluate imaginative suggestibility (Braffman and Kirsch, 1999) and strength of visual imagery.

The following measures were administered before and after therapy to assess general levels of distress and coping styles:

- The Hospital Anxiety and Depression Scale (HADS; Zigmund and Snaith, 1983).
- The Ways of Coping Questionnaire (Folkman and Lazarus, 1988).
- The Internality and Powerful Others Questionnaire (Levenson, 1981).
- The Self Esteem Scale (Rosenberg, 1965).

The wording on three additional measures, also administered before and after therapy, was adapted to make them appropriate for the experience of a termination. These were:

- The Post-traumatic Stress Diagnostic Scale (PTSD; Foa, 1995).
- The Perinatal Grief Scale (PGS; Potvin, Lasker and Toedter, 1989).
- The Trauma Related Guilt Inventory (TRGI; Kubany, Abuerg, Brennan, Haynes, Manke and Stahua, 1996).

Before the first therapy session the client was asked to list 'the most significant effects your abortion may have had' on 'what you do or don't do', 'how you feel', 'your general health', 'images in your mind', 'your thoughts', 'relationships with others' and 'medication, drugs, alcohol'. These headings were based on seven modalities which Lazarus (1981) suggests provide an 'holistic understanding of the person' (p.13). These modalities are Behaviour, Affect, Sensation, Imagery, Cognition, Interpersonal relationships and Drugs/biology (BASIC ID). The answers given by the client generated 39 symptoms that were listed under the seven categories of the BASIC ID, as follows:

- Behaviour (7), for example '*[I] don't read articles or like to see pictures of babies.*'
- Affect (7), for example '*[I feel] fearful about the future.*'
- Sensation (7), for example '*[I have] chest pains.*'
- Imagery (4), for example '*[I have] images of [the] surgical procedure.*'
- Cognition (7), for example '*[I find myself] wanting to "disappear" to "start again" somewhere.*'
- Interpersonal relationships (7), for example '*[My] partner describes me as a "roller coaster" [I] alternate between love and anger.*'
- Drugs/biology (0). No symptoms were described in this category.

The complete set of symptoms was then typed up on a 'target symptom' weekly checklist. Each week the client was asked to rate each of the target symptoms on a scale between zero and 10 'to show where you are at present' in order to monitor change.

S rated how comfortable she felt about her decision to have the termination at weekly intervals on a scale between 1 and 7. The Hopkin's Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth and Covi, 1974), with subscales measuring 'anger/hostility', 'anxiety', 'depression' and 'somatization' was also completed weekly. For three nights of each week (Tuesday, Thursday and Saturday) S recorded whether or not she had experienced a nightmare that night. At the end of each session a Most Helpful Aspect of Therapy (MHAT) form (Parry, Shapiro and Firth, 1986) was completed. The Usefulness of Hypnosis (UOH) form (Walters, 1999; see Appendix II) was administered at the end of the course of therapy. The MHAT and UOH forms both provide data about the client's subjective experience of aspects of therapy.

Background to the case

S was 23 years old when she presented for therapy. She had self-referred to the Hypnosis Unit at UCL after talking to a friend who had seen the project advertised in a London hospital. Her pregnancy had been terminated at six weeks, five months before starting therapy, and had taken place in a specialist clinic. She had experienced extreme fear whilst sitting in the waiting room and intense pain during the procedure (which had been carried out under local anaesthetic). She had expected to feel relieved after the termination, but instead, she experienced ‘unreal feelings and severe distress’. Additionally, S had developed strong maternal feelings towards the aborted fetus following the termination. She interpreted these as proving that she had made the wrong choice. PTSD symptoms included nightmares, intrusive images of the abortion, feelings of no future, fits of anger, avoiding going near the abortion clinic and avoiding TV or radio programmes about abortion. These symptoms affected all areas of her life. S was in a stable relationship and in spite of her distress had managed to continue with a demanding career. Colleagues knew nothing of her termination but had noticed that something was seriously wrong. She identified her goals as wanting to feel more positive, active and energetic, to feel able to socialize and not to feel drained, to feel more focused and to be able to feel that the ‘black cloud’ had lifted. She attributed her distress as being due to guilt.

Results from the pre-therapy questionnaire and other measures

S’s responses to the PTQ identified the following symptoms. Overall, these were taken to support the view that hypnosis would be an appropriate adjunct to therapy in this case:

- *Fantasizing/imagery*: recurrent thoughts of what the baby would have looked like; imagining the baby continuing to grow; thinking of the loss in terms of a baby rather than a fetus.
- *Dissociative experiences*: the termination feeling unreal; feeling like two different selves — one who has had the termination and one who has not; ‘switching off’ when around babies; staring into space.
- *Suggestibility*: heightened sensitivity to suggestion (both from others and the environment), for example intense emotions on hearing strong views against abortion.
- *Negative self-hypnosis* (Araoz, 1981): absorption in self-damning cognitions relating to guilt, shame and regret, which reinforced her low self-esteem.

S scored 29/40 (norm 19) on the Creative Imagination Scale (Barber and Wilson, 1978) and 51 (overall range 32–160, lower scores representing more vivid imagery) on the Vividness of Imagery Questionnaire (Marks, 1973), indicating that she was in the higher range for imaginative suggestibility and that she was a vivid imager. The PSDS (Foa, 1995) showed that S’s PTSD could be classed as chronic with a severe level of impairment in functioning. She endorsed the maximum of 17 symptoms and her symptom severity score was 42/51. She avoided anything that reminded her of the termination, felt distant or cut-off from people around her, and was emotionally numb. On the TRGI she scored above the norm on five of the six trauma-related guilt factors identified by Kubany et al. (1996) and well above the norm associated with responses to fetal death on the PGS (Potvin et al., 1989) (see Table 1 for these sets of scores). Most frequent coping styles scored on the Ways of Coping Questionnaire (Folkman and Lazarus, 1988) were ‘escape-avoidance’ (reflecting her ability to fantasize and dissociate).

Table 1. Pre- and post-therapy scores

	Pre-therapy PTSD classified as 'severe'	Post-therapy Criteria for PTSD not met	Follow-up 1 (3 months) Criteria for PTSD not met	Follow-up 2 (12 months) Criteria for PTSD not met
HADS: anxiety (borderline 8–10)	16	7	6	5
HADS: depression (borderline 8–10)	12	2	1	1
Internality mean (students): 35	14	29	31	38
Powerful others mean (students): 20	39	15	13	11
PGS: active grief mean (fetal death): 31.9	49	22	15	12
PGS: difficulty in coping mean (fetal death): 26.9	49	22	15	11
PGS: despair mean (fetal death): 24.4	47	15	16	11
Self-esteem	19	30	32	36
Ways of coping: most used coping styles	CC*	SS	SS	Not recorded
	AR	SC	D	
	EA	PR	PR	
TRGI: global guilt mean (college students): 1.2	3	1	0.8	0
TRGI: guilt cognitions mean (college students): 1.1	2.8	0.9	0.4	0.8
TRGI: distress mean (college students): 1.9	3.5	0.9	0.8	0.5
TRGI: hindsight bias/responsibility mean (college students): 1	3	0.9	0.6	0.9
TRGI: wrong doing mean (college students): 1	2	0.7	0.2	0.2
TRGI: lack of justification mean (college students): 2.2	2	1.5	0.6	1

* CC – confrontive coping; AR – accepting responsibility; EA – escape – avoidance; SS social support; PR positive reappraisal; D distancing; SC – Self-controlling.

ate), ‘accepting responsibility’ (indicative of her efforts to intellectually accept the abortion decision) and ‘confrontative coping’ (illustrative of the tension with her partner after the termination). Her levels of both depression and anxiety on the HADS were in the clinically significant range. S scored 19 on the Rosenberg Self Esteem Scale which has a range from 10 to 40. The nightmare checklist showed that S had experienced a nightmare on each of the three nights checked on each of the three weeks preceding therapy. Her target symptom rating averaged at 8.8 out of a maximum of 10 (Figure 1).

The therapy

There was a total of 13 sessions spanning 17 weeks, seven of these sessions included hypnotic interventions (see Appendix I and figures 1 and 2).

During the first phase of treatment S was taught self-hypnosis and anxiety control (session 1), she was informed of the PTSD diagnosis (session 2). An age regression (session 3) to a happy childhood experience, resulted in her going back to her eighth birthday party.

Phase two began by exploring her feelings about the abortion (session 4). Safe remembering techniques (Dolan, 1991), in this case playing a video and having control of the handset, were used in an uncovering age regression to being bullied as a teenager (session 5) and in an age regression back to the abortion (session 6). Ego state therapy was used in both age regressions so that the stronger part of herself could comfort and counsel her vulnerable self (Watkins and Watkins, 1997). In session 7 S focused on anger she felt towards her partner and this was followed, in session 8, by exploring her identification with the fetus and the grief she felt. An hypnotic mourning ritual (session 9), in which S said goodbye to her ‘baby’ at the age it would have been had the termination not taken place, marked the end of this second phase (Van der Hart, 1988).

In phase three the main theme was one of ‘moving on’. In session 10 progress was reviewed. In session 11, in spite of stating that she was feeling much better, S reported experiencing particularly disturbing and vivid nightmares (for example, a ‘replay of the

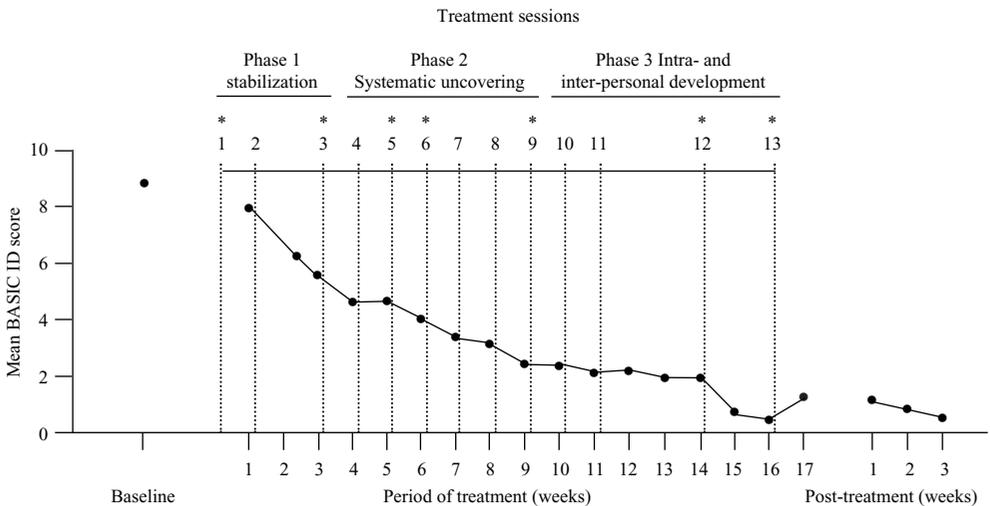


Figure 1. Mean scores based on S’s weekly self-report ratings of the 39 symptoms derived from the BASIC ID (Lazarus, 1989), see text for further details.

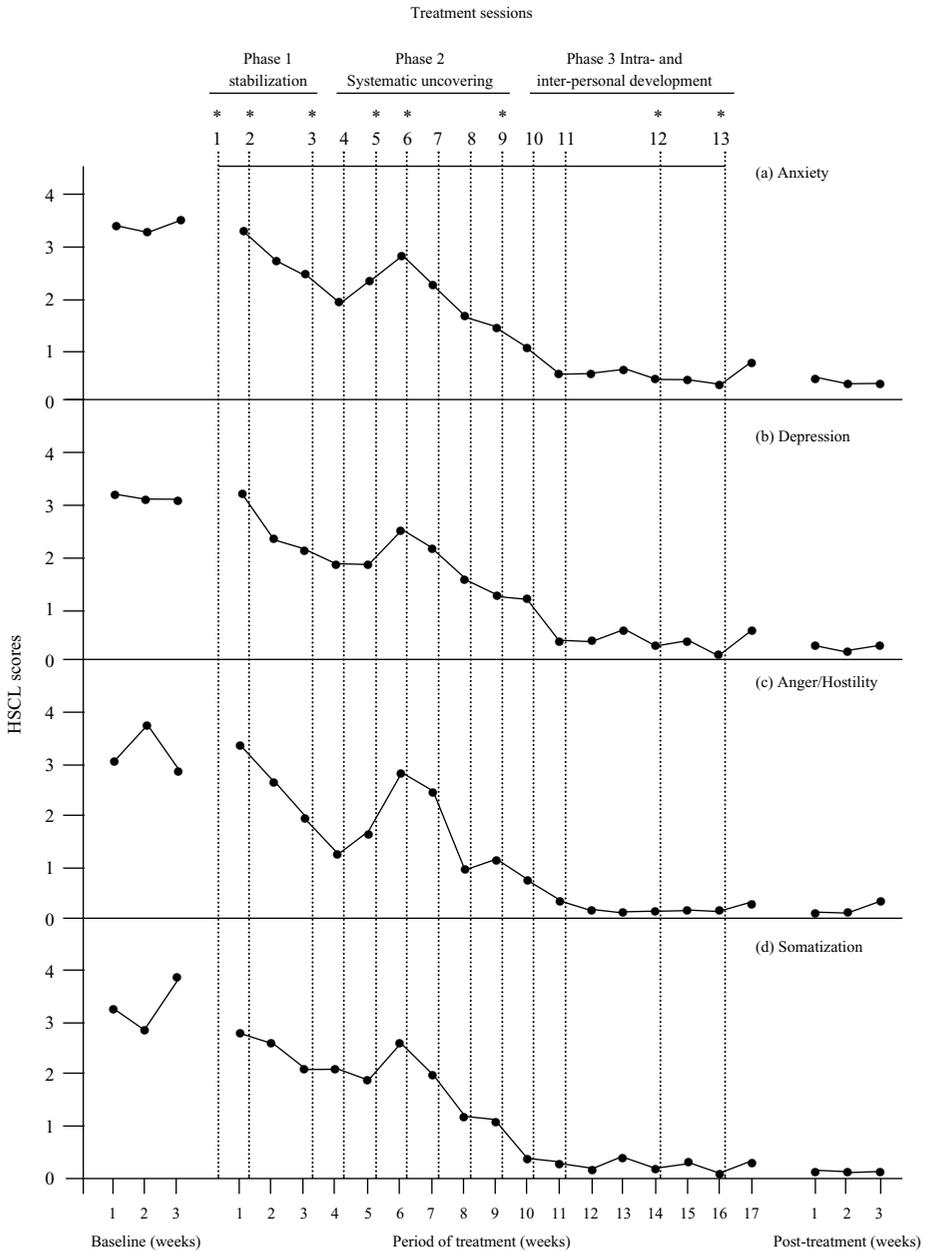


Figure 2 Graphs (a–d) illustrate S’s anxiety, depression anger/hostility and somatization scores on the HSCSL during the baseline period, the 17 weeks which spanned the course of therapy and post-treatment over three weeks. Three baseline measures were taken at weekly intervals before therapy commenced. The course of therapy involved 13 sessions, seven of which included an hypnotic intervention (the sessions involving hypnosis are marked with an asterisk). The HSCSL scores recorded S’s feelings in the week(s) between sessions so the first data point on the treatment sessions part of the graph reflects her self-report ratings in the week following the first therapy session and so on. See text for further information on the three phases of therapy.

abortion', 'being forced to look in a coffin', 'being in a plastic bag trying to breathe'). She attributed these to the impending anniversary in a month's time of what would have been the date of the birth. One particular nightmare, which S felt captured the essence of their frightening nature, was 're-scripted' (Rusch, Grunert, Mendelsohn and Smucker, 2000) in hypnosis (session 12, week 15). This involved S describing her nightmare in hypnosis and then re-experiencing it so that as soon as the frightening part appeared she could change the scenario into a comforting, happy scene. Progress was consolidated with a past/future hypnotic intervention (session 13) in which S left the bad feelings she had been experiencing in a room symbolizing the past and then moved on to the future which was symbolized as another room full of good feelings now that she had psychologically resolved her termination.

Results of measures taken throughout therapy and post-therapy

S's HSCL scores indicated that phase one of therapy had achieved a progressive reduction of anxiety, depression, anger/hostility and somatization (see Figure 2). As soon as the second phase commenced (session 4, week 5), an increase was noted in all her HSCL scores though these remained lower than her baseline scores.

As this second phase progressed, all scores continued to drop again and levelled out following the hypnotic mourning ritual (session 9, week 10). Scores remained constantly low during the third phase of therapy (beginning at session 10 week 11) and over the three weeks on which measures were taken post-therapy.

The incidence of nightmares was monitored from session 1 onwards, S's weekly checklist revealed that she experienced one or two nightmares on each of the three nights checked each week from session 1 to session 15. Her nightmares stopped immediately and completely following the hypnotic 're-scripting' intervention (session 12, week 15) and remained absent post-therapy.

The mean of all 39 target symptoms at baseline, during treatment and post-treatment are shown in Figure 1. In contrast to the HSCL scores, scores for individual target symptoms or groups of symptoms show the same steady decline in all cases and in no instance was any relationship evident on visual inspection between the scores and individual interventions or phases of treatment. By the end of therapy S's average target symptom rating was 1.1 and at the end of three weeks' post-treatment monitoring her mean score was 0.4.

Pre- and post-therapy and follow-up scores of the PSDS (Foa, 1995); TRGI (Kubany et al., 1996); PGS (Potvin et al., 1988); Ways of Coping Questionnaire (Folkman and Lazarus, 1988) and the Self Esteem Scale (Rosenberg, 1965) are shown in Table 1. It may be seen that scores continued to improve post-therapy.

Discussion

Post-treatment scores suggest that the therapeutic package investigated in this study was accompanied by S's improved mental health. Some of these scores are now reviewed in reference to comments made on the MHAT and UOH forms and to weekly checklist scores. The results on the various measures are put in context with the phases of therapy outlined earlier (UOH questionnaire responses are shown in Appendix II).

S's anger/hostility scores (see Figure 2 (c)), as measured by the HSCL, dropped during the first phase of therapy, possibly reflecting her MHAT comments that self-hypnosis (session 1, learning self-hypnosis) was '*Something I could practise to*

restore calm to myself and my body'. This success may have increased S's expectations that hypnosis would work for her. S was encouraged to use positive self-statements during her self-hypnosis in order to break the cycle of negative cognitions and this may also have been partly responsible for her reduction in depression scores (see Figure 2 (b)) during this phase.

A particularly marked lowering of the HSCL depression scores (Figure 2 (b)) followed the disclosure of the PTSD diagnosis (session 2), reflecting S's MHAT comment that the diagnosis had *'Given me hope about my feelings'* and that *'Knowing there is a recognized condition for how I feel puts things in context — stops me feeling I'm going mad!'*. This may indicate that it is important for therapists to recognize PTSD symptoms in clients presenting with severe post-abortion distress, not only in order to treat the problem appropriately but also because informing them of the diagnosis may, in itself, be an effective intervention.

The beginning of phase two of therapy was marked by a peak in all HSCL scores (Figure 2 (a–d)) following the uncovering age regression (session 5) in which painful emotions surfaced about being bullied as a child (see UOH comments, Appendix II). S reported on the MHAT form that up until this age regression she had forgotten how terrified she had been at the time but had been able to see, 'with her adult eyes' (through the use of ego state techniques), how 'immature and childish' her bullies had been. Possibly the opportunity to have replayed this event with feelings of mastery at standing up to the bullies, may also have contributed to S's increased 'internality' and decreased 'powerful other' scores by the end of therapy (see Table 1). S had reported verbally after this particular intervention that the feelings she experienced when bullied as a child were similar to how she had felt during the termination, suggesting that hypnosis had facilitated insight through the re-experiencing of unresolved issues from the past. The rise in her scores after this session may reflect the necessary emergence of strong emotions during the process of therapy. Arguably, this rise in scores indicated progress as opposed to a set-back.

S's target symptom scores showed a steady decrease during the course of therapy. It is interesting that these scores, in contrast to the HSCL scores, did not reflect the three phases of therapy. One possible explanation for this is that the target symptom checklist was a rather crude measure of change in comparison to the HSCL. For instance S's tendency to give a similar score for each symptom may have reflected a feeling about how she perceived the progress of therapy in general rather than her progress in relation to the particular symptom she was asked to rate.

S commented on the UOH form (Appendix II) that an age regression back to the experience of the termination (session 6) 'felt very vivid and real' and helped her to realize that 'although frightening, the situation had not been life-threatening'. She also indicated that ego-state techniques had been helpful to her. Arguably, the 'realness' of the situation had made this experience particularly powerful (see Walters and Oakley, in press). This intervention marked the beginning of a steady decrease of all her HSCL scores which can be seen in phase two (Figure 2 (a–d)), suggesting that S had begun the process of resolving her problem.

All HSCL scores steadily dropped until they reached a low point following the mourning ritual (session 10). The levelling out of her scores after this intervention suggests this marked a stage at which S had completed resolution (see comments on UOH, Appendix II). S's ability as a 'vivid imager' alongside her fantasy-proneness may have contributed towards the success of this intervention. The fantasy S had of her baby at the 'age it would have been' was used in the mourning ritual in which she was encour-

aged to experience the maternal feelings that had previously frightened her. Her MHAT form at the end of this session stated that this intervention had been helpful to say 'goodbye in my terms' and important to her because she 'had not previously done this. I can now move on!!'. This was further illustrated by her PGS scores, which were considerably reduced by the end of therapy. Interestingly, at the two follow-up assessments PGS scores continued to fall quite strongly.

Indeed, the continuing improvement of virtually all scores taken before and after therapy (Table 1) reflects results of the meta-analysis carried out by Kirsch, Montgomery and Sapirstein (1995). In their study it was shown that hypnosis as an adjunct to cognitive-behavioural therapy was more effective than the same therapy without the addition of hypnosis. Moreover, it was found that those who had received therapy with the addition of hypnosis continued to improve after completion of treatment (possibly as a result of continued use of self-hypnosis practice). The therapeutic framework in the present study is not confined to cognitive-behavioural therapy and this may suggest that other established therapies (such as psychodynamic approaches) might also be more effective with the adjunctive use of hypnosis.

During the third stage of therapy S's HSCL scores remained constantly low, in spite of the emergence of particularly disturbing nightmares. As already noted these nightmares stopped immediately following the hypnotic 're-scripting' intervention (session 12). A possible explanation for the success of this intervention is that S had become desensitized to the nightmare or that she had responded to the post-hypnotic suggestion that *'As soon as you begin to notice the unpleasant dream beginning to appear, the happy scenario will immediately come to mind'*.

The hypnotic mourning ritual (session 9) appeared to have enabled S to experience resolution of her grief very vividly and she commented in session 10 that she had felt less guilty and self-punishing since session 9. On the UOH form S had commented that this intervention had given her the opportunity to 'say goodbye'. Arguably, hypnosis had provided this opportunity, since the nature of abortion (that is, the fetus is left in the clinic), had made saying 'goodbye' difficult to do. The vividness of the hypnotic experience might also explain why S had felt the mourning ritual to be particularly profound.

By the end of therapy S had indicated on the weekly checklist that she was feeling a great deal more comfortable about her abortion decision. She had commented that her final score of 6.5, rather than 7 (feeling 'completely comfortable'), did not indicate that she felt some residual guilt, but was an acknowledgement of how special her fetus was to her. Her comment was also borne out by her reduced scores on the six TGRI subscales at the end of therapy (see Table 1).

S's self esteem had increased considerably by completion of therapy (see Table 1) and this was reflected in her comments during session 12 that she could now feel comfortable with herself and felt more 'grown-up and stronger'. Similarly, her decrease in scores for feeling her life was controlled by 'powerful others' (Levenson, 1981) may have been influenced by having experienced mastery in hypnotic age regressions (being bullied as a teenager and the experience of the termination) in which she was able to re-experience these upsetting situations with mastery rather than a feeling of being overwhelmed by external forces. Her change of coping behaviours, as indicated by her responses on the 'Ways of Coping' scale (Folkman and Lazarus, 1988), showed that post-therapy she was now coping adaptively by using 'positive reappraisal' and 'social support'. It is possible that these coping behaviours had been facilitated by some insightful 'self-counselling' when ego-state techniques had been used. Another hypothesis is that self-statements used in self-hypnosis had helped to reinforce new coping strategies.

It should be noted that while the relationship of scores to interventions discussed above indicates that certain hypnotic interventions were followed by change they do not necessarily tell us that the intervention was the sole or major factor in promoting that change or indeed whether they had any relevance at all to the subsequent changes. A related consideration is that even if a causal relationship were present the change may occur some time later. It may be possible, for instance, that certain mental processes take longer to change in response to interventions than others. Nevertheless, S's own comments on the progress of therapy are consistent with there being a direct relationship between particular interventions and subsequent changes.

The questions used at the outset the study to identify S's cognitions, behaviours and beliefs relating to the pregnancy termination, were of a sensitive nature (for example '*Do you have any thoughts about where the fetus is now?*') yet S had written her responses with composure, commenting afterwards on how much she had related to the questions and expressed a feeling of relief that the questions had put into words feelings that she had been unable to articulate before. In view of the possibility that this client group may be highly suggestible, it is likely that the questionnaire was not entirely inert but may have conveyed suggestions that shaped her concept of her abortion. For instance, an indirect suggestion of the need to mourn may have been 'seeded' pre-therapy by asking about where she thought the fetus might be now.

The MHAT forms, completed after each therapy session illustrated the process of S's recovery. These comments, taken with her verbal reports, suggest that she had gradually understood her distress as being partly connected to the termination procedure itself and partly to unresolved feelings about being bullied as a teenager. She had recognized that her feelings following the termination were very similar to feelings that were experienced when she had been bullied. She was also able to integrate feelings of love for the fetus with her decision to have a termination. She no longer felt that the maternal feelings that had emerged after her termination indicated that she had made the wrong decision. Instead of feeling frightened by strong emotions such as these, she felt she was able to embrace them as being a part of herself that she valued. By the end of therapy she conceptualized the abortion as having facilitated personal growth. She was now enjoying life and looking forward to the future with optimism. S reported that she felt that the hypnotic interventions had played a vital part in her recovery.

Conclusions

Results from this single case study indicate that hypnosis may be an effective adjunct to therapy for PTSD following termination of pregnancy. However, it cannot be concluded with certainty that change was related specifically to hypnosis and the therapeutic framework examined in the present study needs to be repeated with further cases in order to make stronger claims. It is hoped that the continuation of this project will enable data to be accumulated over a period of time, and these will be helpful in further evaluating the effectiveness hypnosis is as an effective adjunct to therapy for this problem.

Appendix I

Overview of three phases of therapy

Therapy sessions and major interventions are listed on a week-by-week basis. Asterisks and bold type indicate a session on which hypnosis was used.

Week	Session	Hypnosis	Intervention
Phase 1: Stabilization			
1	1	*	Teaching client self-hypnosis and anxiety control
2	2		Client informed of PTSD diagnosis
3			
4	3	*	Age regression to a happy childhood experience
Phase 2: Systematic uncovering			
5	4		Explored feelings associated with abortion
6	5	*	Uncovering age regression
7	6	*	Age regression to the experience of her abortion
8	7		Explored anger relating to her partner
9	8		Explored identification with the fetus and grief for fetus
10	9	*	Mourning ritual
Phase 3: Interpersonal and intrapersonal development			
11	10		Moving on; reviewed progress made
12	11		'Anniversary' imminent; client reports recent nightmares
13			
14			
15	12	*	'Re-scripting' nightmares
16			
17	13	*	Past/future intervention to consolidate progress

Appendix II

Usefulness of hypnosis questionnaire

This questionnaire was administered at the end of treatment and each row of three response boxes was preceded by the response scale. For the purposes of this report all seven sets of response boxes are presented under a single header and the number circled by the client is shown in the bottom right corner of each. The first box of each row was completed in advance by the experimenter the second and third boxes were completed by S.

The questionnaire

It would be very interesting and useful to have your opinions about how hypnosis might have helped you. The following is a summary of what we have done in the counselling. Could you please add comments in the spaces provided and also circle the number which describes best how you NOW feel each particular hypnosis session helped you with your problem(s).

1	2	3	4	5
Not at all helpful				Very helpful

What we did in hypnosis	What did this feel like?	How might this have helped?	
<p>Week 1/Session 1 You were introduced to hypnosis, taught a relaxation technique and in hypnosis you were asked to let a special word come to mind — this was ‘forgiveness’</p>	<p><i>‘I felt relaxed for the first time in months. It felt like a release of the tension that had built up in me as a result of the pain I felt.’</i></p>	<p><i>‘I think it began to help me with the panic attacks almost immediately. It was good to feel relaxed which is not something that I’d felt in a long time.’</i></p>	4
<p>Week 4/Session 3 You watched a TV screen and watched yourself in the past having fun at your birthday party when you were six or seven.</p>	<p><i>‘Felt very vivid to see myself and remember the experience of my birthday. It made me happy to remember feeling carefree and happy.’</i></p>	<p><i>‘Again, it felt like a release of tension. I couldn’t feel happy under normal circumstances but it helped me to remember what it was like.’</i></p>	4
<p>Week 6/Session 5 You watched a TV screen and went back to a time you were bullied at school. You stood up to the bullies and had support from your older self.</p>	<p><i>‘Terrifying. This had been a frightening time and to go back was hard. Once I had stood up to the bullies I felt great as if I had released a pain that had been in my memory.’</i></p>	<p><i>‘I’d never previously “won” against my bullies and this felt empowering. I never thought that I’d be able to do this.’</i></p>	4
<p>Week 7/Session 6. You went back to the experience of your termination. Your older self comforted you.</p>	<p><i>‘Again this was terrifying. It was very vivid and “real”. My older self was able to help and provide comfort.’</i></p>	<p><i>‘I felt more in control of my decision and that although frightening the situation had not been life-threatening and that I was able to share the pain and therefore accept comfort from my older self.’</i></p>	5
<p>Week 10/Session 9. You hugged your baby on the hill in your ‘special place’. You wrapped the baby in blankets and put it away in a basket and found a way to say goodbye.</p>	<p><i>‘Challenging. I felt a mixture of emotions: sad, attachment, lonely, grief, relief and peace.’</i></p>	<p><i>‘I had not given myself the opportunity to say “good-bye” and had not felt I was able to until this point.’</i></p>	5
<p>Week 15/Session 12 You let a dream come to mind that was typical of the nightmares you have had. You re-played the nightmare and changed it.</p>	<p><i>‘Felt frightened at first as it seemed very clear and vivid but I was able to cope with it.’</i></p>	<p><i>‘Helped conquer a “demon” that had caused prolonged disturbed sleep and left me feeling shaky and upset on waking.’</i></p>	4
<p>Week 17/Session 13 You went into a room of the past and left bad feelings behind. You moved on to a room in the future and felt good.</p>	<p><i>‘I felt strong enough to reface or face bad feelings I had experienced and I felt better; a sense of relief.’</i></p>	<p><i>‘Felt able to divorce myself from these feelings and felt released from them.’</i></p>	5

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