Thesis: Doctor of Psychology

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Hypnotic Imagery as an Adjunct to the Treatment of PTSD and Extreme Distress

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LIST OF ABBREVIATIONS

BDI	Beck Depression Inventory
CADQ	Comfort with Abortion Decision Questionnaire
CBT	Cognitive-behavioural therapy
CIS	Creative Imagination Scale
DESNOS	Disorders of Extreme Stress Not Otherwise Specified
DSM IV	Diagnostic and Statistical Manual of Mental Disorders Fourth Edition
EAQ	Experience of Abortion Questionnaire
ECQ	Evaluation of Counselling Questionnaire
EGA	Elizabeth Garret Anderson (Hospital for Women)
EMDR	Eye Movement Desensitisation and Reprocessing
HADS	Hospital Anxiety and Depression Scale
IES	Impact of Event Scale
IMH	The Integrated Model of Hypnosis
IPO	Internality and Powerful Others Scale
MHAT	Most Helpful Aspect of Therapy
NSH	Negative Self-Hypnosis
PAS	Primary Attentional System
PAS	Post Abortion Syndrome
PDS	Posttraumatic Stress Diagnostic Scale
PE	Prolonged Exposure
PGS	Perinatal Grief Scale
PTSD	Post Traumatic Stress Disorder
RCI	Reliable Change Index
RSE	Rosenberg Self-Esteem Scale

SAM	Situationally Accessible Memory
SAS	Secondary Attentional System,
SCL-90	Symptom Check List-90
TRGI	Trauma Related Guilt Inventory
UCL/UCLH	University College London / University College London Hospital
UOH	Usefulness of Hypnosis' Questionnaire
VAM	Verbally Accessible Memory
VR	Virtual Reality
VVIQ	Vividness of Visual Imagery
WOCQ	Ways of Coping Questionnaire

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DEDICATION

For my parents, Sidney and Winifred Woolnough, to whom I owe so much.

DECLARATION

This is a declaration to grant powers of discretion to the University Librarian to allow the thesis to be copied in whole or in part without further reference to the author. The permission covers only single copies made for study purposes subject to normal conditions of acknowledgement.

SECTION A: INTRODUCTION TO THE PORTFOLIO

1. OVERVIEW

The present study combines a focus on two subjects both of which can elicit strong opinions, firstly, abortion and secondly, the use of hypnosis in therapy.

An article in the Guardian (Ellison, August 10th, 1999) alluded to a public opinion poll in which 42% of respondents described themselves as pro-life, an increase from 36% three years before. Similarly, anti-abortion views were illustrated in an article in the Sunday Times (November 15th, 1998) which referred to the refusal by 33% of junior doctors in the UK to perform abortions 'on moral grounds'. Reluctance to disclose an abortion to friends, or to ask for professional help for post-termination distress, can thus be regarded as understandable given the realistic concern that others might pass subtle, or not so subtle, moral judgement. The emotional impact of such attitudes towards abortion, in addition to a number of other psychological factors, can result in a highly complex emotional mix, yet the lack of attention to this subject in the psychological literature is noteworthy. Fortunately, most women do not suffer psychological problems following pregnancy termination. However, since abortion is experienced by increasing numbers of women, even the small percentage who develop psychological distress will amount to high numbers, and these women appear to be under-represented in the current psychological literature.

My training in the use of hypnosis as an adjunct to therapy and subsequent work in the Hypnosis Unit in the Psychology Department at UCL, has alerted me to the usefulness of hypnosis both as a tool to understand and treat this problem. Yet negative attitudes towards hypnosis expressed by certain mental health professionals (and members of the

public), sometimes restrict opportunities for clients to experience therapy that includes hypnotic techniques.

In recent years there has been a number of influential studies published in high profile peer reviewed journals involving the use of hypnosis as a research tool and a growing literature supporting the effectiveness of hypnosis as an adjunct to therapy for a variety of problems (e.g. Kirsch and Montomery, 1995). There are also a number of clinical reports demonstrating that hypnosis is an effective adjunct to therapies used to treat PTSD (Dolan, 1991; Spiegel, 1997; Watkins and Watkins, 1997; Solomon, Gerrity, & Muff, 1992). This is highly relevant to post-abortion distress, since, whilst the diagnostic label is contentious, it would appear that women suffering from this problem do experience PTSD symptoms. Nevertheless, there is a dearth of accounts in the literature describing the use of hypnosis applied specifically to post-abortion distress.

Included in this portfolio are two client studies. The first illustrates the therapeutic protocol used in the research study and the second illustrates hypnosis as a 'virtual reality' context, a concept referred to a number of times within the research study, particularly in context with the efficacy of hypnotic exposure interventions. Lastly, a critical review of the literature is included, the purpose of which is to examine the similarities and differences between hypnotic and non-hypnotic imagery techniques. If hypnosis is to become a more widely used adjunct to therapy it is important that these differences and similarities are clearly articulated and properly examined.

2. THE RESEARCH COMPONENT

Clients who have received therapy at the Hypnosis Unit for psychological difficulties following abortion have generally indicated that they were previously reluctant to ask for help since they believed that their symptoms might not be well understood. Abortion politics and the stigma attached to abortion would appear to be additional factors that hinder women from seeking the support they need. This study attempts to address the gap in the therapeutic literature regarding the psychological treatment of this problem, which has the potential to affect women unnecessarily for years, and possibly a lifetime.

The study investigates the nature of post-abortion distress and examines a therapeutic package in which hypnosis is used as an adjunct to therapy for women who have difficulty in resolving psychological issues related to the experience of abortion. The first part of the study examines the nature of post-abortion distress in context with mainstream psychological theories as well as findings from recent hypnosis studies. The purpose of this is to contribute to the understanding of post-abortion distress so that health professionals might be better equipped to help women affected. Of particular interest is the possibility that hypnosis theories may provide insights into the nature of the problem, for example whether hypnotic suggestibility might be a relevant factor in the development and maintenance of the problem, a consideration that has not previously been addressed in the literature.

The potentially high hypnotisability of PTSD sufferers suggests that the adjunct of hypnosis to therapy may be particularly appropriate for post-abortion distress (Evans, 2003; Spiegel, 1997; Stuttman and Bliss, 1985). However, no studies have examined the use of hypnosis in the treatment of PTSD following termination of pregnancy. Thus, the second part of the study systematically investigates the use of hypnotic interventions

as a potentially effective addition to therapy for this problem. A therapeutic protocol used in the treatment of 5 women suffering from PTSD following abortion is examined and the hypnotic interventions are evaluated by psychometric measures as well as by subjective feed back from the participants.

3. THE CLIENT STUDY COMPONENT

Two client studies are included. The first describes therapy for 'Sophie', a 23–year old woman suffering from PTSD following termination of pregnancy, in which hypnosis has been used adjunctively. This has been included to illustrate the therapeutic protocol examined in the Research Study component. This experimental client study monitored 'Sophie's' symptomatic changes throughout the course of therapy. The results indicated that she regarded the hypnotic interventions to be central to her psychological resolution. Psychometric measures administered prior to commencement of the course of therapy, on completion of therapy and at a one-year follow-up confirmed that her progress was maintained.

The second client study examined therapy for 'Sarah' who suffered from an environmental phobia. This study has been included to illustrate hypnosis as a 'virtual reality' context, a concept that has been explored in the Research Study component. This case illustrates the use of hypnosis as an adjunct to therapy in phobia treatment. Hypnotic interventions included covert desensitisation, in which the 'Sarah' re-framed her fears and transformed fear-related images so that they no longer caused her distress. These interventions were experienced by her as having an 'as real' quality and successfully reduced her long standing fear of the wind within 3 sessions. This improvement was maintained at 18 months follow-up. This outcome is discussed in

relation to 'virtual reality' approaches to phobia treatments and ways in which hypnosis may facilitate cognitive behavioural techniques.

4. THE LITERATURE REVIEW

This review was written, firstly, in response to the author's observation that clients, who have previously experienced CBT imagery interventions, often comment that these feel different to hypnotic interventions involving imagery, and secondly, in response to comments made by some clinical and counselling psychologists attending introductory hypnosis workshops (pers com VW), that hypnotic techniques are simply guided imagery techniques. The purpose of this review is therefore to examine the use of imagery in therapy within both hypnotic and non-hypnotic contexts and to evaluate whether or not these strategies are essentially the same or different. It was decided to focus, in particular, on imagery used in CBT for the treatment of PTSD, since these techniques are frequently reported in the CBT literature (Foa and Meadows, 1997). The review examines the efficacy of imaginal exposure in the treatment of PTSD and describes hypnotic and non-hypnotic imagery interventions used in exposure therapy. Client studies are then reviewed that illustrate the use of these techniques in the treatment of PTSD. It was thus decided to include this review in the portfolio as the issues explored are highly relevant to the Research Component.

5. PERSONAL STATEMENT

This portfolio reflects my professional interests working as a Chartered Counselling Psychologist specialising in the use of hypnosis in therapy. I have been particularly struck by the intensity of pain experienced by women suffering from post-abortion distress and their struggle to cope, very often in the total absence of support or understanding given to those suffering from less stigmatised traumas. It would seem that

the psychological needs of these women have been largely neglected. I have attempted in this thesis to address this shortfall by examining the psychological complexities of the problem and to evaluate a protocol informed by psychological theories, including recent hypnosis studies which have provided particular insights. It has been my intent to present an understanding of the problem from a perspective that is not driven by undercurrents of abortion politics. It is hoped that this study will provide guidance for therapists helping clients with this very distressing problem.

REFERENCES:

Dolan, Y. (1991). *Resolving Sexual Abuse,* New York: Norton.

Ellison, M. (1999). Abortion cuts crime says study, *The Guardian,* (August 10th)

Evans, B.J. (2003). Hypnosis for posttraumatic stress disorders *Australian Journal of Clinical and Experimental Hypnosis, 31,* 54-73.

Foa, E. B. and Meadows, E.A. (1997). Psychosocial treatments for posttraumatic stress disorder. A critical review. *Annual Review of Psychology, 48*, 449-480.

Kirsch, I., Montgomery, G., and Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 63,* 214-220.

Solomon, S. D., Gerrity, E. T., and Muff, A. M. (1992). Efficacy of treatments for post-traumatic stress disorder: An empirical review, *Journal of the American Medical Association, 268,* 633-638.

Spiegel, D. (1997). Hypnosis in the treatment of post traumatic disorders. In Rhue, J., Lynn, S., and Kirsch, I. (Eds.), *Handbook of Clinical Hypnosis,* Washington, DC: American Psychological Association, pp 493-509.

Stutman, R.K. & Bliss, E. L. (1985). Posttraumatic stress disorder, hypnotisability, and imagery. *American Journal of Psychiatry, 142*, 741-743.

Watkins, J. G., and Watkins H. H. (1997). *Ego States: Theory and Therapy*. New York: Norton.

SECTION B: THE RESEARCH COMPONENT

THE NATURE OF POST-ABORTION DISTRESS AND THE USE OF HYPNOSIS IN ITS TREATMENT

ABSTRACT OF RESEARCH STUDY

Research into post-abortion adjustment has been hindered by abortion politics and there has been a dearth of research into effective therapy for this problem. In general, studies have provided a limited understanding of the psychological mechanisms involved. The debate about the validity of Post Traumatic Stress Disorder (PTSD) as a diagnosis for severe post-abortion distress seems inadequately informed by current theories of PTSD (Brewin, Dalgleish, & Joseph, 1996), for example, the role that dissociation may play in both the development and maintenance of the problem. The high hypnotic suggestibility of PTSD sufferers is well documented (Spiegel, 1997) and clinical experience, as well as clinical reports (e.g. Brien and Fairbairn, 1996) suggest that women suffering from post-abortion distress may be highly suggestible to social cues, yet no studies have investigated the hypnotic suggestibility of women suffering from post abortion distress. Hypnosis theories appear to be under-represented in the mainstream clinical literature yet can provide considerable insights into the psychological mechanisms of a range of clinical problems and hypnosis has been shown to be an effective clinical tool (Cardena, 2000; Spiegel, 1997). The aims of the present study were thus to explore the characteristics of women suffering from post-abortion distress and to investigate the effectiveness of hypnosis as an adjunct to therapy for this problem, in context with a model of hypnosis (Brown and Oakley, 2004). Results suggested that the participants shared characteristics which were associated with their symptoms such as significantly higher hypnotisability than a normative sample, a tendency towards fantasy proneness, and imaginative involvement. The therapeutic protocol was followed by improved mental health of all five participants who received therapy. Analysis of the psychometric measures, calculated by the Reliable Change Index (Jacobson and Truax, 1991), indicated that the majority of measures showed reliable change had taken place following completion of therapy and overall progress was sustained at 16–18 months follow-up. The study concluded that women affected by PTSD following termination of pregnancy, social psychologists and therapists might all benefit from understanding this problem from the perspective of a psychological model that is not driven by undercurrents of abortion politics.

CHAPTER 1

INTRODUCTION

The study begins with a brief review of statistics relating to numbers of abortions carried out in England and Wales and the effect that abortion is estimated to have on mental health. Abortion politics are then considered in context with abortion research. Symptoms of post-abortion distress are examined and the controversy surrounding the diagnostic labelling of post-abortion distress is discussed. The limitations of abortion research methodology are outlined. Post-abortion distress is then examined within the context of psychological theories of dissociation, PTSD, grief, suggestibility, empathy, brain imaging studies and theories of hypnosis. Finally, a framework for both understanding, and treating, post-abortion distress, is presented.

1. 1 Background

Department of Health statistics indicate that 181,600 abortions took place in England and Wales in 2003, an increase of 3.2% on the previous year. Most abortions were carried out between 9-12 weeks gestation. One woman in three will have had an abortion by the time that she is 45 (Royal College of Obstetricians and Gynaecologists, 2004).

The Birth Control Trust (BCT) reports that abortion is a safe medical procedure and that physical complications are very rare (Paintin, 1997). The BCT also estimates that, each year, about 3 per cent of women will have long-term psychological difficulties following an abortion – a percentage representing a possible 5,500 women. With accumulation of numbers over time, it is likely that many thousands of women in

England and Wales may be experiencing distress associated with a past abortion.

1. 2 Abortion research and political issues

An early review of studies between 1935-1961 examining the psychiatric sequelae of abortion (Simon and Senturia, 1966) drew attention to a particular issue regarding this topic - that interpretation of data may be biased by political (i.e. pro-life or pro-choice) views. Nearly thirty years later a similar point was made by Wilmouth (1992) in his editorial comment of a special issue of the Journal of Social Issues. Published at a time of renewed pro-life / pro-choice debate in the USA, this issue provided a forum for the main contributors to abortion research, drawing together the central arguments concerning abortion and mental health. Wilmouth made particular reference to abortion politics, identifying researchers who had allegiance to pro-life or pro-choice views. Acknowledgement of these polarised standpoints in a respected, peer-reviewed journal reflects the intensely emotional backdrop behind much of the research into this topic. Findings of research into psychological adjustment following abortion cannot, it seems, be viewed out of context with abortion politics.

Another consideration is that much of the literature on this topic has been published in the USA where state abortion provision is not widely available and where the subject triggers 'unremitting fury' (Hadley, 1996). Notwithstanding abortion provision differences, the USA and UK share similar exposure to the well rehearsed pro-life versus pro-choice debate, including strong reactions to events that might threaten either side's argument within this debate.

In spite of the political agendas of both sides of the debate and differing opinions about *why* some women may experience post-abortion distress, it would appear that there is

agreement that some women do experience psychological problems following pregnancy termination (Paintin, 1997) whilst reviews of the literature generally conclude that following abortion women do no worse than those who give birth (see Bradshaw and Slade, 2003). Particular foci in the investigation of post-abortion adjustment fall broadly within two areas, the examination of cognitive predictors of psychological adjustment and psychosocial factors that may mediate adjustment.

1. 3 Cognitive styles and psychological adjustment to abortion

In conceptualising abortion as a stressful life event in which individual differences in styles of coping are likely to influence ability to cope, abortion researchers have drawn upon theories developed from stress research carried out in the 1970s and 1980s (Lazarus & Folkman, 1984; Cohen and Wills, 1985; Kobasa, 1979). A study by Cohen and Roth (1984), for example, found that an avoidant coping style is predictive of greater anxiety and depression following abortion, whilst an active coping style is predictive of better adjustment. It should be noted, however, that assessment of mood took place only 5 hours following the procedure and the study therefore says nothing about longer-term adjustment.

Major, Mueller and Hildebrandt (1985) further contributed to this line of enquiry by addressing, 'self efficacy expectations' (Bandura, 1977, 1982), i.e. a style of coping that both initiates and sustains coping behaviours. Using a random sample of over 247 women, Major et al (1985) asked participants how well they expected to cope with their abortion and found that those who expected to cope well were likely to do better. This study was repeated with another sample of 283 women who were asked more specific questions relating to coping with the abortion (e.g. to what extent the participants were able to think comfortably about babies) and results again showed that pre-abortion self-

efficacy was related to positive post-abortion adjustment (Mueller and Major, 1989). A weakness of these studies, however, is that results were based on data collected just 30 minutes and 3 weeks following the abortion.

Another study (Major and Cozzarelli, 1992) investigated not only the woman's coping expectations, but also those of her partner. Results indicated that women whose partners did not expect to cope well with an abortion were more likely to be depressed following the procedure, as measured by the Beck Depression Inventory (BDI) (Beck and Beck, 1972) and that this was particularly true when the woman herself had negative expectations of coping.

Attributional style, as a predictor of the ability to cope with negative life events, has particular relevance to post-abortion adjustment. Studies have shown that those with a tendency towards an attributional style that is global (e.g. generalises difficult feelings from one aspect of life to all aspects of life), internal (i.e. blames self for negative events) and stable (e.g. feels the problem cannot be changed) are more likely to cope poorly and become depressed (Abramson, Seligman and Teasdale, 1978). Furthermore, when a distinction is made between characterological and behavioural self-blame (Janoff – Bulman, 1979) studies have shown that self-character blame may lead to particular distress following abortion. For example, Major et al, (1985) and Mueller and Major (1989) have consistently found that women who blamed their character or another person for an unintended pregnancy had higher scores on the Beck Depression Inventory (Beck and Beck, 1972) than those who blamed their behaviour. These authors interpret their results in the light of Janoff-Bulman's findings (1979) suggesting that behavioural self-blame is associated with the individual feeling more in control of events, whilst character self-blame is associated with feeling less in control.

1.4 Social factors and psychological adjustment to abortion

i) The abortion decision

Pregnancy termination takes place in a social context and this may directly impact upon psychological adjustment. For example, Adler (1992) highlights the wide range of reasons why women decide to have an abortion and the inadequacy of the generic term 'unwanted pregnancy'. She points out that an abortion decision may be made within a wide range of pregnancy contexts including one in which a genetic defect has been diagnosed, an 'out of time' pregnancy (e.g. when existing children have grown up, or during adolescence) or indeed when a pregnancy has resulted from rape. Russo, Horn and Schwartz, (1992) observe that there is a tendency to stereotype women who have experienced a termination as 'selfish' and argue that the decision to have an abortion is often motivated by concern and responsibilities towards others. Similarly, Hadley (1996) questions depictions of a woman who has had an abortion, as 'the ultimate hedonist, indulging in her own convenience, for her own selfish reasons' (p185). Such prejudice reflects findings of a study by Crandall and Moriarty (1995), in which physical illnesses caused by certain behaviours (as opposed to causes that the person has no control over) were found to lead to rejection by others and the withholding of help.

Studies examining the decision-making process in relationship to post-abortion adjustment have shown that greater difficulty in making the decision is followed by poorer adjustment (Shusterman, 1979; Osofsky and Osofsky, 1972; Payne, Kravitz, Notman and Anderson, 1976; Bracken, M.B., Klerman, L., & Bracken, 1978; Adler, 1992). Likewise, initial commitment to a newly discovered pregnancy, is associated with depression, guilt and hostility should the pregnancy be terminated (Lydon, Dunkel-Schetter, Cohan and Pierce, 1996). Similarly, Major et al (1985) found that women who attached more meaning to their pregnancy were more likely to anticipate not coping

well with the abortion and reported more physical symptoms immediately following the abortion. For some woman, particularly those in the USA, the abortion experience may be accompanied by anti-abortion picketing. Such experiences have been shown in a study by Cozzarelli, Major, Karrasch and Fuegen (2000) to lead to greater guilt (rather than anger) in women who were already conflicted about their decision. Most studies have found that religious beliefs (particularly Roman Catholicism) and belonging to a culture that is generally anti-abortion may predict difficulty in making an abortion decision and subsequent post-abortion adjustment (e.g. Osofsky and Osofsky, 1972; Lask, 1975; Payne, Kravitz, Notman and Anderson, 1976). In contrast, however, a more recent study by Russo and Dabul (1997) found no evidence that either race or religion affected adjustment.

ii) Abortion in the public eye

A recent UK televising of an abortion procedure entitled '*My Foetus*' (Black, Channel Four, April, 2004) resulted in an upsurge in the airing of both pro-life and pro-choice opinions in the media (Day, The Sunday Telegraph, April 11th, 2004; The Guardian, May 4th, 2004). Similarly, Hadley (1996) noted earlier intense and polarised public reaction following the showing of ultrasound images of an abortion procedure in a film, '*The Silent Scream*', which was used by anti-abortionists to support their views. This same film was, on the other hand, described by a professor of Obstetrics and Gynaecology (Campbell, The Times, 3rd February, 1989) as "misleading and unfair" for suggesting that a 12-week foetus is capable of feeling pain (see also Derbyshire, 1995).

Ultrasound imagery may also have influenced the public's conceptualisation of foetal development. Imagery of a recognisable human form is more likely to evoke an

emotional response than rational consideration of the underlying stage of foetal development. It has been argued that when such emotive imagery is accompanied by anti-abortionist language, public opinion can be led into uncritically reacting against abortion, judging the women involved as 'murderers' of their 'unborn babies' (Hadley, 1996). In describing a practice in one state of America where women are obliged to view their foetus on an ultrasound screen before they are allowed an abortion, Hadley (1996) goes as far as to label the ultrasound pregnancy scan 'a torture weapon against women'.

The professionals responsible for abortion procedures may remain the only people that a woman ever discusses her abortion with and the impact of their attitudes on psychological well being following abortion cannot be underestimated (Lemkau, 1988). Views on the issue of abortion by health professionals are mixed. An article in the Sunday Times (15th November, 1998), for example, reported that 33% of junior doctors in the UK refused to perform abortions 'on moral grounds'. Other newspaper articles relate disturbing accounts of insensitive treatment within the health care system. For example, Revill (Evening Standard, 14th June 2000) wrote of the 'dozens' of women who described being shocked by their 'conveyer belt' treatment in clinics run by a national abortion care charity. Furthermore she highlighted the possibility that such treatment might be widespread, since the taboos surrounding the subject may leave women feeling unable to complain.

The opinions of the general public on this issue may also add to the difficulties experienced by women suffering from post-abortion distress. For example, an opinion poll conducted in 1998 by the New York Times confirmed the strength of feeling about the subject, revealing that 50% of Americans believe "abortion" equates to "murder".

There is also evidence that views against abortion are currently becoming more prevalent in society. An opinion poll taking place in the UK in 1999 for example found that 42% of respondents described themselves as pro-life, an increase from 36% in the same poll three years earlier (Ellison, Guardian August 10th, 1999). An increase in negative attitudes towards abortion has also been observed by a hospital chaplain (pers. com., July, 1998) who attributed this to an increase in right wing evangelicalism witnessed in the church in recent years. Thus, for women who are sensitive to the views of others, negative societal responses towards abortion may increasingly be a factor contributing to post abortion distress. Moreover, opinion polls may further polarise views on the subject, giving credence to extreme views and implying permission to judge women adversely for having had an abortion.

iii) Social support and abortion

Given the relative high levels of public condemnation of abortion, it is not surprising that only two-thirds of women may disclose abortion to a friend and that less than 25% will tell their parents (Major, Cozzarelli, Sciacchitano, Cooper, Testa, Mueller, 1990; Major, Zubeck, Cooper, Cozzarelli and Richards, 1977). Thus, many women keep an abortion a closely guarded secret motivated by the possibility that others will disapprove (Lane and Wegner, 1995; Pennebaker, 1993), a behaviour that can be conceptualised as an adaptive coping strategy providing protection from the realistic expectation that an abortion disclosure may be met by lack of support (Llewellyn and Pytches, 1988), disapproval and negative reactions by others (Major and Gramzow, 1999). Keeping an abortion secret may, however, lead to an intense preoccupation with it (Lane and Wegner, 1995) or, conversely, to avoidance of thoughts associated with it. Shutting off thoughts and feelings can also result in the subsequent development of intrusive thoughts that come to mind at unexpected times (Horowitz, 1997).

Some theorists (e.g. Pennebaker, 1997; Horowitz, 1997) suggest that disclosure of a secret, and talking about the associated feelings and thoughts, will lead to reduction of distress. However Major and Gramzow (1999) found that in their sample of 442 women, disclosure resulted in even *more* intrusive thoughts and concluded that the social stigma attached to abortion has, in some sections of society in effect, created a double bind in which disclosure is likely to lead to further, rather than reduced, distress.

1.5 Symptoms of post-abortion distress

Flashbacks to the abortion have also been reported by women suffering from post abortion distress, sometimes triggered by gynaecological examinations or exposure to babies and pregnant women (Spekhard and Rue 1992). Brien and Fairbairn (1996) write of the initial relief frequently expressed by women immediately following an abortion and suggest that once the euphoria has worn off women may find themselves unexpectedly experiencing sadness and grief. They also suggest that the secrecy associated with an abortion, alongside a desperate need to avoid confronting such painful feelings, may contribute to feelings of unreality and a sense of detachment from the world.

Dana (1984) describes detachment as a sense of dream-like disconnection, as if everything is seen through a glass wall and even an uncertainty about whether the abortion had really happened. Bagarozzi (1994) similarly observes denial of feelings following abortion, as well as attempts to deny that the abortion took place. Dana (1984), in emphasising the complex nature of grief following abortion, stresses the confusion felt by some women who find it difficult to integrate unexpected unbearable feelings of loss along with the knowledge that the loss occurred as a result of a decision made by the woman herself. Ashurst (1990) suggests that these conflicting feelings,

especially when accompanied by ruminations on what a woman believes to be selfish reasons for having the termination, may lead to a form of survivor guilt.

Brien and Fairbairn (1996) observe that women presenting for post-abortion counselling have experienced their abortions as a particularly complicated, agonising and overwhelming loss. They note that severity of distress frequently relates to the degree to which a woman may have become emotionally attached to her foetus and that unsuccessful completion of mourning may lead to being persistently haunted by the pregnancy.

Erikson (1993) alludes to accounts of ruminations about what the child would have looked like (if it had been born) as well as anniversary reactions, not just at the time of the abortion, but also at the time when the birth would have taken place. Spekard and Rue (1992) similarly describe a preoccupation with characteristics of the 'foetal child', who is sometimes given a name and to whom the woman continues to remain attached beyond the abortion. Furthermore, they cite reports of visual and auditory hallucinations of the child, as if it had not been aborted and suggest that this reflects a symptom of grief experienced in over 50 per cent of people who have lost a loved one, representing a desire to reverse the loss (Rando, 1991). Ashhurst (1990) speculates that continued fantasising about the child might be more evident in women who are anaethetised during the procedure and for whom some level of denial that the procedure actually took place is more possible.

Nightmares and disturbing dreams may also be a symptom of post-abortion distress. Spekhard and Rue (1992) observe that nightmares usually fall into 3 categories: firstly, horror about how the foetus died, secondly, fear of judgement and thirdly, a searching

for something precious that cannot be found. Brien and Fairbairn (1996) suggest that the vivid, haunting dreams frequently experienced by women suffering from post-abortion distress may serve the function of providing information about the woman's deepest (and possibly unexpressed) feelings. Likewise they speculate that panic attacks may be a manifestation of overwhelming emotional pain that can only be expressed through the body. Such physical symptoms may furthermore lead to a general somatisation and perception of ill health (Salvoskis, 1988; Brown, 2004).

Whilst some commentators might argue from their own moral standpoint that guilt is a valid response to abortion, more psychologically based formulations suggest a far more complex picture in which a mix of factors including those pertaining to personality, beliefs about oneself laid down in childhood, and social influences may determine whether or not a woman is likely to experience guilt (Brien and Fairbairn, 1996). Indeed, for some women, having an abortion may lead to a shattered identity if strong anti-abortion beliefs were previously part of her self-view (Neustatter, 1986).

Ashurst (1990) notes that guilt may be maintained by vivid intrusive memories of upsetting remarks made to women around the time of their abortion. For example, she alludes to the humiliation felt by women when, in a state of heightened arousal, they are subjected to judgmental comments by health professionals that may be ruminated on for years after the abortion. Such experiences may also lead to a build up of anger that has to be contained, either through fear of upsetting the professionals on whom the woman has to rely, or for fear of the consequences of disclosing the abortion.

Spekhard and Rue (1992) in discussing the impact of abortion on relationships observe that women may develop a feeling of anger, irritability and distrust towards men. They

suggest that anger may become self-punitive, leading to defensiveness and unwillingness to disclose emotions. Brien and Fairbairn (1996) also note that emotions following abortion may be difficult to access and that anger may emerge 'with great difficulty under layers and layers of sadness' (p152).

1.6 The classification of severe adjustment problems following abortion

Many of the symptoms described above are characteristic of Post Traumatic Stress Disorder (PTSD), an observation noted by many who work with women suffering from severe post abortion distress (e.g. Spekhard and Rue, 1992; Bagarozzi, 1994). There are, however, two contentions regarding the diagnosis of PTSD for severe post-abortion distress. The first is whether or not PTSD can be regarded as a valid diagnosis for this problem, and indeed whether it should be labelled 'Post Abortion Syndrome' (PAS), a distinctly separate category of PTSD. The second is whether the problem is as wide spread as suggested by pro-life researchers, or whether it is a rare occurrence – as argued by pro-choice researchers.

In order for PTSD to be considered a valid diagnosis for severe post-abortion distress, abortion must be recognised as being potentially traumatic. The revised DSM IV criterion for PTSD (American Psychiatric Association, 1994) no longer characterises a valid PTSD stressor as needing to be 'outside the range of normal human experience' (as was the case in DSM III, American Psychiatric Association, 1987) but stipulates that the reaction to the stressor must have evoked an intensely negative emotional reaction (e.g. terror, grief etc). On this basis, if an abortion is experienced as traumatic and evoked a severe reaction, it would warrant inclusion as a traumatic event. Nevertheless, extreme pro-choice abortion politics has largely disregarded DSM IV criteria for PTSD choosing instead to focus on the benign nature of abortion and evaluating negative

reactions to abortion as an abnormal response.

Lee and Gilchrist (1997), for example, argue that abortion is a common, normal experience that women should be able to integrate into their lives and that any psychological difficulties following abortion are due to issues relating to the woman, not the abortion itself. Likewise Russo (1997) asserts, "There is no need to construct abortion as a traumatic event. You can make it an event that is benign, means little, and simply deals with the consequences of unwanted pregnancy". In putting emphasis on the normality of abortion, pro-choice abortion researchers have thus created an impression of women who experience severe psychological difficulties following abortion as psychologically weak.

Spekhard and Rue (1992) criticise pro-choice abortion research for implying that post abortion distress reflects a type of pathology and for failing to acknowledge that abortion can be traumatic even for psychologically healthy women. However, in referring to abortion as 'a violation of parenthood' their own argument takes on an apparently judgemental quality.

It is widely accepted in the relevant literature that PTSD does not automatically follow a traumatic experience (Keane and Wolfe, 1990; Kessler, Foster, Saunders and Stang, 1995) and there is an increasing awareness that the majority of people show a great resilience to trauma (Bonano, 2004). Nevertheless there is also wide acceptance that some people are more vulnerable to PTSD than others (Halligan and Yehuda, 2000). A number of factors that may increase vulnerability to PTSD have been investigated in the wider literature. These include childhood trauma (Speigel, 1991); being female (Breslau, 1998); chronic stress (Davidson and Smith, 1990); previous mental health

(Breslau, Chilcoat, Kessler, Peterson & Lucia, 1999b); dissociation at the time of trauma (Bremner, Southwick, Brett, Fontana, Roesenheck, Charney 1992; Speigel and Cardena, 1991); biological factors such as low cortisol levels (Bremner, Southwick, Brett, Fontana, Roesenheck, Charney 1992; Speigel and Cardena, 1991; Yehuda,, Resnick, Kahana,, & Giller, 1993a) and the particular nature of the specific trauma (Breslau, 1999a).

Whilst much abortion research has dismissed abortion as a traumatic event, PTSD research (e.g. Horowitz, 1986; Brewin, Dalgleish, & Joseph, 1996) has taken a broader view on what constitutes a trauma, suggesting that PTSD may follow the violation of basic assumptions about oneself and one's connection with the world, however this might occur for the individual. Such research acknowledges the effect that PTSD can have on individuals and does not disregard common traumas such as car crashes and rape on the basis that they, like abortions, are frequent occurrences.

Irrespective of the political debate, however, the labelling of severe reaction to abortion as PTSD appears to be increasingly acknowledged following the revised DSM IV criteria and the use of PTSD measures has been included in several studies (e.g. Slade, Heke, Fletcher and Stewart, 1998; Miller, Pasta and Dean, 1998). Major, Cozzarelli, Cooper, Zubeck, Richards, Wilhite and Gramzow, 2000 included a PTSD measure adapted from the Impact of Event Scale (IES, Horowitz, Wilner and Alvarez, 1979) when examining the mental health of women following abortion. A random sample of 882 women attending an abortion clinic were targeted, of whom 442 returned questionnaires given to them one hour after the procedure. These women were contacted at one month and 2-year follow-ups. Fewer questionnaires were returned at each time point and by the 2-year follow-up only 50% of women responded of whom

1% scored positively for PTSD. This rate is lower than the national (i.e. American) average for a group matched for age and gender (quoted by the authors as 2%) and these results were interpreted by Major et al (2000) as indicating that mental health of this sample of women did not decline following an abortion.

Nevertheless there remain considerable inconsistencies in the literature. For example, a study by Barnard (1990), in which questionnaires, including an adapted version of the IES (Horowitz, Wilner and Alvarez, 1979) were sent out to a random sample of 984 women who had experienced an abortion 3 to 5 years earlier (yielding only 80 completed questionnaires) showed that 20% of the sample met the DSM III-R diagnostic criteria for PTSD (i.e. based on pre-revised criteria for an event to be classed as traumatic described above), a percentage considerably higher than that established by Major et al (2000).

Not surprisingly, these studies have been quoted selectively in order to advance particular points of view. Barnard's study has been frequently quoted by Speckard and Rue (1992), for example, to support their assertion that PTSD following an abortion is 'an emerging public health concern' (p95) and Major et al's study (2000) has been used to argue for the rarity of post- abortion distress (e.g. Arthur, 2003).

A number of therapists treating women for post abortion distress make reference to the unhelpfulness of views that have minimised the severity of psychological reactions following abortion (e.g. Coleman and Nelson, 1998; Brien and Fairbairn, 1996). Similarly, Spekhard and Rue (1992), in alluding to claims that PTSD is rare following termination of pregnancy, assert that professional denial may lead to an underestimation of the scale of the problem and consequent lack of psychological help for women

affected. They cite clinical reports as evidence that poor post-abortion adjustment is widespread and have proposed that post-abortion distress merits a diagnosis of Post Abortion Syndrome (PAS) as a specific form of PTSD. Other commentators such as Lee (1997), however, have dismissed this proposal as being politically motivated:

> *'I can confidently argue that there is no such thing as PAS. In fact it is no more than a term that has been invented by opponents of abortion to discredit abortion'. (Lee,1997, p42).*

Likewise, a fact sheet written for the Planned Parenthood website, focussing on the American Psychological Association's stance on the specialist label of PAS for PTSD following abortion states:

> *The fact is that anti-abortion groups have invented this condition to further their cause. The American Psychological Association does not recognise 'post abortion syndrome' (1994) and the studies that purport to prove PAS contain methodological flaws that render their conclusions nongeneralizable beyond their subjects'.*

The suggestion that a special category of PTSD should be used to distinguish abortion from other possible PTSD stressors does, indeed, seem unnecessary, but has paradoxically provided an opportunity for critics to discredit not only the PAS categorisation but, by implication, the PTSD diagnosis too. Yet, as suggested by Friedman (2000), the PTSD diagnosis can provide a helpful explanatory model both for clients and therapists. Likewise, Dolan (1991) observes that the diagnosis often leads to relief and hope. To dismiss PTSD as a potentially valid diagnosis for women who have been traumatised by abortion raises ethical considerations in that it may prevent appropriate treatment for a substantial number of women. As Coleman and Nelson (1998) point out, "unfortunately, political efforts to secure access to abortion may have

had the negative effect of obscuring the suffering of a meaningful proportion of those undergoing abortions" (p. 441).

Abortion politics may thus put pressure on therapists not to support PTSD as an appropriate diagnosis for fear of being labelled 'pro-life' and the prospect of intimidation by pro-choice activists. Moreover, appropriate treatment for this 'meaningful proportion' of women may thus be under-represented in the literature in contrast to treatments for other less stigmatised and contentious problems, denying women access to treatment that has been methodologically examined and peer reviewed.

1. 7 Abortion research methodology

Whilst there have been numerous studies examining adjustment to abortion, issues relating to the sensitivity of the subject should not be ignored. For example, women who are most distressed following an abortion are arguably less likely to respond to questionnaires given to them by researchers at this time. High attrition rates may therefore lead to biased samples. Similarly, studies (e.g. Reardon, 1987; Spekhard, 1987) using samples of women provided by pro-life groups, or groups of women who had already identified themselves as having psychological difficulties following abortion, have been criticised (Wilmouth, Alteris, and Bussell, 1992). Likewise, there is a tendency for pro-life proponents to quote mainly from case reports, a practise which does not generally gain the same credibility as research using large random samples and sophisticated research methodology (Adler, 1992). Indeed, case reports have frequently been dismissed by researchers such as Major and her associates.

A weakness of many studies that have found low levels of post-abortion distress (e.g. Major, Mueller and Hildebrandt, 1985; Major and Mueller, 1989; Cohen and Roth,

1984) is that they have analysed data from responses to questionnaires and psychometric tests administered within a very short time of the abortion, when post-abortion euphoria (Brien and Farbairn, 1996) might be the dominant feeling. Importantly, studies measuring women's adjustment shortly after the procedure do not address the more enduring distress experienced by women who present for psychological help months or years later. Cohen and Roth (1984), for example, used results of scores on the Impact of Event Scale (Horowitz, Wilner and Alvarez, 1979) administered before the abortion and just hours later, as evidence for psychological adjustment. Measures taken so soon after the procedure do not enable emotions to be tested in everyday social and environmental contexts and risk presenting an inaccurate picture. Indeed, Major et al's study (2000), which was notable for including a 2-year follow-up, reported that dissatisfaction with the abortion decision, as well as negative emotions, increased over time, showing a less optimistic picture of post abortion adjustment than was reported in earlier studies. It would seem, therefore, that long-term follow up is essential to gain a more accurate understanding of the course of adjustment, as the psychological complexities of PTSD at an individual level have generally been ignored in larger studies.

Wilmouth, Alteris, and Bussell (1992), in reviewing methodology used in abortion research, recommend that at the very least, depression, pathological grief, psychosomatic disorders and PTSD should be assessed, as should variables such as the type of abortion procedure, gestation time of abortion, type of abortion provider, demographics and psychological characteristics. They advise that only normed measures showing reliability and validity should be used and urge more clarity in the reporting of results of psychometric tests and clinically significant cut-off scores.

Another observation is that many published case reports present a psychodynamic interpretation of PTSD (e.g. Bagarozzi, 1994) following abortion. These do not address more current cognitive theories of PTSD from which a more systematic, measurable approach to therapy for post–abortion distress might be developed.

1. 8 Theories that may inform the treatment of post abortion distress

A number of theories from the wider PTSD literature offer further insights into PTSD following abortion and may inform therapeutic interventions for this problem. These are reviewed below in reference to the symptoms of post-abortion distress (see 1.5 and 1. 6).

i) Dissociation

Dolan (1991) describes dissociation as 'an unreliable defence' for the purpose of self–protection and survival, mild dissociation being similar to daydreaming and the more extreme forms possibly manifesting as total amnesia for an event. Holmes, Mansell, Brown, Fearon, Hunter, Frasquilho and Oakley (2004) have recently attempted to further analyse and clarify what is understood by the term 'dissociation' and propose that there are two distinct forms - detachment and compartmentalisation. Holmes et al (2004) suggest that 'spaced out', or 'unreal' feelings' are characteristic of detachment and that 'compartmentalisation' is characterised by forgetting, or separating off, aspects of a traumatic experience. Whilst not consciously accessible, these 'compartmentalised' memories may continue to impact on emotions and somatic responses (Brown 2002a).

Women suffering from PTSD following abortion have described both types of dissociation, for instance, unreal feelings at the time of the termination or shortly after (Brien and Fairbairn, 1996; Clinical experience VW). Likewise they have described

symptoms of non-volitional forgetting, for instance being unable to remember an aspect of an abortion, such as the month during which the abortion took place, or whether or not a scan was seen (clinical experience, VW). As Holmes et al (2004) point out the clinical advantage of being able to distinguish between these two forms of dissociation is that each type of dissociation requires a different type of therapeutic intervention. In particular, the authors suggest that, whilst treatment should include interventions to *prevent* detachment, interventions should be used that *encourage* reactivation of information that has been compartmentalised.

Similarly, Brewin, Dalgleish and Joseph's (1996) Dual Representation Theory (DRT) of trauma-related memories proposes that there are two main representations of trauma memories, firstly, nonconscious 'situationally accessible memories' (SAMs) and secondly, consciously processed, 'verbally accessible memories' (VAMS). From the perspective of this cognitive model, dissociated memories of issues related to an abortion represent the SAMS. These memories may be generally 'shut off' from consciousness but are triggered by external (e.g. hearing a radio programme about abortion) or internal (e.g. a pre-menstrual distended abdomen) cues. Memories of the abortion may manifest as flashbacks, overwhelming emotions, intrusive thoughts, nightmares or physiological symptoms of anxiety. As also described by Holmes et al (2004), such memories may be entirely compartmentalised and remain verbally inaccessible. However, the woman's ability to talk about aspects of the abortion (VAMs), even if it is just 'I had an abortion' forms part of normal biographical memory. Accordingly, in treating post-abortion distress, the SAMs would need to be accessed by exposure (e.g. by re-living techniques) and then integrated with non-threatening information so that distressing memories may be stored, more comfortably, within everyday, biographical, verbally accessible memories (VAMs).

There has been a great deal of interest in the link between trauma and dissociation in the PTSD literature which is highly relevant to post abortion distress. For example, individuals who dissociate at the time of the trauma (examples may include an experience of time distortion, a feeling of unreality, confusion etc) have shown a particular vulnerability to developing subsequent PTSD (Holen, 1993; Koopman et al, 1991). Indeed, findings of a study involving subjects who had been present during a highway collapse showed that the level of dissociation experienced at the time of the accident was a predictor of subsequent PTSD (Holen, 1993). These findings may relate to the 'unreal' feelings described by women at the time of a pregnancy termination (see 1.5.) a feeling conceptualised by Holmes et al (2004) as 'detachment'. We may perhaps speculate that women experiencing dissociation at the time of an abortion are more likely to be vulnerable to subsequent PTSD. Therapists thus need to be aware of appropriate treatment for clients who have a tendency to dissociate. For example, a therapeutic task at the beginning of therapy would need to include teaching clients anxiety reduction techniques to help them feel more in control of symptoms of detachment. Likewise, reliving techniques may be used to reactivate compartmentalised memories, so that these can be modified by new information (Holmes et al, 2004).

A number of findings have shown that some individuals have a particular tendency to dissociate (Marmar, 1997), including those who have had a history of childhood abuse (Chu and Dill, 1990), those who have experienced a number of particularly severe traumas (Carlson and Rosser-Hogan, 1991) and those of high hypnotic susceptibility (Spiegel, Hunt and Dondershine, 1988). Findings from a study by Bryant, Guthrie, Moulds, Nixon & Felmingham (2003) suggest that hypnotisability, a normally stable trait (Barber and Wilson, 1978), may possibly increase over time in the case of PTSD sufferers, and that this phenomenon may be particularly associated with those who

experience avoidant symptoms of dissociation (such as withdrawal, emotional numbing and amnesia). Cohen and Roth's (1984) study suggests that an avoidant coping style is predictive of greater anxiety and depression following termination of pregnancy termination and we may speculate that such women may also have a tendency to dissociate and are possibly highly hypnotisable. It may therefore be appropriate to consider using hypnosis as an adjunct to treatment for this problem.

ii) Complex PTSD

Another issue that has been largely ignored in the abortion literature is the consensus of opinion that 'Complex PTSD', or disorders of extreme stress not otherwise specified (DESNOS), may be an appropriate diagnosis for individuals who have experienced multiple, or ongoing, traumas in which the symptoms may be particularly severe (van der Kolk and McFarlane, 1996). Indeed, results of a study by Breslau, Davis and Andreski (1995) indicated that some individuals are more vulnerable to being exposed to trauma which the authors suggest may be related to personality or lifestyle factors. A recognition that, for some women, a severe psychological reaction to abortion may be just one of many traumas she has experienced is essential since therapy for post-abortion distress might need to address other traumas experienced too.

iii) Complicated grief

Case reports have frequently alluded to the particularly complex nature of loss associated with abortion. Horowitz (1997) has suggested that complicated grief may include symptoms of unbidden memories or intrusive fantasies related to the loss; strong spells or pangs of severe emotion related to the loss; distressingly strong yearnings or wishes that the deceased were there; feelings of being far too much alone or personally empty; excessive staying away from people, places, or activities that

remind the subject of the deceased; unusual levels of sleep disturbance; and loss of interest in work, social care-taking, or recreational activities, to a maladaptive degree. Such symptoms have also been described as traumatic grief (Prigerson, Shear, Jacobs, Reynolds, Maciejewski, Davidson, Rosen-Heck, Pilkonis, Wortman, Williams, Widiger, Frank, Kupfer, & Zisook, 1999) and show remarkable resemblance to symptoms described of post-abortion distress (see 1.5 and Walters and Oakley, 2000).

Clearly, therapy for post abortion distress may need to include some grief work. Whilst no efficacious treatment has yet been identified (Shear, Smith-Caroff, 2002) to treat such severe grief reactions, some accounts of successful interventions have been described, for example, guided mourning (Mawson, Marks, Ramm and Strern,, 1981), prolonged exposure (PE) (Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999) and Gestalt 'empty chair' techniques (Joy, 1985). These techniques show some similarity to interventions that have been described in a hypnosis context (e.g. Wadsworth, 1996; van der Hart, 1988).

iv) Suggestibility

Observation of certain psychological changes in pregnant women have been reported in the literature, for example, increased vividness of fantasies, daydreams (Brien and Fairbairn, 1996) becoming less logical and more intuitive (Condon,1987), but such changes have not been considered in context with suggestibility or indeed hypnotic suggestibility. However, one study (Tiba, 1990), investigating the use of hypnosis as an adjunct to preparation for childbirth, measured the hypnotisability of 38 women throughout pregnancy and found that pregnant women achieved a mean score of 23 (first trimester), 25 (second trimester) and 27 (third trimester) on the Creative Imagination Scale (Barber and Wilson,1978) compared to 20.7 for non-pregnant

women. These results prove an exception to the normally traditional view that hypnotisability is a stable trait (Brown and Fromm, 1986) and furthermore raises the intriguing possibility that women suffering from post-abortion distress might have become 'stuck' in a more intuitive, fantasy-prone mind set indicative of increased hypnotisability. There are parallels here to the findings of Bryant and Mallard (2003) who found that the hypnotisability of those suffering from PTSD may also increase over time (see section on 'Dissociation' above).

As referred to earlier (see 1.4), some studies have indicated that sociocultural influences, such as belonging to certain religious or cultural groups, may predispose women to psychological problems following abortion (Osofsky and Osofsky, 1972; Lask, 1975; Payne, Kravitz, Notman and Anderson, 1976). We might, therefore, speculate that those who suffer from extreme post-abortion distress may be highly suggestible in their response to sociocultural influences. However, there are no studies that have investigated specifically the suggestibility of women who experience post abortion distress, though certain studies on eating disorders may have relevance.

A study by Oakley and Frasquilho (1998), for example, found that hypnotisabilty correlated with an over-concern about body image and weight, indicating an increased suggestibility to sociocultural influences, such as 'the thin ideal'. Indeed, a review by Stice (1994) also drew attention to the link between sociocultural factors (including cultural, social, and media influences) that may lead to body dissatisfaction, negative effect and low self-esteem. Such observations are comparable to the impact that cultural, social and media influences can have on women who have had an abortion such as the 'demonisation' of women who have abortions (Hadley, 1996) and the 'sanctification' of motherhood and the state of pregnancy.

Results of studies by Wickramasekera (1984, 1991b) also have relevance to the present study, since findings suggest that both high and low hypnotisability increases vulnerability to emotional disorders and a tendency to catastrophise when faced with stressful situations. Furthermore, results indicate that this tendency is increased for those with poor coping skills and lack of social support. In the case of women experiencing abortion as a stressful life event, it may thus be speculated that those who are particularly high or low in hypnotisability, have limited coping skills and lack social support might be at high risk of emotional distress following abortion.

Suggestibility can be measured by the Creative Imagination Scale (Barber and Wilson, 1978) which correlaltes with standardised hypnotisability scales, especially when administered in a hypnotic context (Spanos, Gabora, Jarrett and Gwyn, 1989). An awareness of a woman's level of suggestibility may be helpful, therefore, not just in understanding cognitive processes that have underpinned her distress, but also in informing choice of treatment since 'hypnotic suggestibility' can be conceptualised as a 'natural talent' that can be used constructively to facilitate emotional resolution. Furthermore, as asserted by Lynne, Meyer and Shindler (2004), many established treatments for a range of emotional problems depend on the use of imagery, and imagery techniques can be enhanced when delivered in a hypnotic context (Kirsch, Montgomery and Saperstein, 1995).

v) Empathy and brain imaging studies

There are some recent studies on empathy that may also throw light on post-abortion distress. For example, Wickramasekera and Szlyk (2003) examined the ability of participants to empathise with fictional characters, such as the ability to experience compassion and tenderness towards another person's suffering, the tendency to shift

into the worldview of others and the ability to experience another person's distress. Using the Harvard Group Scale of Hypnotic Susceptibility: Form A (Shor and Orne, 1962) and the Interpersonal Reactivity Index (Davis, 1994), as a measure of empathy, Wickramasekera and Szlyk (2003) found that the ability to empathise with others is related to high hypnotisability.

Another recent study has shown that empathy for a loved one's pain may lead to the pain being actually felt by the observing partner. Singer, Seymour, O'Doherty, Kaube, Dolan and Frith (2004), using functional imaging, assessed brain activity of the female partner whist painful stimulation was applied to her partner's hand. Mirrors were set up to enable the female partner to view the painful stimulus being applied to her partner's hand as well as a large board indicating the current level of intensity. The female partner's brain activity during this procedure showed that affective pathways of pain were influenced but not the sensory pathways.

Such ability to empathise has been observed in women who identify with the feelings of their aborted foetus (VW & DO, clinical experience, Hypnosis Unit, UCL 1997 onwards). For example, women who are absorbed in a belief that their foetus may have felt victimised by the abortion, and, furthermore, identify with the emotion they fantasise the foetus to have experienced (Brien and Fairbairn, 1996). Others describe a concern that the foetus may have experienced pain during the procedure. In the light of Wickramasekera and Szlyk's study (2003) we might predict that such women are highly hypnotisable. An awareness that some women may have a particular capacity to identify, and empathise, with the foetus, and that these women might be highly hypnotisable, may be useful in the selection of effective therapeutic interventions. For example, this 'talent' to empathise could be used therapeutically in ego-state techniques,

so that the 'stronger self' is able to give strength and support to the more 'vulnerable self' (Watkins and Watkins, 1997).

Women concerned that their foetus may have felt pain will benefit from being given the factual information that foetuses in the first 26 weeks of pregnancy do not have sufficiently developed nervous systems to experience pain (e.g. Derbyshire, 1995). However, at a more emotional level, the woman may benefit from exploring her possible identification with the foetus, perhaps with re-living techniques that may reveal the source of the projected feelings so that these can be resolved. For instance, during the reliving of an emotionally significant event, cognitive behavioural techniques could be used to reframe negative and distorted thoughts (Beck, Rush, Straw and Emery, 1979). Likewise, the therapist may use schema-focused interventions (Young, Kloskko and Weishaar, 2003) to help the woman gain insight into her feelings. The effectiveness of such techniques may be enhanced if they are used in a hypnotic context (see Kirsch, Montgomery and Saperstein, 1995) with the intention to help facilitate growth and provide a narrative that constructs the abortion as a meaningful, rather than destructive, experience.

vi) The 'as real' experience of hypnosis and brain imaging studies

Studies using functional imagery have shown that suggested experiences in hypnosis have a more 'as real' quality than when simply imagined. A brain imaging study by Szechtman et al (1998), for example, has shown that highly hypnotisable participants could hear a hypnotically suggested sound and that this produced similar brain activation to when the same sounds were actually heard. This brain activation did not occur when the same participants were asked to *imagine* the sound as vividly as possible. Similar results were observed in Derbyshire, Whalley, Stenger & Oakley's

study (2004) investigating hypnotically induced and imagined pain. Other studies have also shown that, in highly hypnotisable subjects, a hypnotically suggested visual effect (a coloured light) may trigger neurophysiological responses comparable to when the actual visual effect was seen, (Bryant & Mallard, 2003; Kosslyn, Thompson, Constanti-Ferrando, Alpert and Spiegel, 2000).

This ability to experience suggested situations in hypnosis as 'real' may be an important consideration, not only when considering hypnosis as a useful adjunct to the treatment of post abortion distress, but to understand the internal world of women suffering from post-abortion distress. For example, the ongoing presence of the aborted 'child' experienced by some women following an abortion (see section 1.5) might be understood as an internal representation, self-suggested by the 'realness' of the experience and activating brain mechanisms that perpetuate the fantasy. Absorption in such fantasy may indicate a talent that can facilitate resolution too. For instance, hypnotic interventions could be used to create 'as real' experiences in order to enhance the effectiveness of CBT imaginal exposure interventions to treat both PTSD and complicated grief. In this way, the fantasied 'child' may provide a useful image that enables mourning to be completed.

Reports by clients who have experienced a particular suggested scenario in hypnosis frequently indicate that a more 'as real' quality is experienced in comparison to when the same scenario is simply imagined (Walters and Oakely, 2000). The capacity to experience suggested situations in hypnosis as real may therefore be an important factor when considering hypnosis as a useful adjunct to the treatment of PTSD. Foa and Kozak (1986) suggest that in treating PTSD, the fear must first be activated (i.e. re-lived) before it can be reduced and that at this point, new information, not present in the

'pathological state', is introduced. In this way a new, modified memory is formed in which the fear is diminished.

The adjunct of hypnosis may enable such re-living experiences, and importantly, resolutions, to be experienced particularly vividly, possibly activating similar brain mechanisms to those active during the actual occurrence of such situations. The potential value of providing PTSD clients with 'as real' experiences is further endorsed in a number of studies in which technological advances have facilitated the creation of virtual environments (e.g. Kahan, Tanzer, Darvin and Borer, 2000; Wiederhold and Wiederhold, 2000; Rothbaum, Hodges, Smith., Lee and Price, 2000).

1. 9 Hypnosis and the treatment of post-abortion distress

i) Hypnosis and mainstream psychology

Brown and Oakley (2004) note that mainstream psychology has largely ignored the contribution that hypnosis research has made to an understanding of mental processes, as well as the aetiology and treatment of a range of clinical problems. Indeed, an article on cognitive-behavioural therapy (CBT) for anxiety (Deacon and Abramowitz, 2004) published recently in a peer-reviewed journal, is representative of numerous ill-informed views on hypnosis in therapy. The authors stated:

> *'a strength of this approach [CBT] over other approaches to therapy (e.g. hypnosis) is that cognitive and behavioural techniques are derived logically from scientifically supported theoretical models of anxiety problems'* (p139).

Such representations of hypnosis are erroneous on two counts. Firstly, hypnosis is not an 'approach to therapy', but rather an adjunct to therapy. In this way a CBT therapist would use hypnosis as an *adjunct* to CBT not *instead* of CBT. Secondly, as Brown and

Oakley suggest (2004), hypnosis research is largely ignored, rather than non-existent.

ii) What is hypnosis?

The hypnosis literature has generally focussed on the quest for a theory that can adequately explain hypnotic phenomena and individual differences in hypnotic responsiveness, a quest that has been dominated by an ongoing debate between those who favour a 'state' view (i.e. hypnosis is an altered state of consciousness or special 'trance') and those who take a 'non-state', or sociocognitive, view (i.e. hypnosis is a normal, yet complex, psychological process) (see Heap, Brown and Oakley 2004 for a review). Those who subscribe to an altered state view have focussed on topics such as absorption and focussed attention (e.g. Crawford, 1994), regression (e.g. Fromm, 1992), dissociation (e.g. Woody and Bowers, 1994; Hilgard, 1979; Spiegel, 1997) and more recently, neurophysiological markers of hypnosis (e.g. Gruzelier, 1998). Those who subscribe to a non-state view have focussed on, for example, vividness of imagination (e.g. Barber, Spanos and Chaves, 1974), expectation and motivation to respond to hypnotic suggestion (e.g. Kirsch, 1991) and compliance (e.g. Wagstaff, 1991). Neither side of the debate has succeeded in developing a theory that has sufficiently accounted for the complex experience of hypnosis.

A model that integrates both views has been developed by Brown and Oakley (2004), who propose that response to suggestion involves 'trance', i.e. the ability to become absorbed and disattend to extraneous distractions, as well as a belief and expectation that hypnotic suggestion will be followed by the desired response. These factors involve normal psychological processes but nevertheless activate mechanisms that enhance receptiveness to suggestion.

iii) Hypnotic susceptibility

There is general agreement that individuals vary in their ability to be hypnotised. There are a number of hypnotisability scales that can measure a person's overall hypnotic susceptibility in clinical settings, for instance, the Stanford Hypnotic Clinical Scale (Morgan and Hilgard, 1975) and the Creative Imagination Scale (Barber and Wilson, 1978) (see Bates, 1993 for an extensive review). Hypnotic susceptibility scales measure responses to a range suggestions designed to elicit hypnotic phenomena. These may include, for example, suggestions invoking or preventing a movement (such as an arm rising or conversely suggesting that the person cannot open his or her eyes), hallucinatory suggestions (such as suggesting the person is able to hear a piece of music), 'age regression' suggestions (such as suggesting the person 'goes back in time'). However, whilst there is some evidence that hypnotisability correlates with outcome in the treatment of certain clinical problems (such as pain), hypnotisability does not generally relate to clinical outcome (Bates, 1993). Hypnotisability scales are thus most useful to establish the type of suggestions that the client is most responsive to. For example, should a client respond well to a particular type of suggestion the therapist will bear this in mind when developing a hypnotic routine for a client. As mentioned earlier, the general consensus of opinion is that the PTSD population are potentially high in hypnotisability (Evans, 2003; Spiegel, 1997; Stuttman and Bliss, 1985) a tendency which may have developed due to an ability to dissociate or become involved in imagery as a distraction from trauma-related memories (Oakley, Alden and Degun Mather, 1996).

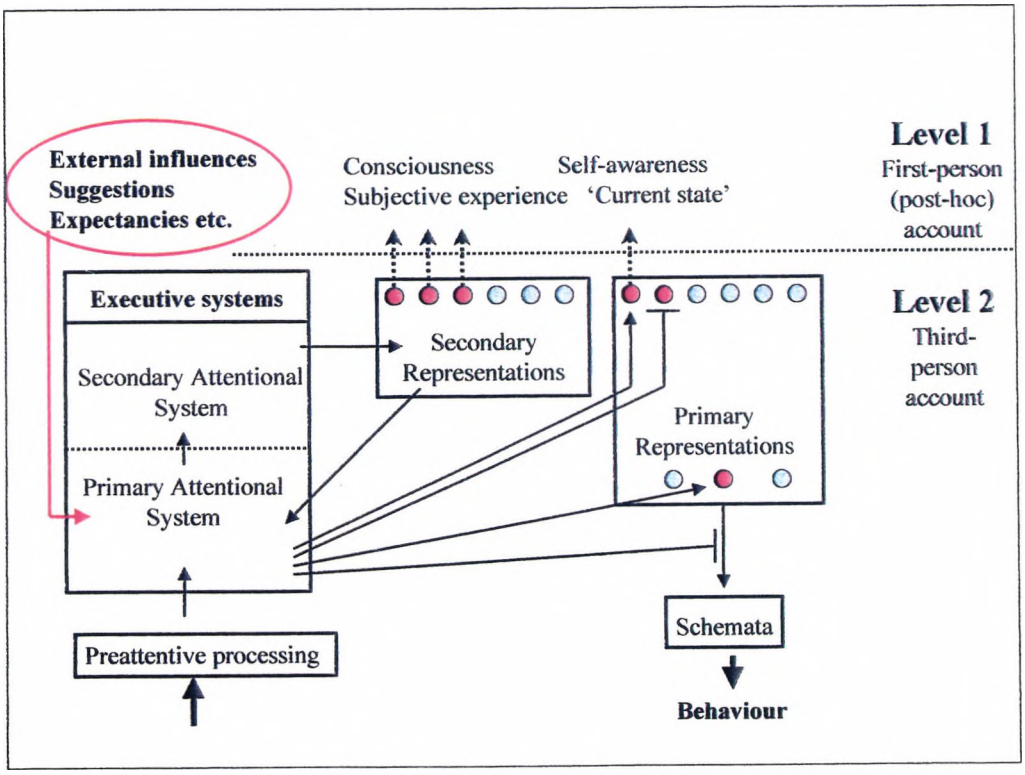
vi) A model of hypnosis in context with understanding and treating post-abortion distress

Figure 1.1 shows how the model assumes that external influences, suggestions, expectancies etc. may impact, at a non-conscious level (i.e. in Level 2), on the executive systems and that this non-conscious process determines what is experienced in conscious awareness. The model describes how, out of awareness, the executive systems, i.e. the Primary Attentional System (PAS) and Secondary Attentional System (SAS), effectively perform a joint search to make sense of incoming information based on what is available in stored representations. What is selected is mediated by, for example, prior learning and the presence of other activated representations. Selected representations provide a conscious account (i.e. in Level 1) of the current state of the cognitive system as it is represented to the outside world and recorded in episodic (autobiographical) memory.

Figure 1. 2 illustrates a model for post-abortion distress that is based on a simplified version of Brown and Oakley's (2004) integrated cognitive theory of hypnosis. The figure describes how exposure to pro-life views, mediated by beliefs about the self and influenced by activation of basic perceptual processes (including the stress response) result in activated conducive representations, which are fed into awareness (Level 1). Thus, a woman may experience an overwhelming feeling that the abortion was a terrible mistake, unaware, for example, that this feeling was underpinned by previously held feelings about herself. This feeling, when verbalised or heard as 'inner speech', in turn consolidates this belief as valid so that distress is maintained.

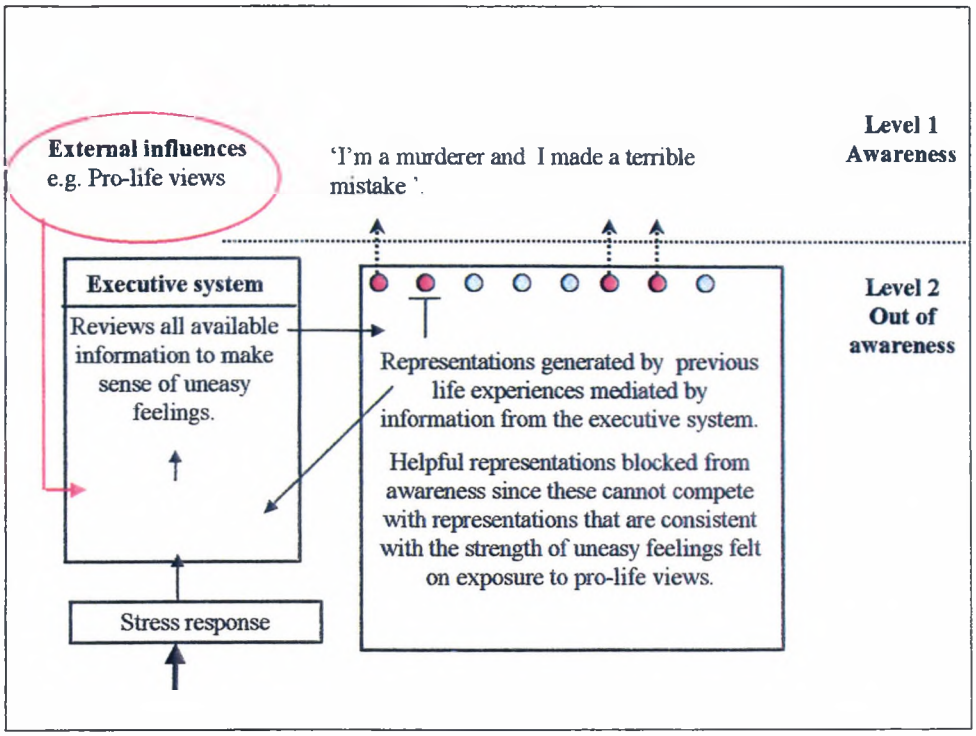
This model may be helpful both in understanding the particular processes that underpin post-abortion distress, as well as in providing a framework for treating the problem. The

model suggests that an inability to resolve an abortion is based on heightened suggestibility to social cues mediated by responsiveness to internal cues. In this way a feeling may be consciously experienced but the complex network of associations that give rise to the emotion is out of awareness. Damasio (1999) similarly describes how emotions result from an endless array of external cues, such as exposure to an image, sound, smell and internal cues as diverse as state of general health, exercise taken that day, hormones etc. Furthermore, it may be that the cue (image, sound or smell, etc) was not even consciously attended to. A related account for this type of process might be partially explained as 'emotional reasoning' (Burns, 1988) in which an individual might use a feeling as evidence for negative self-evaluation.



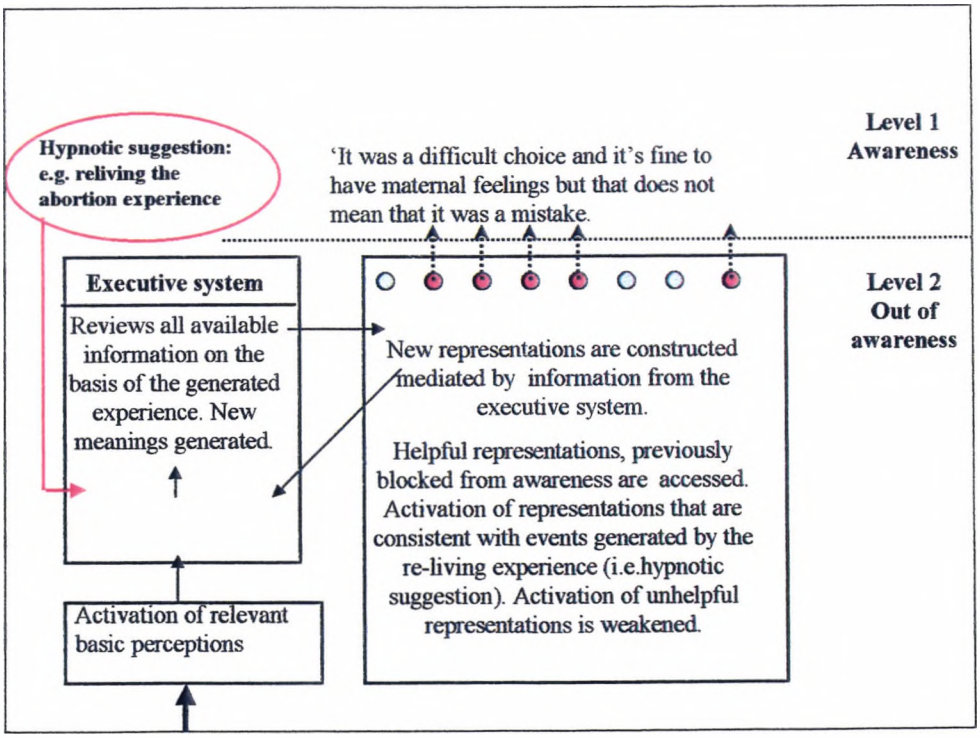
Red circle = selected representations Blue circle =non-selected representations

Figure 1.1. An integrative model of hypnosis (Brown and Oakley, 2004)



Red circle = selected representations Blue circle =non-selected representations

Figure 1.2. A model of post abortion distress based on the integrative model of hypnosis.



Red circle = selected representations Blue circle =non-selected representations

Figure 1.3. The process of change and therapeutic hypnotic suggestion.

Figure 1.3 shows how resolution may occur following interaction between hypnotic suggestion and representational systems. In this case the hypnotic suggestion triggers basic perceptual activation and facilitates a 'felt' experience of the abortion that enables new interpretations to be made. New representations are thus constructed which override previous unhelpful representations. An hypnotic suggestion may be strategically introduced by the therapist in order to indirectly challenge negative beliefs to facilitate resolution. In this way a client is able to access both new resources and resources that had previously 'resided' in Level 2 but had not contributed to Level 1 awareness. These new (or modified) representations are in turn accepted by Level 2 as valid, so that resolution and self-growth is consolidated and experienced by the client as change.

It is assumed that receptivity to suggestion is facilitated by absorption or 'trance'. As stated earlier neuro-imaging studies have shown that suggestions in a hypnotic context, especially when language is chosen carefully, can evoke an experience that is not only felt to be more real than an imagined experience but is represented as such at the level of brain activations (Szechtman et al. 1998). The Integrated Model (Brown and Oakley, 2004) accounts for this phenomenon by suggesting that expectations about hypnosis facilitate the activation of representations conducive to this expectancy. For example, an intervention may involve initially engaging the person, who believes that hypnotic procedures might be helpful, in imagery of a relaxing place. The participant closes her eyes (reducing external stimuli), is expectant that she will respond to suggestion, listens to the hypnotist's voice and becomes absorbed in the imagery suggested. Her increased absorption may then have the effect of confirming her belief that 'something is happening', which in turn increases her suggestibility to further suggestions (Brown et al, 2001). The primary attentional system becomes more active so

that thoughts become more intuitive, emotional, holistic and more automatic, whilst the secondary, more analytical, attentional system becomes less active (Gruzelier, 1988). The person feels increasingly focused on the therapist's words and 'goes with the flow'. Should the suggestion be made inviting the person to 'Go back to a time that would be useful to revisit', the suggestion is responded to without critical analysis and the person is then able to slip into responding to the therapist as if she really is, for example, 5 or 6 years old. Further suggestions, such as 'I wonder if you could look down and tell me the colour of your shoes', further engages the person in the realness of the situation. Thus, as she becomes increasingly absorbed in the process, more and more representations of being aged 5 or 6 are activated.

1.10 A therapeutic framework for the treatment of post-abortion distress.

The therapeutic framework to be examined in this project has been underpinned by theories presented in 1.8 and 1.9 in context with the following considerations.

Lemkau (1988) points out that therapists should not regard abortion as a unique therapeutic issue. She suggests that interventions may include grief work, normalisation of feelings, review of the decision-making process and possibly self-forgiveness rituals. A framework for treating post-abortion distress may need to combine these considerations whilst being informed by established protocols for treating PTSD alongside frameworks that have been successful in treating complicated grief.

There have been few systematic studies into the treatment of PTSD in general and none that have addressed PTSD following termination of pregnancy. The most researched protocols are those based on CBT and eye movement desensitisation and reprocessing (EMDR) (Shapiro, 1995). The majority of studies show that CBT (essentially involving

both anxiety management training and exposure therapy) is the most effective treatment for PTSD (Solomon, Gerrity and Muff, 1992).

Importantly, a meta-analysis by Kirsch, Montgomery and Saperstein (1995) indicates that the addition of a hypnotic context to CBT leads to greater effectiveness of therapy for a range of disorders. Moreover, the potentially high hypnotisability of PTSD sufferers suggests that it is worth considering the adjunct of hypnosis to therapy for this problem (Evans, 2003; Spiegel, 1997; Stuttman and Bliss, 1985). The successful use of hypnosis in the treatment of PTSD has, indeed, been well documented (see Cardena, 2000) but mostly in the form of descriptive case reports (e.g. Ffrench, 2000; Degun-Mather, 1997) and there is, as yet, insufficient empirical evidence to make stronger claims (Lynn, Kirsch, Barabasz, Cardena and Patterson, 2000).

Van der Kolk, McFarlane and van der Hart (1996), identify two guiding principles in treating PTSD, firstly 'deconditioning of anxiety' and secondly, establishing a 'feeling of integrity and control'. Horowitz (1986) argues that clients need to assign meaning to trauma and proposes that a combination of CBT and psychodynamic approaches facilitates this process.

A phased approach, based on these considerations, is frequently alluded to in the treatment of PTSD (e.g. van der Hart, Steele, Boon and Brown, 1993, Herman, 1992), in which stabilisation, deconditioning, restructuring and social reintegration are all addressed. Brown's (1995) 'standards of care' for treating clients suffering from PTSD proposes that a phase orientated treatment should include firstly, stabilization, secondly, systematic uncovering and thirdly, interpersonal and intrapersonal development. The therapeutic framework outlined below follows the framework suggested by Brown

(1995) whilst incorporating techniques used by Dolan (1991) to resolve sexual abuse. Dolan's techniques were further developed by Oakley and Walters (Hypnosis Unit, UCL 1997 onwards), for treating psychological problems following termination of pregnancy and it is this framework, as outlined below, that has been used in the present study.

The first stage of therapy (i.e. 'stabilization') concentrates on reducing anxiety levels, building resources (Dolan, 1991) and also beginning the process of gaining insights. The second stage involves identifying links between past and present, confronting the abortion experience in order to facilitate emotional processing (Foa and Kozak, 1986) and completing grief. The third stage focuses on self-growth (including identity issues), interpersonal issues and the future in general.

Cognitive behavioural techniques are used to reframe negative and distorted thoughts (Burns, 1989; Beck et al, 1979) and psychodynamic techniques help the client gain insight into her feelings. Ego state therapy is used to give the vulnerable-self strength and support (Watkins and Watkins, 1997). The hypnotic interventions are all client centred. For instance the client may be asked to 'return to a time that will be useful in helping you to understand your problem in a new way'. Similarly all suggestions are based on the client's own imagery goals and insights. This therapeutic framework does not assume that the abortion is the only issue that may need to be resolved, indeed it may be necessary to use this framework to deal with other issues first. Likewise, as painful emotions surface it may be necessary to introduce ego-strengthening and to access further resources. Thus it can be seen that this framework allows for flexibility so that it can meet each individual's needs.

The suggested number of sessions required to treat PTSD varies in the literature, for example, 13-18 sessions (Muse, 1986), 15 sessions (Brom, Kleber and Defares, 1989), 9 sessions (Rothbaum, Foa, Riggs, Murdock and Walsh, 1992) or 10 sessions (Scott, 2000). Clinical experience of treating clients with simple PTSD (VW and DO, Hypnosis Unit, UCL) has indicated that 12 sessions have generally been sufficient. It is anticipated that more complex cases may generally require more sessions since the stabilisation phase may need to be repeated (van der Kolk, McFarlane and van der Hart, 1996).

1.11 Introduction to the present study

As already noted, research into post abortion adjustment has been hindered by abortion politics and there has been a dearth of research into effective therapy for this problem. Whilst some attempt has been made by researchers to understand the cognitive processes of women who experience post abortion distress, these studies have provided a very limited understanding of the psychological mechanisms involved. Social factors, as identified in chapter one may play a major part in how a woman may adjust to pregnancy termination. Furthermore, the debate about the validity of PTSD as a diagnosis for severe post abortion distress seems inadequately informed by current theories of PTSD, for example, the role that dissociation may play in the possibility of developing PTSD (see 1.8). Understanding individual differences in suggestibility, alongside dissociative tendencies, may thus help to predict who may be at risk of developing PTSD following an abortion.

1.12 Research predictions

The research predictions to be examined in this study are presented below, firstly, in context with the nature of post-abortion distress and secondly, in context with therapy for the problem.

A. The nature of post-abortion distress.

Table 1.1 summarises the research predictions that a) the participants will share similar characteristics, b) they will have shared similar life experiences life experiences, and c) they will be sharing similar symptoms following their abortion experience. Measures and questionnaires used to test these predictions are indicated.

Table 1.1. Summary table of research predictions: The nature of post abortion distress.

The participants will share the following characteristics:-		
	Characteristic:	**Observed by:**
1.	Have above average vividness of imagery	Vividness of Visual Imagery (Marks, 1973) Experience of Abortion Questionnaire: version 'a' (EAQa) (Walters and Oakley, 2000): Section 6
2.	Be sensitive to the views that others have about abortion.	EAQa: Section 8
3.	Be of above average hypnotic suggestibility.	Creative Imagination Scale (Barber and Wilson, 1978)
4.	Have anti-abortion beliefs; Have religious beliefs that are associated with anti-abortion views.	EAQa: Section 8 EAQa: Section 9

5.	Have an attributional style in which they blame their character for their distress, rather than their behaviour. Have a stable, pessimistic attributional style.	EAQa: Section 10 EAQa: Section 12
6.	Have a tendency towards maladaptive, rather than adaptive, coping style.	EAQa: Sections 12, 14 Ways of Coping Questionnaire (Folkman and Lazarus, 1988)
7.	Have a perception of generally having experienced poor self-esteem prior to becoming pregnant and the abortion experience. Have low self-esteem compared to non-clinical norms.	Self-Esteem Scale (Rosenberg, 1988) (answered retrospectively) EAQa: Section 3A Self-Esteem Scale (Rosenberg, 1988)
8.	Have a perception of generally having experienced negative affect prior to the abortion experience.	EAQa: Section 3B
9.	Perceive that they have little control over events as compared with non-clinical norms.	Internality and Powerful Others Scale (Levenson, 1981).

The participants will have shared similar life experiences:-		
	Experience:	**Observed by:**
1.	Exposure to life stressors previous to the abortion.	EAQa: Section 17 Posttraumatic Stress Diagnostic Scale (Foa, 1995).
2.	Experience of previous mental health problems.	EAQa: Sections 17, 18,

3.	A negative abortion experience e.g. *insensitive treatment by professionals involved in the abortion;* *difficulty in making the abortion decision(s);* *persuasion to either have or not to have the abortion;* *a perception of poor social support at the time, and after, the abortion.*	 EAQa: Section 2 EAQa: Section 7 EAQa: Section 7 EAQa: Section 13

The participants will be sharing similar symptoms following their abortion experience, such as:-		
	Participants will be experiencing:	**Observed by:**
1.	Clinically significant anxiety and depression following their abortions. Symptoms of anxiety and discomfort which impact on daily functioning.	Hospital Anxiety and Depression Scale (Zigmund and Snaith, 1983) EAQa: Sections 4 and 16
2.	Feelings of guilt comparable to that experienced by a group widely accepted as having been involved in traumatic experiences (Vietnam veterans), and associated feelings of shame and self-rejection.	Trauma Related Guilt Inventory (Kubany, Haynes, Abueg, Manke, Brennan and Stahura, 1996) EAQa: Section 8
3.	Grief levels comparable to that of women who spontaneously abort.	Perinatal Grief Scale (Potvin, Lasker and Toedter, 1988)
4.	Negative feelings *Directly related to having had an abortion.* *In general.*	 EAQa: Section 5A EAQa: Section 5B

5.	Poor self-concept and lower self-esteem than mean scores of a non-clinical population following the abortion.	EAQa: Sections 5C Self-Esteem Scale (Rosenberg, 1988).
6.	Continued attachment to the aborted foetus.	EAQa: Section 6
7.	Dissociative experiences	EAQa: Section 11
8.	A perception that general health has been affected by the abortion experience	EAQa: Sections 15, 16
9.	PTSD symptoms that meet the diagnostic criteria for Post Traumatic Stress Disorder and severity of symptoms comparable to the norms of the PTSD population.	Posttraumatic Stress Diagnostic Scale (Foa, 1995)

B. The efficacy of hypnosis as an adjunct to post-abortion distress.

Table 1.2 below summarises the research predictions that a) the overall CBT package will be followed by improvement of the mental health of the participants and that b) during the course of therapy, the addition of particular hypnotic interventions will be followed by improvement of the participants' symptoms. Measures and questionnaires used to test these predictions are also listed.

Table 1.2. Summary table of research predictions: The efficacy of hypnosis as an adjunct to post-abortion distress.

The overall CBT package will be followed by improvement of the mental health of the participants:-		
	Therapy will be followed by:	**Observed from:**
1.	Improved scores on the psychometric tests which will relate to the participants' hypnotic suggestibility, and to the psychological history of the participant, such as previous experience of trauma.	Psychometric tests (see Table 1 above) responded to by the participants at pre therapy, post therapy and at follow up. Responses to the EAQ a: Sections 4, 5, 6, 11, 15, 16 and EAQb: Sections 1-12 EAQa: Section 17
During the course of therapy the addition of particular hypnotic interventions will be followed by improvement of the participants' symptoms:-		
	During the course of therapy participants will:	**Observed from:**
1.	Experience a reduction of anger-hostility, anxiety, depression and somatisation in response to particular hypnotic interventions.	Hopkins Symptom Checklist (Derogatis, Lipman, & Covi, 1973) rated at weekly intervals
2.	Experience increased comfort with the abortion decision in response to particular hypnotic interventions.	The Comfort with Abortion Decision Questionnaire (CADQ).

CHAPTER 2

THE NATURE OF POST ABORTION DISTRESS: METHODOLOGY

2.1 Design

As recommended by Wilmouth, Alteris, and Bussell (1992), standardised psychometric tests were used to provide norm-referenced measures against which the participants' mean scores could be compared. In particular, the Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995) was administered to establish whether the participants met the DSM IV criteria for PTSD.

A battery of questionnaires was also used. This was designed by the author of this study to identify characteristic thoughts, feelings and experiences shared by women suffering from post-abortion distress. Information was elicited through the use of open-ended questions and statements with rating scales that had anchored end-points.

The study involves two parts firstly, examining the nature of post-abort distress and secondly, evaluating a therapeutic protocol for this problem. It was therefore decided that twelve participants would be enrolled in order for the two parts of the study to be completed within the time-scale available.

A one-sample, 2-tailed *t*-test was used to compare the means of psychometric test results with the means of the non-clinical or clinical population, as appropriate (Robson, 1995). These comparisons, along with information collected from the specially designed questionnaire, were used to test the research predictions.

The project was granted approval by the joint UCL/UCLH Committees on the Ethics of Human Research.

2.2 The participants

Recruiting the participants

A poster and leaflet (see Appendices I and II) were designed to inform women of a therapeutic service for women experiencing severe post-abortion distress, which included the addition of hypnosis, at the Hypnosis Unit, UCL. These were accepted by the Elizabeth Garret Anderson Hospital for Women (EGA) and a 'well woman' clinic in an East London borough for display. In addition, a psychiatrist at the EGA agreed to refer women who were experiencing severe adjustment problems following a pregnancy termination.

A total of twelve women were initially recruited. Six of these participants (1069, 2314, 1120, 1010, 7808, 4040) self-referred after seeing the poster at EGA, two participants (2553 and 2210) were referred by a psychiatrist at the EGA; one participant (1055) was informed about the project by a clinic nurse at the EGA; one participant (1805) self-referred after she was informed about the project by a friend who had seen a poster displayed at the EGA; and two participants (2891, 2112) were referred by a counselling psychologist who worked at an outer London Community Mental Health Team.

Explaining the study to the participants

Each potential participant was informed about what was involved in taking part in the study. This was explained as an initial commitment to complete two sets of questionnaires (Booklets A and B, see Appendices IV and VI) during two separate sessions one week apart. For ethical reasons, it was explained that all participants who

completed these questionnaires would be given the opportunity to receive therapy at the Hypnosis Unit free of charge regardless of the questionnaire results. It was also explained that participants receiving therapy would be required to complete further questionnaires throughout therapy and at follow-ups (see Chapter 4).

Criteria for taking part in the study

Potential participants who indicated that they were experiencing severe distress relating to difficulty in psychologically resolving an abortion were eligible to take part in the first part of the study. Ten of the participants completed their questionnaires at the Hypnosis Unit, one in her home (participant 2891) and one in an office of the Community Mental Health Team in the participant's locality (2112). One woman (2210) was eliminated from the project because her questionnaire responses revealed that the distress she was suffering did not result from her termination. Thus, of the 12 women in the original sample, 11 were recruited into the first part of the project. Criteria for taking part in the second part of the project are addressed in Chapter 4.

Table 2.1 Demographic details of the participants in the first part of the project.

Code	Age	Marital status	Children (ages in years)	Family (ages in years)	Occupation	Working?	Living arrangements
2891	35	Married	2 girls: 11 & 3	Mother: 54 Father: 56 2 sisters: 29 & 13	NIL	NO	Living with children and husband
2112	36	Divorced.	2 girls: 8 & 6 2 boys: 10 & 4	Mother: 58 Father: 59 Sister: 35	NIL	NO	Living with children and partner
1055	45	Divorced.	1 boy: 17	Mother: 77 Father: deceased 1 brother 1 sister	Publishing	YES	Living with partner and her son.
1069	24	Single	Nil	Mother: 46 Father: 50 Sisters: 18,16, 4 Brothers: 14,13,5	Managerial charity work	YES	Shares a flat with a friend.
1085	23	Single	Nil	Mother: 52 Father: 52 Brother: 27	Managerial /media	YES	Living with friends
2553	37	Remarried	1 girl: 12	Mother: 62 Father: 66 Brothers: 33, 3 Sister: 35	Creative freelance.	YES	Living with husband and daughter from previous marriage.
2314	28	Single	Nil	Mother: 67 Father: 72 Sister: 33	Skilled outdoor work	YES	Living with partner
1120	36	Divorced	1 boy: 4	Mother: 57 Father: 61 Brother: 31, Brothers twins: 34	Local government worker	YES	Living with mother and brother
1010	33	Single	Nil	Mother: 68 Father: deceased	Receptionist	YES	Living with partner
7808	22	Single	Nil	Mother: 55 Father: age unknown Brothers: 40,32 Sisters: 25,38	Student	NO	Partly at home partly with friends
4040	40	Single	Nil	Mother: 67 Father: 70 Brothers: 45, 43	Medical profession	YES	Living with friends

2.3 Materials

Two sets of questionnaires were compiled:

i)The Experience of Abortion Questionnaire: version (a) (EAQa) (Walters and Oakley, 2000), designed specifically to examine post-abortion distress and referred to as 'Booklet A'.

ii) A compilation of relevant standardised psychometric tests, referred to as 'Booklet B'.

Booklet A was completed by the participants one week before Booklet B. Each booklet took approximately 45-60 minutes to complete.

i) The Experience of Abortion Questionnaire: version (a) (EAQa) (Walters and Oakley, 2000)

(i.e. Booklet A, see Appendix IV)

This 23-page booklet, containing 18 sections, was designed to identify patterns of thoughts, feelings and behaviours experienced by the participants. The sections are based on questionnaires used in previous studies (e.g. Mueller and Major, 1989), the abortion literature and on clinical experience, and address the research predictions.

Section 1: Demographic details

Section 1 asks questions about the participant's age, occupation, living arrangements, marital status and family. David (1985) found that separated, widowed or divorced women were at greater risk of developing psychological problems following an abortion. Likewise some studies show that older women with existing children are more vulnerable to emotional problems following abortion (Pare and Raven, 1970; Lask, 1975).

Section 2: Details about the termination / perception of professional sensitivity

To test the research prediction: 'The participants will have had a negative abortion experience'.

Questions in Section 2 asked about the participants' experience of the abortion procedure, the stage of gestation at the time of the abortion and whether or not the participant saw a pregnancy scan. An additional question asked each participant to rate (on a Likert scale) how sensitively she was treated by staff at the abortion clinic / hospital where the termination took place, ranging from 0 (not at all sensitively) to 10 (completely sensitively). The purpose of these questions was to identify any unresolved issues relating to the experience of the termination and to determine possible stressors contributing to the development of any subsequent psychological difficulties.

Initially, a section for 'second termination' was included to avoid making the assumption that the participant had had only one abortion. Later in the study, further sections were added for third, fourth, fifth and sixth abortions, in response to a participant who had had four terminations, and who expressed feelings of shame on realisation that the form only had spaces for two.

Section 3A and B: Self concept and emotions before the termination

To test the research prediction: 'The participants will have a perception of having experienced poor self-esteem prior to becoming pregnant and the subsequent abortion experience.'

Psychometric test used: Rosenberg's Self-Esteem Scale (RSE) (Rosenberg, 1989) worded in the past tense.

Section 3A is the RSE worded in the past tense, to establish *perceived* retrospective self-esteem *prior* to the pregnancy and subsequent termination. The participants were asked to indicate on a Likert scale ranging from 1-4 whether they 'strongly agreed', 'agreed', 'disagreed', or 'strongly disagreed' with the ten statements listed. The sum of scores could thus range between 10 and 40. Whilst a retrospective response to the RSE cannot provide a valid assessment of prior self-esteem, the purpose of asking this was to identify the participants' *perception* of their prior self-esteem rather than their *actual* self-esteem at the time.

The RSE is a widely used, validated measure of global self-esteem and personal worthlessness. It has a Coefficient of Reliability of 92 per cent, a Coefficient of Scalability of 72 per cent and test- retest reliability of .82. Whilst the authors of the scale do not suggest cut off points for high or low self esteem, a high score indicates high self-esteem and low score indicates low self-esteem. A recent study, using a sample of college students, found a mean score of 29.71 for non-clinical females (Cheng and Furnham, 2003).

Section 3B of the questionnaire is a list of words (e.g. shame, anger, irritability etc) used by Meuller and Major (1989) in a study examining psychological response to termination. These words were used in 3B in context with describing emotions *prior* to the termination. The participants were asked to rate these words *retrospectively* in order to establish *perceived* affect *prior* to the pregnancy and subsequent termination.

Section 4: Thoughts, behaviours and feelings about the abortion.

To test the research predictions: 'The participants will share symptoms of anxiety and discomfort which impact on daily functioning'; and 'Be sensitive to the views that others have about abortion'.

Section 4 consists of 18 statements concerning thoughts, behaviours and feelings about the abortion, in context with various situations (e.g. 'thinking about babies'). Participants were asked to rate a Likert scale to indicate how comfortable they felt about each statement, from 0 ('not at all comfortable') to 10 ('completely comfortable').

The first 10 of these statements were used in a study by Mueller and Major (1989) in order to measure perceived self-efficacy following termination of pregnancy. The additional 8 statements are based on prior clinical experience of post-abortion distress (Oakley and Walters, Hypnosis Unit, UCL 1997 onwards), as well as the literature on post-abortion counselling (e.g. Brien and Fairbairn, 1986). Some of the questions related to avoidant behaviours (e.g. 'discomfort going near the place where the termination took place') whilst others related to suggestibility to social influences. (e.g. 'discomfort on hearing public debate about abortion').

A further question asked whether there was anything else (i.e. not listed in the statements) that the participant had found uncomfortable seeing, hearing or doing, since the termination. If so, the participant was invited to write this in a space provided.

Sections 5A, B and C: Self-concept and emotions after the termination

Section 5A

To test the research prediction: 'The participants will be experiencing negative affect directly related to the abortion'.

In Section 5A each participant was asked to rate agreement with words (on a Likert scale from 0 to 7) describing polarity of possible emotions about her termination (e.g. 'relieved / not relieved', 'regretful / not regretful' etc). The rating of these emotions was used to provide information about negative affect in direct relationship to the abortion. The same list of words was used in a study by Meuller and Major (1989), in order to evaluate post–abortion adjustment.

Section 5B

To test the research prediction: 'The participants will be experiencing general negative affect'.

Section 5B is the same list of words used in 3B, but in contrast to 3B, the participants were asked to rate these words in context with feelings *since* the abortion.

Section 5C

To test the research prediction: 'The participants will be experiencing poor self-concept and low self-esteem following the abortion'.

Psychometric test used: Rosenberg's Self-Esteem Scale (RSE) (Rosenberg, 1989).

Section 5C is the Rosenberg Self-Esteem Scale (Rosenberg, 1989), as in Section 3A, but worded in the present tense (i.e. as the original Rosenberg version) and thus focuses on the participants' self-esteem at the time of responding (i.e. *after* the abortion). Sections 5A, B, and C were included to identify any commonalities of emotions and self-concept experienced by women in this group.

Section 6: Imagery and cognitions in context with the pregnancy loss.

To test the research prediction: 'The participants will have a continued attachment to their aborted foetus'

The participants were asked to rate a list of statements such as 'I think of the baby as loving me', 'I think of the pregnancy loss as a child', 'I imagine the foetus as a baby that continues to grow'. A Likert scale was used ranging from 0 ('never') to 7 ('all the time'). These questions were devised using prior experience of post-abortion counselling and also from the literature (e.g. Brien and Fairbairn, 1986). Thoughts, for example, about whether the foetus felt pain during the termination, were also included in order to identify any fears (possibly evoked from anti-abortion literature) that might be contributing towards the distress felt.

Section 7: The abortion decision

To test the research predictions: 'The participants will have experienced difficulty in making the abortion decision(s) and persuasion to either have, or not to have, the abortion'.

Greater difficulty in making the decision has shown to be related to poorer post-abortion adjustment (Shusterman, 1979; Osofsky, 1972; Payne et al., 1976; Bracken, Klerman

and Bracken, 1978; Adler, 1992). This section comprises of a list of statements describing possible ambivalence about the abortion decision (e.g. 'I feel I never really made a decision, I felt unsure even just before the termination'), which the participant was asked to rate on a Likert scale ranging from 0 ('completely' or 'strongly agree') to 7 ('not at all' or 'strongly disagree'), to indicate the extent that each statement corresponded to her feelings. Statements also relate to the influence of significant others in making the decision. This section was included in order to identify whether there was a pattern of indecision about the termination experienced by women in this sample.

Section 8: Views about abortion

To test the research predictions: 'The participants will have anti-abortion beliefs and will be sensitive to the views that others have about abortion'.

Each participant was asked to rate statements regarding the participants' own views of abortion (i.e. 'abortion is never wrong or always wrong') to indicate their abortion views both *prior* to their pregnancy and subsequent abortion, and *after* their abortion, in order to identify whether having the abortion conflicted with any anti-abortion beliefs.

Also included in this section were statements relating to views of others about abortion and how these might invoke feelings of shame or fear of rejection (e.g.' I feel like I have committed a murder'). These statements were rated on a Likert scale ranging from 0 ('completely' or 'strongly agree') to 7 ('not at all' or 'strongly disagrees'), to illustrate how each statement corresponded to her feelings. Greer (1974) suggests that negative societal response to abortion may be linked to post-abortion grief, guilt and self-punishment. Major and Cozzarelli (1992) assert that women expect harassment from negative cultural views on abortion. Clinical experience of the author of the present

study has similarly indicated that women feeling distressed following an abortion can feel considerably intimidated by anti-abortion views. Of interest to the present study is whether sensitivity to adverse comments about abortion might reflect above average scores on the Creative Imagination Scale (Barber and Wilson, 1978).

Section 9: Religion / spirituality

To test the research predictions: 'The participants will have prior religious beliefs that are associated with anti-abortion views and also continued attachment to the aborted foetus'.

Studies (Dunbar, 1967; Osofsky and Osofsky, 1972; Payne, Kravitz, Notman and Anderson, 1976) have shown that women may experience more negative affect following abortion if they had previously held negative views of abortion due to religious beliefs or cultural influences. Similarly it has been found that believers of certain faiths (e.g. of Roman Catholicism) may experience more guilt after an abortion than followers of other faiths (e.g. Protestantism and Judaism) (Osofsky and Osofsky, 1972).

Statements in this section are listed in relation to religion and spirituality, and participants were asked to rate a Likert scale ranging from 0 ('not at all') to 7 ('very') to indicate the extent to which they identified with these retrospectively (i.e. prior to the abortion), and after the abortion. This section includes the question, 'do you have thoughts of where your foetus / baby is now?' This question was asked since the author's clinical experience of post-abortion counselling identified a need to address issues relating to unfinished mourning which has often reflected continued attachment to the foetus.

Section 10: Expectations of change

To test the research prediction: The participants will have a stable, pessimistic, explanatory style.'

This section was included to evaluate expectations of change. Participants were asked to rate agreement or disagreement with 3 statements about the future ('I feel generally optimistic about the future', 'I will feel comfortable about the termination with time' and 'I will gain from the experience of the termination with time'). It was hoped that these questions would identify any commonalities in thinking style that may be a maintaining factor in post-abortion distress. Studies have shown that explanatory style (i.e. pessimistic or optimistic) is related to psychological functioning (Abramson, Seligman, & Teasdale, 1978).

Section 11: Dissociative experiences.

To test the research predictions: 'The participants will have dissociative experiences'.

Clinical experience (VW, 1997 onwards), as well as the post-abortion counselling literature (Brien and Fairbairn, 1996; Dana, 1984), has indicated that women experiencing severe post-abortion distress may experience dissociative behaviours (e.g. prolonged staring into space, the ability to convince herself for a period of time that an abortion had not been experienced, etc). Statements were therefore included in this section to identify any shared symptoms of dissociation across the participants. Participants were required to rate the extent to which they agreed with statements on a Likert scale ranging from 0 ('strongly disagree') to 7 ('strongly agree'). Statements described dissociative behaviours, such as ' 'I think of myself like two different people- the one who had the termination and the one who finds this difficult to accept'.

Section 12: Coping strategies and attributional style.

To test the research predictions: 'The participants will have a tendency towards maladaptive, rather than adaptive coping'; and 'The participants will have an attributional style in which they blame their character for their distress rather than their behaviour.'

In this section participants were asked to identify anything that had already helped them to feel better and if there was anything that could help them feel better if it were possible for it to occur.

Also included in this section are statements that describe the participants' attributional style (Abramson, Seligman, & Teasdale, 1978. These statements relate to situational blame, chance and 'other-blame'. Since Janoff - Bulman, (1979) found that 'self-character blame' is more likely to lead to depression than 'self-behaviour blame' statements are included in order to distinguish between these two types of self-blame. Each participant was asked to rate her beliefs about the cause of her distress (e.g. 'I blame myself because of something I did or did not do'), on a Likert scale ranging from 1 (not at all) to 7 (totally). Similar questions were asked by Meuller and Major (1989) in context with becoming pregnant, however it was felt more appropriate that the focus of questions for the present study should be attributions of *distress.* These questions were included to identify any patterns of coping and attributional style within the group.

Section 13: Perception of social support

To test the research prediction: The participants will have a perception of poor social support at the time of, and after, the abortion experience.'

Major & Cozzarelli (1992) assert that a woman's perception of support is particularly important as a buffer against strong 'moral sanctions against abortion in western cultures' and indeed Llewellyn & Pytches (1988) found that women experienced higher levels of anxiety when unsupported by a partner.

The statements are based on questions used in a study by Major, Cozzarelli, Sciacchitano, Cooper, Yesta, and Mueller (1990), with additional questions relating to support from partners, family and friends *after* the termination. For example, in the present study participants were asked to rate, on a Likert scale ranging from 1 (not at all) to 7 (totally), the extent to which they perceived they could depend on their partner for support both at the time of the abortion and after.

Section 14: Coping at work

To test the research prediction: 'The participants will have a tendency towards maladaptive, rather than adaptive, coping.'

The participants were asked to rate, on a Likert scale ranging from 1 ('strongly agree') to 7 ('strongly disagree'), the extent to which they agreed with statements regarding both enjoyment and coping with work both before and after the termination. Prior post-abortion counselling experience (VW, 1997 onwards) has shown, paradoxically, that women may become particularly involved in their work, perhaps as a distraction from their distress or as a way to feel more in control. One reason for including this question was to investigate whether post-abortion distress may be difficult to detect by mental health professionals due to an 'escape avoidant' or 'self-controlling' coping style (Folkman and Lazarus, 1988) characteristic in women experiencing this problem.

Section 15: General health.

To test the research prediction: 'The participants will have a perception that their overall general health has been affected by the abortion experience.'

Questions in this section were included to investigate the participant's perception of her general health, and health-related habits, both prior to and after her termination. Details were asked about medication, on-going health problems, units of alcohol consumed each week and numbers of cigarettes smoked each week.

Section 16: Sleep quality, panic attacks and overwhelming thoughts.

To test the research prediction: 'The participants will experience symptoms of anxiety and discomfort which impact on daily functioning.'

This section focussed on increased arousal and re-experiencing, i.e. symptoms of PTSD, and was included to explore the extent to which these symptoms had become part of the participants' life. Each participant was asked to estimate numbers of dreams, nightmares, flashbacks, anxiety attacks, sleep difficulties and overwhelming thoughts experienced over the previous three weeks, as well as over the last three months.

Section 17: The impact of life events on the participant's understanding of her distress.

To test the research prediction: 'The participants will have had exposure to life stressors previous to the abortion.'

It was hoped to identify any possible common life stressors shared by the participants. Another purpose of this section was to identify the participants' understanding of their post-abortion distress.

A list was presented in sections, each section covering 5 years of life (i.e. 0-5, 6-10 and so on). Participants were asked to record (in spaces provided for each life stage) any events or memories that 'you believe may help you to understand your feelings' in each section.

Section 18: Previous experience of counselling and hypnosis.

To test the research prediction: 'The participants will have had experience of previous mental health problems.'

One purpose of this section was to identify whether the participants had experienced any previous mental health problems and if so, whether these may reflect any pattern across the group. Another purpose of this question was to establish attitudes towards previous counselling and to identify what, if anything, met the participant's needs. The participants were asked to state whether they had experienced previous counselling and if so, how helpful this might have been.

This section also asks questions relating to any previous experience, understanding and expectations of hypnosis. These questions were asked to establish whether the participants had any particular expectation about how hypnosis could help their specific problem (i.e. post-abortion distress).

ii) Booklet B: (see Appendix VI)

This 23-page booklet was completed by each participant at the second meeting, one week following completion of Booklet A. It was decided that asking the participants to complete 2 booklets (each taking between 45-60 minutes) in one session would be too demanding for many participants. The booklet consists of seven scales. In accordance with Wilmouth, Alteris, and Bussell's (1992) recommendations only norm-referenced scales showing reliability and validity have been used.

Section 1: The Hospital Anxiety and Depression Scale (HADs) (Zigmund and Snaith, 1983).

To test the research prediction: 'The participants will be clinically depressed and anxious following their abortion(s)'

Wilmouth, Alteris, and Bussell (1992) recommend that any study investigating post – abortion adjustment should include a measure of depression. The HADs comprises of 7 statements related to anxiety and 7 statements related to depression. Participants were asked to underline which statement came closest to how they felt in the past week. Statements were scored between 0-3, thus a maximum of 21 can be scored for each sub section. Scores between 8-10 represent mild depression, 11-15 represents moderate depression, and scores over 16 are considered to represent severe depression. A total score of over 8 for either anxiety or depression is suggested by Zigmund and Snaith, (1983) as being clinically significant. The norm score for the non-clinical population is 6.14 for anxiety and 3.68 for depression (Crawford, Henry, Crombie and Taylor, 2001). Subscale scores are significantly correlated with psychiatric ratings for depression, $r = .70$ ($p < .001$) and for anxiety, $r = .74$ ($p <$

.0001). Test-retest reliability for total scores is .91(Roberts, Bonnici, Mackinnon and Worcester, 2001).

Respondents are asked to rate the extent to which a list of 14 items had applied to them over the course of the previous seven days, on a four option Likert scale, for example; "Not at all" (0); "Not often" (1); "Sometimes" (2); "Most of the time" (3). Two scores are derived from the scale: (a) the total anxiety score, which is obtained by summing the scores on each of the 7 anxiety subscale items, and (b) the total depression score, which is obtained by summing the scores on each of the 7 depression subscale items. The range of scores, therefore, is from 0 - 21 for each subscale (higher scores equal more anxiety and more depression respectively). It was hoped that the HADs would provide a general anxiety and depression profile, and enable some distinction to be made between anxiety and depression across the sample.

Section 2: Internality, Powerful Others, and Chance Scale (IPO) (Levenson, 1981)

To test the research prediction: 'The participants will perceive that they have little control over events as compared with non-clinical norms. '

Of particular interest to the present study was the influence that others had on the participants' self-concept following the abortion it was thought that the sub-scales 'Internality' and 'Powerful Others' related more to 'people' whilst the 'Chance' sub-scale related more to abstract concepts. It was therefore decided to include only the 'Internality' and 'Powerful Others' sub-scales. The purpose of using this validated scale (see Robinson, Shavers and Wrightsman, 1991) was thus to identify any common characteristics of locus of control between the participants. The Likert scale ranges

from -3 (strongly disagree) to +3 (strongly agree). A high score for 'Internality' indicates that an individual feels a high level of control over life. A high score for 'Powerful Others' indicates a belief that *others* have a high level of control over the individual's life. The mean score of college students for Internality is 35 and for Powerful Others is 20. Test re-test reliability over both subscales used is between .66 and .73.

Section 3: Posttraumatic Stress Diagnostic Scale (PDS) (Foa, E., 1995)

To test the research predictions: 'The participants will have dissociative experiences, have experienced previous life stressors, will meet the diagnostic criteria of PTSD and severity of symptoms will be comparable to the norms of the PTSD population.'

The PDS was devised by its authors as a brief self-report questionnaire designed to aid the diagnosis of posttraumatic stress disorder (as defined by DSM IV criteria, American Psychiatric Association), for measuring severity of symptoms and for monitoring outcome of treatment. Foa (1995) reports good reliability of the PDS, for example, high internal consistency (Cronbach alpha of .92) and .74 test- retest reliability of symptom severity scores. Foa (1995) reports that the mean score of the clinical population for symptom severity is 33.59 whilst the mean score of the non-clinical population is 12.54. The scale has been validated on a normative sample aged 18-65 years, of whom all had experienced, witnessed or confronted a traumatic event.

This scale was used in the present study to establish whether the participants met the DSM IV criteria for PTSD and whether there were any commonalities between the participants' specific PTSD symptoms. Questions refer to the nature of the traumatic event, as well as symptoms such as re-experiencing, avoidance, arousal, symptom

duration, and impairment on daily functioning. Participants were asked to tick the type of trauma that they had experienced and then briefly describe the one that troubled them most. Further questions relate to feelings during the trauma and the impact of the trauma on the participant's life.

For the purpose of the present study the following adaptation to the PDS was made. The participant's responses to a set of 6 questions (prefixed from 'a' to 'f') which asked about the type of trauma experienced (e.g. 'Did you think someone else's life was in danger?', Was someone else physically injured?) were followed by an additional question asking, 'Did you answer a)-e) on the previous page in relation to a termination?'. If the participant answered 'yes', she was asked the additional question, 'if you answered 'yes' to the question, '*Did you think someone else's life was in danger*?', please state below who the 'someone' was'. If, conversely, the participant answered 'no' to the question *'Did you think someone else's life was in danger?*', she was asked to respond to a further question in order to establish whether she thought that the *'someone else'* could have included a foetus. If the participant responded that she had not thought that this answer could have included a foetus, the participant was then asked what her response would have been if the 'someone' could have included a foetus and allowed to adapt her form as necessary at this stage.

Whilst these additional questions effectively invalidate results for those participants who need to change responses, it was felt essential to add these questions in order to ascertain that participants felt able to respond to the scale in context with a pregnancy termination rather than the demand characteristics of the form. In particular, the listed examples of traumatic events (e.g. a 'fire', 'accident', 'natural disaster', 'combat' or 'war zone') may have implied to the participant that an abortion was not relevant. Such demand

characteristics might otherwise lead to a result that did not truly reflect the participant's distress.

The PDS was also used as a screening instrument since participants eligible for enrolment on the second part of the project were required to meet the DSM IV criteria for PTSD (see 2.2).

Section 4: Trauma Related Guilt Inventory (TGRI) (Kubany, Haynes, Abueg, Manke, Brennan and Stahura, 1996)

To test the research prediction: 'Participants will have feelings of guilt comparable to that experienced by a group widely accepted as having been involved in traumatic experiences (Vietnam veterans)'.

The TRGI is a sensitive, validated scale that measures, identifies, and distinguishes six factors of guilt. It was developed by the authors in context with a cognitive model of guilt (Kubany 1994) and norms are provided of women college students, Vietnam veterans and battered women. The six subscales 'global guilt', 'hindsight bias / responsibility', 'distress', 'wrong doing', 'guilt cognitions' and 'lack of justification', reflect findings that guilt is a common outcome following exposure to a range of traumas (Kubany, 1994). Test-retest reliability for the subscales Hindsight Bias / Responsibility, Wrong Doing and Lack of Justification range from .73 to .75 and from .84 -.86 for the subscales Global Guilt, Guilt Cognitions and Distress. All subscales have been used.

Identification of the particular types of guilt cognitions experienced by women suffering from severe post-abortion distress may be helpful in understanding the complex nature

of guilt attached to abortion. The additional statement, 'All items are related to your termination', were included in the instructions in order to ensure that this scale related specifically to the participant's experience of abortion. The Likert scale ranges from 4 (extremely true / always true) to 0 (not at all true / never true). Higher scores indicate higher levels of guilt.

Section 5: Vividness of Visual Imagery Questionnaire (VVIQ) (Marks, 1973)

To test the research prediction: 'The participants will have above average vividness of imagery.'

In studying the grief reactions of the male partner following miscarriage, Johnson and Puddifoot (1998) found that high vivid imagery scores on the VVIQ correlated with higher scores on the Perinatal Grief Scale. The VVIQ was included in the present study in order to examine whether women who are vivid imagers may be similarly more vulnerable to grief following termination of pregnancy.

Each item of the VVIQ is measured on a five point scale 'Perfectly clear and as vivid as normal' (score of 1), to 'No image at all' (score of 4). Four scenarios are presented for the participant to imagine. Firstly, all scenarios are tested with eyes open. Secondly, the items are measured with eyes closed. A score between 32 and 57 indicates a vivid imager, a score of 58 to 83 indicates a mid-range imager and a score of over 83 indicates an unvivid imager.

Section 6: Perinatal Grief Scale (PGS) (Short Version), (Potvin Lasker and Toedter 1988)

To test the research prediction: 'The participants will experience grief levels comparable to that of women who spontaneously abort.'

This scale is the shorter 33-item version of the original full scale containing 84 items (Toedter, Lasker and Alhadeff, 1988). It is an empirically validated measure (a total Cronbach alpha of .95) specifically examining grief following pregnancy-related loss. Test-retest reliability is between .59 and .66 over all three subscales, 'Active Grief' (31.85); 'Difficulty in Coping' (21.4); and 'Despair' (20.5) (mean scores for women experiencing spontaneous abortion are shown in brackets).

The wording has been slightly changed to make it specific to abortion rather than miscarriage (the focus of the original version), for example, 'I feel worthless since he/she died' (in the original version), was changed to 'I feel worthless since the termination'. Wilmouth, Alteris, and Bussell (1992) suggest that studies that investigate adjustment to abortion should measure pathological grief. The purpose of including this scale was to ascertain the particular characteristics of grief suffered by women experiencing severe distress following termination of pregnancy and to compare these to levels of grief suffered by women who have miscarried at an approximately equivalent stage of pregnancy. The authors of the scale suggest that the subscales 'despair' and 'difficulty in coping' have particular clinical importance as these may reflect 'pathological grief'.

The Likert scale ranges from 5 (strongly agree) to 1 (strongly disagree). The sum of each subscale thus ranges from 11 to 55, higher scores indicating the more severe levels of grief.

Section 7: Ways of Coping Questionnaire (WOCQ) (Folkman and Lazarus, 1988)

To test the research prediction: 'The participants will have a tendency towards maladaptive, rather than adaptive, coping.'

This is an empirically supported scale with proven reliability (Cronbach alpha co-efficient of .91) and was used to identify characteristic coping styles across the sample of participants. All subscales have been used and these can be divided into 'problem–focussed' or 'emotion-focused' coping. Folkman and Lazarus (1988) suggest that 'problem–focused coping' is used mainly when the stressor can be changed, whereas 'emotion–focused coping' is used when the situation cannot be changed. Eight coping factors are measured. 'Confrontive coping' (an aggressive or assertive style of coping), 'distancing' (detachment from the significance of the problem), 'self-controlling' (efforts to regulate affect and behaviour), 'seeking social support' (this includes seeking information, tangible and emotional support from others), 'accepting responsibility' (efforts to put things right), 'escape-avoidance' (wishful thinking and behavioural escape), 'planful problem solving' (a deliberate, logical focussing on the problem) and 'positive appraisal' (an effort to create positive meaning by concentrating on personal growth).

The Likert scale ranges from 0 (does not apply/ not used) to 3 (used a great deal). Relative scores are calculated for each sub scale. The total of these scores is divided by 8 (i.e. the total number of sub scales) and all individual sub scale scores which are higher than the relative score for the total scale indicate coping processes that are used most.

iii) The Creative Imagination Scale (CIS) (Barber and Wilson, 1978) (see Appendix XVI)

To test the research prediction: ' The participants will be of above average hypnotic suggestibility.'

In addition to the 7 psychometric tests which formed Booklet B, the participants were administered a hypnotic suggestibility scale.

The CIS (Barber and Wilson, 1978) is a permissively worded standardised instrument that can be used in clinical or experimental settings. The protocol script encourages participants to use their own creative imagination to experience 10 suggested scenarios and takes approximately 20 minutes to administer. Participants self rated their experience on a Likert scale ranging from 0 (not at all the same as the real experience) to 4 (almost exactly the same as the real experience). The norm for the CIS is 20.8, the range being 0-40 (Barber and Wilson, 1978. Higher scores indicate greater responsiveness to suggested imagery and thus identify the participants' particular hypnotic abilities. Test – re-test reliability is .86 (Wilson, 1976).

The CIS was administered at the end of the second base line session, after Booklet B was completed. It was decided to administer the scale at this point for two reasons. Firstly, it was felt that the CIS was more appropriately placed in the assessment session than in the first therapy session, and secondly, participants who arrived for the second baseline session would be demonstrating commitment to the project and more likely to agree to the extra 20 minutes required to complete the CIS.
In the present study this scale was administered without a formal induction, but within a 'hypnotic' context since it was presented to each participant as 'a way to find out the best way to use hypnosis with you'. This scale correlates with hypnotisability, especially when administered in a 'hypnotic' context (Spanos, Gabora, Jarrett, & Gwynn; 1989).

The purpose of administering this scale was to identify, and therefore begin to evaluate, the significance of hypnotisability in the possible development of post abortion distress as well as in the outcome of therapy for this problem. The CIS has the added advantage

of introducing the participants of this project to the experience of hypnosis and to identify the participants' particular hypnotic strengths.

iv) Summary of scales used in Booklets A and B.

Booklet A:

Self Esteem Scale (Rosenberg, 1989)

Booklet B:

Hospital Anxiety and Depression Scale (Zigmund and Snaith, 1983)

Internality, Powerful Others, and Chance Scales (Levenson, 1981)

Posttraumatic Stress Diagnostic Scale (Foa, 1995)

Trauma Related Guilt Inventory (Kubany, 1996)

Vividness of Visual Imagery Questionnaire (Marks, 1973)

Perinatal Grief Scale (Potvin, Lasker and Toedter, 1988)

Ways of Coping Questionnaire (Folkman and Lazarus, 1988)

The Creative Imagination Scale (Wilson and Barber, 1978). NB: The response form for the CIS was given to the participants after administering the scale so that the participants' experience would not be influenced by the questions asked on the form. This form was therefore not included in Booklet B.

2. 4. Procedure

In the first session each participant was given an information sheet about the study (Appendix II). Hypnosis was described as a combination of trance (examples of everyday trance were given) and suggestion. After being given the opportunity to ask questions about hypnosis and the study in general a consent form was signed (Appendix III). The participant was then asked to complete Booklet A and was given the opportunity to clarify aspects of the questions as necessary, otherwise the booklet was

completed in silence. The completion of this booklet took approximately 45-60 minutes. The participant was also asked to complete the Symptom Check List-90 (SCL-90) and Comfort with the Abortion Decision Questionnaire (CADQ) (see Chapter 4 and Appendix VIII), in the event that they would take part in the second part of the project. The participants were given another SCL-90, / CADQ form and instructed to complete this immediately prior to the second baseline session (one week following the first session).

At the second baseline session the SCL-90/ CADQ form was handed in and then the participants were asked to complete Booklet B (taking approximately 45–60 minutes). After this, the Creative Imagination Scale was administered (taking approximately 20 minutes).

On completion of the 2 baseline sessions participants were asked to confirm whether they wished to proceed to the second part of the study (i.e. to receive therapy in the Hypnosis Unit). If the participant wished to do so an appointment was made for the first therapy session. Additional SCL-90 / CADQ forms were given to these participants who were instructed to complete these at weekly intervals, immediately prior to the following session.

CHAPTER 3

THE NATURE OF POST-ABORTION DISTRESS: RESULTS

The questionnaires (i.e. Booklets A and B, Appendices IV and VI) each took between 45 minutes and 1 hour for the participants to complete. It was decided to withdraw the Vividness of Visual Imagery Questionnaire (Marks, 1973) after the first 7 participants as this was found to be particularly time-consuming.

Criteria for interpretation of results

For the purpose of this study, criteria set for interpreting the results of the EAQa (Booklet A) were as follows:

i) Scale scores 0-10

0, 1, 2 and 8, 9, 10= strong responses

ii) Scale scores 1-7

1, 2 and 6, 7 = strong responses

Scores rated in the middle section of the scales were taken to reflect a moderate response or uncertainty. In contrast, ratings at the far end of the scales were considered to reflect strength of agreement with the statement.

Analysis of data involved calculating mean scores of the groups' psychometric test results and comparing these to norms from standardised measures. Statistical analysis of psychometric tests was carried out using the Statistical Package for the Social Sciences (SPSS) Version 9 to compute a one-sample 2-tailed *t*-test. This analysis, along with information collected from the specially designed questionnaire, was used to test the research predictions. It was felt that statistical analysis of psychometric tests that

compared current emotions with emotions experienced in the past, would not, however, be reliable. Retrospective ratings were thus examined in context with *perceptions* of past emotions rather than a measure of *actual* past emotions. Results are discussed below and then summarised alongside the research predictions (see 3.11).

Individual / subgroup scores were compared with relevant groups (clinical or non-clinical as appropriate) as this was considered a useful indication of where the participants' scores were in relation to the normative data. However, this comparison does not necessarily indicate significant difference from normal values.

3.1 Demographics

(see EAQa, section 1)

The table below summarises demographic details of the 11 participants (age, marital status, ethnicity and numbers of children).

Table 3.1. Summary of demographic information

Age range	21-30 years n=4	31-40 years n=5	41-50 years n=2	Mean age: 32.6 *SD: 7.11*
Marital status	Single n=8	Married n=1	Divorced n=1	Remarried n=1
Ethnicity	White Caucasian n=10	Mixed race n=1	-	-
Children	Total* born before termination =1		Total* born after termination =4	

*Total of the group

Numbers of participants are given for each category listed.

3.2 Background to the terminations

***i) Details of the pregnancy** (see EAQa, section 1).*

The table below summarises information about when the participants' terminations took place, numbers of terminations each participant experienced, the stage of pregnancy at

which the pregnancy was terminated, whether or not a pregnancy scan was carried out, and perceptions of professional sensitivity.

Table 3.2. Details of first terminations (N=11): Timing, stage of pregnancy, exposure to pregnancy scan, and professional sensitivity.

Timing of terminations	less than 1 year ago n=3	1-5 years ago n=4	6-10 years ago n=2	over 10 years ago n=2
Stage of pregnancy*	during 1st trimester n=9	during 2nd trimester n=2	-	-
Seen a pregnancy scan	YES n=4	NO n=6	'Can't remember' n=1	-
Professional sensitivity	0-2 rating n=5	3-7 rating n=5		8-10 rating n=1

0=not at all sensitive-10=completely sensitive

Table 3.3. Details of second terminations (N=5):

The table shows responses to questions eliciting information regarding timing, stage of pregnancy and exposure to a pregnancy scan. The participants' evaluation of how sensitively they perceived they were treated by professionals involved in their abortion was rated on a scale from 0-10.

Timing of terminations	less than 1 year ago n=2	1-5 years ago n=2	6-10 years ago n=0	over 10 years ago n=1
Stage of pregnancy*	during 1st trimester n=3	during 2nd trimester n=2	-	-
Pregnancy scan	YES n=1	NO n=3	'Can't remember' n=1	-
Professional sensitivity	0-3 rating n=3	4-7 rating n=2		8-10 rating n=0

0=not at all sensitive-10=completely sensitive

One participant had four terminations but gave no details about the third and fourth one. Between them the participants had experienced 18 terminations of which the majority had taken place during the first trimester of pregnancy. The latest abortions took place at 17 weeks and 19 weeks. Six participants had seen a pregnancy scan and there appears to be no pattern as to whether this had resulted in higher distress in subsequent

foetal-related thoughts and images (e.g. looking at photos of foetuses, worries that the foetus felt pain etc).

As hypothesised, a common experience of the participants was that they felt treated by the professionals at the place at which their termination was carried out with less than complete sensitivity and only one participant had regarded her treatment as completely sensitive (rated at 10). In the case of the first termination, five took place in a specialist clinic and six in a hospital. In the case of the second termination, three took place in a specialist clinic and two in a hospital. There appears to be no pattern in which professionals were perceived to be more, or less, sensitive in either the hospitals or clinics.

Two of the four participants who had had two terminations indicated that their second termination bothered them most and all responses to questions in both questionnaire booklets refer to the second termination. The other two participants made no distinction and in this case all responses to questions in both questionnaire booklets A and B refer generally to the two terminations. For the participant who had had four terminations it was not entirely clear which termination her responses related to.

ii) The abortion decision (see EAQa, section 7).

The table below summarises the participants' responses to statements relating to feelings (level of comfort, ease and certainty) about the decision to have the abortion 'that bothered them most'.

Table 3.4. Feelings about the abortion decision.

Statement	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
I feel uncomfortable about my decision to have a termination.	0	2	9
The decision to have a termination was difficult to make.	1	0	10

Rating scale 1-7 e.g. agreement with statements 1 = not at all, 7= completely.

I feel I never really made a decision, I felt unsure even just before the termination.	6	2	3
The decision to have a termination conflicted with my views on abortion.	3	4	4
I feel confused about my decision to have a termination.	8	1	2

N=11

Rating scale 1-7 e.g. 1=strongly agree, 7=strongly disagree

Values refer to numbers of participants who rated the scale within the range of values indicated.

Results show, as predicted, that the majority of the participants felt completely uncomfortable about their decision to have a termination and found the decision difficult to make. It should be noted also that the majority of participants indicated that they had never really made a decision, felt unsure immediately prior to the abortion, and felt confused about the decision. Only three participants felt that the decision was in conflict with their views on abortion. It would seem from these results that the majority of participants had particular difficulties and ambivalences relating to the abortion decision– a factor frequently associated with subsequent post-abortion distress (Osofsky and Osofsky, 1972; Payne, Kravitz, Notman and Anderson, 1976; Bracken, M.B., Klerman, L., & Bracken, 1978; Shusterman, 1979; Adler, 1992; Major and Cozzarelli, 1992).

iii) Reason stated for having the termination (see EAQa, section 7).

The table below summarises responses to a question inviting participants to state the reason for the pregnancy termination 'that bothered them most'. Participants were not, however, required to state a reason and three chose not to respond to this question.

Table 3.5. Reasons stated for having the termination.

	Don't know	Nil stated	Poor health	Relationship with father of the expected baby
Spread of participants	1	3	1	6

N=8

Values refer to numbers of participants who rated the scale within the categories indicated.

Six of the participants related the abortion decision to their relationship with the father of the expected baby with reasons almost equally divided between being put under pressure to have the termination, feeling unsupported and poor quality of relationship.

iv) Influence on the abortion decision (see EAQa, section 7).

The table below summarises sources of influence regarding the abortion decision 'that bothered the participants most'.

Table 3.6. Influence on abortion decision

	No	Yes	Source*
Persuasion not to have the termination	7	4	Friend (3) Partner and his parents (1)
Persuasion to have the termination	4	7	My partner's parents (1) My partner (5) My family (4)
Suggestions of regret	4	7	Parents (2) Friend (5)
Suggestions of abortion being wrong	9	2	LIFE Counsellor (1) Parents (1)

N=11

* participants experienced more than one source of influence.

The table summarises numbers of women who did or did not experience the influences stated

Regardless of direction of persuasion it would appear, as predicted, that most participants had been put under pressure during the decision-making process. Only three participants had not experienced being persuaded, at least to some degree, by another (i.e. either to have or not to have the abortion). Two participants had been persuaded in both directions and two participants experienced being persuaded by more than one source. 64% had been warned by others that they would regret their decision. However, in contrast to predictions, only two participants experienced being told that abortion is wrong.

3.3 Imaginative involvement

i) Imagery related to the aborted foetus (see EAQa, section 6).

Table 3.7 summarises responses to statements relating to imaginative involvement with the foetus.

Table 3.7. Imagery-related cognitions regarding the aborted foetus

Statement	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
I think of what he / she would have looked like	1	5	5
I imagine how life would have been with the baby	0	6	5
I imagine the foetus as a baby that continues to grow	2	6	3
I think of the foetus / baby as loving me	4	4	2
I think of the foetus / baby as hating me	5	3	3
I wonder if the foetus / baby felt pain during the termination	1	2	8
I think about what happened to the foetus / baby after the termination	0	5	6

N=11 *Rating scale 1-7 e.g. 1 = never, 4 = sometimes, 7 = all the time.*

The table summarises numbers of women experiencing the types of imagery/cognitions stated

The majority (91%) of the participants indicated that they were involved in thoughts at least sometimes about what the baby would have looked like, imagined what life would have been like with the baby and imagined the foetus as a baby continuing to grow.

Approximately 40% of the participants had these thoughts 'all the time'. Being loved or hated by the 'foetus / baby' was experienced by six of the participants. 81% of the participants thought 'all the time' about the possibility that the foetus felt pain during the procedure.

Thoughts about what had happened to the foetus after the abortion were experienced by all participants and one participant added 'I remember that I gave permission to the doctors to use the foetus as an experiment and I regretted that as I felt I should have given the foetus a certain blessing. I regret that doctors used it as an experiment / research.'

As predicted these results suggest that it was common for the participants to have continued attachment to the foetus.

ii) Vividness of Visual Imagery Questionnaire (Marks, 1973) (see EAQb, section 5).

The table below summarises levels of vividness of imagery attained by the participants who completed this questionnaire. Possible levels of vividness of imagery are 'vivid imager', 'mid range' and 'unvivid imager'.

Table 3.8. Vividness of Visual Imagery scores.

Unvivid imager	Mid range imager	Vivid imager
2	3	2

N=7

The table shows the range of results for the 7 participants completing the VVIQ.

Levels of imagery calculated according to cut-off points suggested by Marks (1973)

The length of time needed to respond to this scale had been underestimated by the author. Thus, this scale was withdrawn after the first 7 participants. However, for those

participants who did complete the questionnaire, there appears to be no predominant level of vividness of imagery across the group contrary to predictions.

3.4 Suggestibility

i) Hypnotic suggestibility (measured after the EAQb was completed).

Table 3.9 shows the spread of the participants' Creative Imagination Scale (CIS) scores across categories identified by Barber and Wilson (1978). Values refer to the overall CIS scores calculated from adding together each of the 10 subscales of the CIS. It can be seen that most (8) participants fitted into the upper end of the 'medium high category'.

Table 3.9. CIS: mean scores and spread

	Low 0-10	**Medium low**		**Medium high**		**High 31-40**
a)		11-15	16-20	21-25	26-30	
b)	0	0	2	3	5	0

a) Values refer to total scores of the CIS (possible range of scores from 0-40).

b) Values refer to numbers of participants. The majority of participants are clustered within the medium-high category as identified by Barber and Wilson (1978).

Table 3.10. CIS: Participants compared with a normative sample

Table 3.10 shows the participant's mean scores compared to those of a non-clinical population, standard deviations are in parenthesis. A one-sample, 2-tailed *t*-test revealed a significant difference between the participants' scores and the normative sample.

Participants N=10	College Students* N=217	*t*	*df*	*p*
24.2 (3.99)	20.8 (8.6)	2.569	9	.030

*Barber and Wilson, 1978

Values are expressed as mean scores, standard deviations are in parenthesis

It can be seen that the majority (8) of participants were of 'medium high' hypnotisability (thus above average), as predicted. Of these eight participants, three scored between 21-25 and five scored between 26-30. Interestingly, the participants' mean scores for items categorised by McConkey, Sheehan, Law and White (1977) as 'difficult' (time distortion, temperature 'hallucination' and finger anaesthesia), were higher than those of the student sample.

One participant's score was eliminated since she was only able to remember one of the items of the scale. This participant had become so absorbed in the first items on the scale that she had not remembered any following items. Such a response indicates a high level of absorption (Kirsch and Council, 1992) and is characteristic of high hypnotisability. Thus the results indicate a conservative group mean score.

ii) Suggestibility and interpersonal / sociocultural influences *(see EAQa, sections 4 and 8)*

The participants' responses to a series of statements reflecting their thoughts and feelings about the abortion in context with internalisation of negative sociocultural opinions are summarised in Table 3.11.

Table 3.11. Suggestibility and interpersonal / sociocultural influences

Statement	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
Hearing strong views against abortion upsets me	0	3	8
I fear others will reject me for having had a termination	0	3	8

N=11
Rating scale 1-7 e.g. 1 = strongly disagree - 7 = strongly agree.
Values refer to numbers of participants rating the scale within the range of values indicated.

Statement	Ratings between 0-2	Ratings between 3-5	Ratings between 8-10
Comfortable when hearing public debates about abortion	8	2	1
Comfortable when hearing other peoples opinions about abortion	8	2	1
Comfortable about your termination being recorded in your medical records	8	2	1

N=11
Rating scale 0 - 10 e.g. 0 = not at all - 10 = completely.
Values refer to numbers of participants rating the scale within the range of values indicated.

Results suggest that, as predicted, the majority (72%) of the participants appeared to be highly sensitive to views of others about abortion and the possibility of rejection due to having had an abortion.

A further observation, in context with susceptibility to interpersonal influences and distress following the abortion, is that seven of the participants had stated that friends or parents had suggested to them that they would regret their decision (see Table 3.6).

3.5 Affect

The majority (nine) of participants had received counselling prior to enrolling on the present project. Table 3.12 summarises the types of counselling experienced. *(see EAQ, section 18).*

Table 3.12. Types of previous counselling experiences.

CBT	Psychodynamic	Person-centred	Multiple types	Group	Unspecified
2	1	2	1*	1	2

Values refer to numbers of participants experiencing the type of therapy indicated.

*Experienced CBT, Psychodynamic, and group therapy.

i) Anxiety and Depression (EAQb, section 1).

Table 3.13 shows the participant's mean scores for each subscale of the Hospital Anxiety and Depression Scale (HADS) (Zigmund and Snaith, 1983) compared to those of a non-clinical population, standard deviations are in parenthesis. A one-sample *t*-test revealed a significant difference between the participants' scores and a normative sample for both anxiety ($p = .000$) and depression ($p=.002$) subscales (both 2-tailed).

Table 3.13. HADS: Participants compared with a normative sample.

	Participants N=11	Non-clinical norms* N=1792	*t*	*df*	*p*
Anxiety	15.09 (4.25)	6.14 (3.76)	6.98	10	.000
Depression	10.27 (5.10)	3.68 (3.07)	4.29	10	.002

*Crawford, Henry, Crombie and Taylor, 2001

Possible range of scores for each subscale = 0-21. Scores higher than 8 for either subscale are considered clinically significant (Zigmund and Snaith, 1983).

Data expressed as means, standard deviations in parenthesis.

Eight of the participants scored over 8 for depression and all participants scored over 8 for anxiety which, according Zigmund and Snaith, (1983), suggests clinical significance Statistical analysis confirmed that the participants mean scores for anxiety and depression were significantly different to those of the non-clinical population. Five participants were taking anti-depressants. Of the three participants who scored under 8 for depression, 2 were taking anti-depressants at the time of completing the HADS.

Thus, as hypothesised, the majority of participants were both clinically depressed and anxious according to criteria set by Zigmund and Snaith (1983).

Table 3.14 summarises numbers of participants experiencing particular symptoms of anxiety relating to sleep, panic attacks and overwhelming thoughts.

Table 3.14. Anxiety symptoms in context with general well being following the abortion

	Nightmares	Dreams about babies	Panic attacks	Difficulty in sleeping	Overwhelming thoughts
Numbers of participants experiencing at least once a week .	11	8	10	9	11

N =11

Values refer to numbers of women experiencing the anxiety symptoms stated.

The majority of participants experienced, as predicted, nightmares, dreams about babies, panic attacks difficulty in sleeping and overwhelming intrusive thoughts at least once a week. These symptoms are representative of 're-experiencing', characteristically associated with PTSD.

ii) Discomfort with situations relating to babies and abortion*(see EAQa, section 4).*

Table 3.15 lists situations relating to babies or abortion together with the participants' ratings describing level of comfort they experience in each situation.

Table 3.15. Discomfort with situations relating to babies / abortion.

Situation	Ratings between 0-2	Ratings between 3-7	Ratings between 8-10
Being with babies/ small children	5	4	2
Thinking about babies	6	4	1
Thinking of future pregnancies	6	4	1
Watching TV programmes / listening to radio programmes about abortion	7	3	1
The anniversary of the expected birth	9	1	1
Visiting or going near the place where your termination took place	8	3	0
Hearing or saying the word 'abortion'	9	2	0
Reading newspaper/ magazine articles about abortion	8	3	0
Looking at photos/ pictures of babies/ small children	5	5	1
Looking at photos/ pictures of foetuses	8	3	0

N=11
Rating scale 0 - 10 e.g. 0 = not at all comfortable - 10 = completely comfortable.

Values refer to numbers of participants rating level of comfort with the listed statements within the range of ratings indicated.

It can be seen that, as predicted, the majority of participants experienced the listed activities as 'not at all comfortable'. The two situations causing most participants extreme discomfort were related directly to the abortion – the anniversary of the expected birth and saying the word 'abortion'. The two situations causing least participants discomfort were those connected with exposure to babies and small children.

iii) General affect prior and after the pregnancy / termination (EAQa, section 3B).

Table 3.16 compares the participants' retrospective ratings of emotions before the termination to the same emotions experienced after the termination. The figures in the far right column indicate the differences between means of retrospectively rated and current emotions expressed as a percentage of the current ratings.

Table 3.16. Emotions prior to and after pregnancy / termination

Emotion	Before termination (retrospective ratings)			After termination (current ratings)			
	Rating 1-2	Rating 3-5	Rating 6-7	Rating 1-2	Rating 3-5	Rating 6-7	*% Increase of participants experiencing*
Shame	5	3	3	0	2	9	55%
Irritable	0	9	2	1	2	8	55%
Confused	2	4	5	2	11	9	36%
Angry	0	7	4	3	1	7	27%
Envy	3	6	2	1	5	5	27%
Anxious	2	4	5	1	2	8	27%
Depressed	0	6	5	0	3	8	27%
Isolated	2	2	7	1	1	9	18%
Lonely	1	3	7	1	3	7	0%

N=11

Rating scale 1-7 e.g. 1 = not angry 4= neither angry nor not angry, 7 = completely angry

Figures in the far right column indicate the differences between means of retrospectively rated and current emotions expressed as a percentage increase from retrospective ratings.

These results indicate that nearly half of the participants regarded themselves to be 'completely' confused, anxious and depressed before the pregnancy / abortion had occurred, and that 64% had felt 'completely' isolated and lonely. However, only 2 participants rated themselves as 'completely' irritable and only 3 experienced shame or envy prior to the abortion. Numbers of participants strongly rating the listed negative emotions post-abortion (shown as % changes in Table 3.16) increased for all emotions (particularly for shame and irritability) with the exception of 'loneliness'. Perhaps related to these results is that the majority (nine) of participants had experienced counselling prior to enrolling on the present project. Contrary to the prediction that the participants would generally have experienced negative mood prior to the pregnancy / abortion experience, these results indicate that some moods were more intensified by the abortion than others. These results are thus only partially as predicted.

iv) Affect directly related to the abortion (see EAQa, section 5a).

Table 3.17 summarises all strongest rated negative and positive emotions.

Table 3.17. Ratings of emotions in general context with the termination

Positive emotions (1-2)		Neither (3-5)	(6-7) Negative emotions	
Happy	0	0	11	Sad
Good	1	1	9	Bad
Not regretful	0	1	10	Regretful
Relieved	2	3	6	Not relieved
Not guilty	1	1	9	Guilty
Right	1	5	5	Wrong
No loss	1	0	10	Loss
In control	1	3	7	Not in control

N=11

Rating scale 1-7 e.g. 1 = completely happy, 4= neither happy nor sad, 7= completely sad

Values refer to numbers of participants experiencing positive emotions, negative emotions or neither.

Certain negative emotions about the abortion were, as predicated, strongly felt by the majority of the participants. However, some negative emotions relating to the abortion were less commonly experienced than predicted.

For example, strong feelings of sadness, badness, regret, guilt and loss about the termination were experienced by between 81% -100% of participants.

v) Guilt (see EAQa, section 8; (see EAQb, section 4).

As predicted, the majority (64%) of the participants strongly agreed that having the termination felt like committing a murder, however, four strongly disagreed with this statement. Five of the participants strongly agreed that they deserved to feel better about the termination, indicating that a feeling of self-punishment was not common to all respondents.

Table 3.18 shows the participant's mean scores for each subscale of the Trauma Related Guilt Inventory (Kubany, 1996) compared to those of Vietnam veterans, standard deviations are in parenthesis. A one-sample, 2-tailed *t*-test revealed significant

differences between the participants' scores and the comparison group for all subscales, with the exception of Wrongdoing.

Table 3.18. TRGI: Participants compared with a clinical group

	Participants N=11	Vietnam veterans N=74	*t*	*df*	*p*
Global guilt	3.41 (0.59)	2.8 (0.89)	3.4	10	.007
Guilt cognitions	2.76 (0.77)	2.1 (0.69)	2.82	10	.018
Distress	3.57 (0.35)	3.1 (0.70)	4.49	10	.001
Hindsight-bias	3.11 (0.67)	1.8 (0.90)	6.50	10	.000
Wrongdoing	2.15 (0.70)	2.5 (0.80)	-1.64	10	.132
Lack of justification	2.90 (0.95)	2.1 (0.91)	2.79	10	.019

G = Global Guilt
C = Guilt Cognitions
D = Distress
HBR = Hindsight-Bias / Responsibility
WD = Wrongdoing
LJ = Lack of Justification

Mean subscale scores of each participant were totalled and a mean score calculated for the group.

The data are expressed as mean values (standard deviations in parenthesis) of subscale scores for the group.

Range of scores is from 0-4 for each item of the subscale. The higher rating indicates greater guilt.

All results were significantly different from the clinical comparison group, with the exception of the subscale 'wrongdoing'.

It had been predicted that the participants would experience guilt comparable to Vietnam veterans (a group widely accepted as experiencing extreme emotional challenges), however, the results indicate that the participants' guilt was generally even greater. The results also showed that guilt relating to Wrongdoing (violation of thoughts, beliefs and values) was not significantly different to the comparison group. Indeed, the majority of participants' (81%) rated 'wrong doing' lower (or equally low as scores for 'lack of justification', in the case of 3 of these participants) than other factor of guilt. This finding was reflected in the views that the participants expressed about abortion. Table 3.19 below summarises the participants' beliefs about whether abortion is wrong, retrospectively perceived prior to their abortion and also after the abortion.

Table 3.19. Beliefs about abortion

Statement	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
Prior to your termination	5	4	2
Since your termination	4	5	2

N=11
Rating scale 1-7 **e.g. 1 = never wrong, 7= always wrong**

Values refer to numbers of participants rating statements about their abortion beliefs within the range of ratings indicated.

It would appear that contradictory to predictions, only two participants (18%) held strong anti-abortion beliefs. Seven (64%) participants reported having similar beliefs before and after their abortion, suggesting that beliefs were relatively stable before and after the termination. Of the remaining four participants no pattern could be identified regarding direction of change following the abortion.

vi) Grief (see EAQb, section 6 and EAQa section 6).

Table 3.20 summarises responses to possible concepts of the pregnancy loss.

Table 3.20. Concept of the pregnancy loss

Concept	Number of responses	Given a name
A bunch of cells	2	0
A foetus	2	0
A baby	7	1
A child	2	0
A person	2	1
A boy / girl	5	2

N=11
Values refer to numbers of participants conceptualising the abortion according to the concepts listed and the number in each category who had given the 'prospective child' a name.

Most participants (64%) perceived the pregnancy loss as a 'baby', and three participants marked more than one category indicating that their concept of the pregnancy loss was not consistently held. Of the participants who conceptualised their foetus as a baby, a person or a boy / girl, four had given the pregnancy loss a name. Of particular interest to the present study is that only three participants indicated that they thought of the

pregnancy loss as a bunch of cells or foetus and none of these participants consistently held this conceptualisation. Indeed, all of the participants' responses were biased towards a concept of the foetus as a baby, a person or a boy / girl, suggesting some fantasising that it had not been aborted. These results further supported the prediction that the participants continued to be emotionally attached to their aborted foetuses.

Table 3.21 shows the participant's mean scores for each subscale of the Perinatal Grief Scale (PGS) (Potvin, Lasker and Toedter, 1988) compared to those of women who had spontaneously aborted, standard deviations are shown in parenthesis. A one-sample, 2-tailed *t*-test revealed significant differences between the participants' scores and the comparison group.

Table 3.21. PGS: Participants compared with a clinical group

	Participants N=11	Spontaneous abortion* N=63	*t*	*df*	*p*
Active grief	45.91 (3.18)	31.85 (10.18)	14.68	10	.000
Difficulty in coping	44.55 (6.76)	21.40 (8.32)	11.36	10	.000
Despair	42.36 (5.71)	20.51 (6.83)	12.57	10	.000

* Potvin, Lasker and Toedter, 1988)

Mean subscale scores of each participant were totalled and a mean score calculated for the group.

The data are expressed as mean values (standard deviations in parenthesis) of subscale scores for the group.

The sum of each subscale ranges from 11 to 55, higher scores indicating the more severe grief

The finding that the participants' grief levels were significantly higher than those of women who had experienced a miscarriage, was unexpected. 'Active grief' is described by Potvin et al, (1988) as 'normal grief' such as sadness and crying, was 45.9 compared to 31.85 for women who had spontaneously aborted. The participants' mean score for 'difficulty in coping', described by Potvin et al, (1988) as difficulty in functioning,

withdrawal from others and severe depression, was 44.55, over twice as high as the mean score of women who had spontaneously aborted (21.40). The participants' mean score for 'despair', described by Potvin et al, (1988) as indicating serious and long-lasting effects of loss was, likewise, over twice as high (42.36) compared to the mean score of women who had spontaneously aborted (20.51). Whilst it was predicted that the participants would experience grief comparable to women who had spontaneously aborted, the extreme level of grief (as compared to the mean scores of women who miscarry) was unexpected, revealing a particularly intense grief and vulnerability to serious long-lasting effects of loss (Potvin et al, 1988).

3.6 Self-concept

i) In context with religion and spirituality (see EAQa, section 9).

Table 3.22 summarises responses to questions relating to religion and spirituality.

Table 3.22. Feelings about religion / spirituality.

Statement	Before termination (retrospective ratings)			After termination (current ratings)		
	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
I see/saw myself as religious	4	7	0	5	5	1
I see/saw myself as spiritual	3	6	2	5	5	1
It is important for me to think my foetus / baby is in a resting place	N/A	N/A	N/A	2	3	6
Religion / spirituality has helped me feel better about my termination	N/A	N/A	N/A	0	4	7

N=11

Rating scale 1-7 e.g. agreement with statements 1 = strongly agree, 7= strongly disagree

Values refer to numbers of participants rating statements concerning religiosity and spirituality within the range of values indicated.

The second 2 statements were not applicable prior to the termination.

In contrast to predictions, none of the participants saw themselves as very religious before the termination, and only one saw herself as very religious following her termination. Seven of the participants saw themselves as moderately religious before the terminations and only five viewed themselves as religious following the termination(s), perhaps reflecting the majority of responses indicating that religion had not helped them feel better about their terminations. Ratings for spirituality were similar to those for religion.

Whilst only one participant rated herself as very religious post termination, an interesting finding is that the majority (nine) of the participants felt it at least moderately important that the aborted foetus / baby was in a 'resting place' after the abortion, and six (55%) felt this was very important. Indeed, whilst two of the participants gave very literal answers to the question relating to thoughts about where their foetus / baby was following the termination ('in a test tube', 'down the drain')

seven of the participants had thoughts that their foetus / baby was somewhere such as 'heaven' or 'somewhere nice'. These results indicate that religious / spiritual symbolism was important to the majority of participants even though most did not see themselves as strongly religious/ spiritual.

ii) Self-efficacy (see EAQb, section 2).

Participants' mean scores of perceived control over their lives, measured by Levenson's Internality and Powerful Others Scale (1981), are summarised in Table 3.23, standard deviations are shown in parenthesis. Mean scores of college students are also shown for comparison. A one-sample *t*-test revealed a significant difference between the participants' and the comparison group for 'Powerful Others', but no significance difference for 'Internality'.

Table 3.23. Internality and Powerful Others Scale: Participants compared with a normative sample.

	Participants	Non-clinical norm*	*t*	*df*	*p*
Internality	28.55 (10.86)	35 (7.0)	-1.972	10	.077
Powerful Others	33.36 (10.65)	20 (8.5)	4.161	10	.002

* Students (Levenson, 1981)

Possible range of scores is from 0-48 for each subscale. Higher scores for 'Internality' represent greater perception of control over life; higher scores for 'Powerful Others' indicate a perception that others have greater control over the individual's life.

Mean subscales of each participant were totalled and a mean score calculated for the group.

The data are expressed as mean values (standard deviations in parenthesis).

'Powerful Others' results were significant compared with the clinical comparison group. 'Internality' results were not significant compared with the clinical comparison group.

As predicted, results indicate that the participants shared a perception that others controlled their lives, compared to the mean scores of college students. Ten (91%) of the participants scored over the mean score of students for 'Powerful Others'.

However, whilst eight (73%) scored below the mean score of students for 'Internality', this was not statistically significant.

It should be noted that eight of the participants strongly expected to be rejected by others for having had a termination (Booklet A).

iii) Self-Esteem (see EAQa, sections 3A and 5C).

Table 3.24 summarises responses to Rosenberg's Self-Esteem Scale (1988). The possible range of scores is 0-40.

Table 3.24. Participants' Rosenberg Self-Esteem (RSE) scores before and after pregnancy / termination.

Before (Retrospectively rated)	**After**
24.1 (mean)	20.7 (mean)

The data is expressed as mean values (standard deviations in parenthesis).

Table 3.25 shows the participant's mean scores for each subscale of the Rosenberg Self Esteem Scale' (Rosenberg, 1989) compared to those of women college students (Cheng and Furnham, 2003) standard deviations are shown in parenthesis. A one-sample, 2-tailed *t*-test revealed a significant difference between the participants' scores and the comparison group.

Table 3.25. RSE: Participants compared with a normative sample

Participants N=11	Non-clinical* N=60	*t*	*df*	*p*
20.73 (7.82)	29.71 (3.88)	-3.81	10	.003

The sum of scores ranges between 10 and 40, the higher scores indicating greater self-esteem.

The data are expressed as mean values (standard deviations in parenthesis).

All results were significant compared with the clinical comparison group at the.005 level.

Retrospectively perceived self esteem (i.e. before the pregnancy / termination), measured by the 'Rosenberg Self Esteem Scale' (Rosenberg, 1989), ranged from between 10 and 40 (mean 24.1). Eight participants (73%) rated the scale lower than the mean score of college students. Post-abortion self-esteem ratings were similar, ranging between 10-39, (mean score 20.7), however six participants rated themselves as having lower self-esteem following their abortion and 91% of the participants' scores were lower than the mean score of college students.

As hypothesised, these results suggest that the majority of participants generally had lower self-esteem than the mean for college students, both retrospectively rated and when related to current pre-therapy feelings and these differences were statistically significant.

These results reflected responses to ratings of statements in Booklet A which indicated that only one of the participants strongly agreed that she could accept herself for having had an abortion and seven felt strongly that they could not accept them selves for having had an abortion.

iv) Concept of physical health before and after pregnancy / termination (see EAQa, section 15).

Table 3.26 summarises responses regarding physical health in context with the termination.

Table 3.26. Concept of physical health

	Yes	No
Physically well before your termination?	8	3
Physically well after your termination?	3	8

N=11

The table summarises numbers of participants responding to the two health-related statements within the yes/no categories.

Whilst three participants reported not feeling physically well either before or after the termination, results show, as predicted, a notable shift towards a perception of physical ill-health following the pregnancy termination, perhaps reflecting interpretation of physiological sensations as a result of increased arousal (Salkovskis, 1988).

3.7 Attributional style

i) Expectations for the future (see EAQa,section 10 and 18).

Table 3.27 summarises responses to questions in Booklet A that focussed on stability of attributional style.

Table 3.27. Statements about expectations for the future

Statement	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
I feel generally optimistic about the future	4	6	1
I will feel comfortable about the termination with time	7	3	1
I will gain from the experience of the abortion with time	6	4	1
Hypnosis will help me feel better	0	7	4

N=11

Rating scale 1-7 (1= strongly disagree, 7= strongly agree)

The table summarises numbers of participants agreeing with the listed statements within the identified categories.

Participants were, as predicted, generally pessimistically biased towards the future, and likewise generally pessimistic that they would feel comfortable about the abortion with time or gain from the experience with time. A tendency towards a stable attributional

style thus appeared to be characteristic of the majority of participants, a style associated with vulnerability towards depression (Abramson, Seligman and Teasdale, 1978).

However, there was some strong optimism felt by the participants that hypnosis could help them with their problem. Indeed, all of the participants felt at least some optimism that hypnosis could help them. It should be noted that the nature of this study is likely to have attracted participants who felt positive towards hypnosis, however, it is interesting to note that whilst the participants shared a general pessimism about change, hypnosis was generally regarded as having some potential to help them feel better.

ii) Blame (see EAQa, section 12).

Table 3.28 summarises responses to statements reflecting situational blame, chance, other-blame, self-behaviour blame and self-character blame.

Table 3.28. Attributions for post-abortion distress.

Statement	Ratings between 1-2	Ratings between 3-5	Ratings between 6-7
I blame the situation I was in at the time for the distress I feel now.	1	2	8
It is just bad luck / chance that has caused my distress	9	2	0
I blame other people for my distress	3	6	2
I blame myself because of some thing I did or did not do.	1	2	8
I blame myself for my distress – having the termination reflects something about my character.	1	1	9

N=11

Rating scale 1-7 e.g. agreement with statements 1 = not at all, 7= totally.

The table summarises numbers of participants agreeing with listed statements according to the categories identified.

The table shows that eight participants (73%) of the participants blamed 'the situation', for the distress that they felt post abortion. This result is unexpected since an 'external attributional style' is generally agreed to be predictive of better adjustment (Abramson,

Seligman and Teasdale, 1978). However, in contrast, none of the participants totally disagreed that their distress was due to 'chance', reflecting an attributional style generally agreed to be more predictive of poor adjustment (Abramson, Seligman and Teasdale, 1978).

Of particular note was that 73% of the participants strongly agreed with statements which suggested that it was something about 'what they did or didn't do' (self-behaviour blame) that had caused their post-abortion distress and 91% of the participants strongly agreed that something about their character (self-character blame) had caused their post-abortion distress. Whilst these results reflect the hypothesis that the participants would be involved in self-character blame (which is associated with higher depression, e.g. Janoff-Bulman, 1979), they do not reflect the hypothesis that the participants 'self-behaviour blame' may lead to better adjustment following negative life events (Janoff-Bulman, 1979).

3.8 Coping style

i) Coping styles most used (see EAQb, section 7).

Table 3.29 summarises responses to the Ways of Coping Questionnaire (Folkman and Lazarus, 1988).

Table 3.29. Coping styles used most by each participant

Ways of coping	D	SC	EA	PPS	AR	CC	SSS	PR
Numbers experiencing	4	7	10	2	6	3	1	0
% of participants using	36%	64%	91%	18%	55%	27%	9%	0%

N=11

D=Distancing *SC=Self-Control* *SSS=Seeking Social Support*
EA=Escape–Avoidance *PPS=Planful Problem Solving* *PR=Positive Reappraisal*
AR=Accepting Responsibility *CC=Confrontive Coping*

The table summarises numbers of participants using the listed coping styles.

'Escape–avoidance', 'self-control' and 'accepting responsibility' were the most frequently used coping styles.

It can be seen that by far the most commonly used coping style was 'escape-avoidance', a style of coping that can involve maladaptive fantasising and has been found to increase psychological distress (Aspinwall and Taylor, 1992). Coping by 'accepting responsibility' (used by 55% of the participants), may have been maladaptive when considered in context with the participants' tendency to 'self-character blame'. Likewise, 'self-control' (used by 64% of the participants) may have been maladaptive when considered in context with the participants' tendency towards a stable, pessimistic explanatory style, which may indicate a belief that painful emotions need to be controlled since they cannot be changed. Only one of the participants used 'social support' and none of the participants used 'positive appraisal' – the two most adaptive coping strategies (Folkman and Lazarus, 1988).

Responses to a question asking 'what would help you feel better if it were possible to happen?' suggest that the majority of participants generally had difficulty in identifying possible adaptive coping strategies. All but 2 responses (those suggesting talking in therapy / expression of feelings) were maladaptive, depending on 'changing history' thus reflecting an 'escape avoidant' coping style and hopelessness.

As predicted these results suggest that the participants showed a general tendency towards maladaptive coping.

ii) Dissociative experiences (see EAQa, section 11).

Table 3.30 below summarises dissociative experiences such as unreal feelings, denial and 'spacing out'.

Table 3.30. Dissociative experiences

Statement	Ratings between 1-2	Rating between 3-5	Ratings between 6-7
When I think of the termination it seems unreal.	1	3	7
I think of myself as two different people - the one who had the termination and the one who finds this difficult to accept.	3	3	5
Sometimes it's like I try to pretend that I haven't had a termination.	5	1	5
Sometimes I find myself staring into space, in a sort of daydream, thinking about it all.	0	2	9

N=11
Rating scale 1-7 e.g. agreement with statements 1 = strongly disagree, 7= strongly agree.

The table summarises numbers of participants agreeing with the statements listed within these response categories.

In line with the research prediction, the majority of the participants (91%) had some experience of feeling that the termination seemed unreal and all shared a tendency to daydream whilst thinking about the abortion, a behaviour suggested by Holmes et al, (2004) to be representative of 'detachment'. Likewise, the majority of participants (73%) had experienced dissociating from 'the self' who had had the termination, a type of dissociation suggested by Holmes et al, (2004) to be representative of 'compartmentalisation'. It should be noted that whilst the statement suggesting a conscious effort in *trying to pretend* the abortion had not taken place (i.e. not representative of the characteristic involuntariness of dissociation) was strongly disagreed with by 5 of the participants, another 5 strongly agreed with this statement.

iii) Social support (see EAQa, section 13).

Questionnaire feedback showed that nine of the participants (81%) had told their partners about the termination and of these, five supported the decision to have the termination. However, only one participant anticipated and experienced support from her partner following the termination and most felt 'completely uncomfortable' talking

to their partner about the termination. Six participants (55%) had told their families about the termination. Three of these families were supportive about the decision but only two participants expected and received support following the termination. Whilst ten participants (91%) had told friends about their termination these disclosures were restricted to 'one or very few' friends, reflecting findings of Major and Gramzow's study (1999). Moreover, nine participants (81%) indicated that they felt 'completely uncomfortable' talking to friends about their termination. Only one participant had told all her friends. These results suggest, as predicted, that the participants commonly perceived that they were poorly supported at the time of, and after, the abortion.

3.9 Previous experience of life stressors.

(EAQa, section 17)

All participants had indicated that they had experienced important life events that they believed helped them to understand their post-abortion distress. These are summarised in the table below.

Table 3.31. Previous experiences of life stressors

Rape	Sexual abuse	Parental divorce	Own divorce	Conflict with a sibling	Conflict with parent (s)	Bullied at school	Other
3	7	4	4	3	6	1	3

N=11

The table summarises numbers of participants experiencing the types of life stressors stated.

As predicted all participants had experienced life stressors prior to their abortion experience. 3 participants indicated only one stressor, the other participants identified up to five stressors each. Stressors that were most commonly experienced were sexual abuse and conflict with parents. 'Other' life stressors included difficulty in coping with

the death of a father, difficulty in a relationship with a partner and general difficulty with relationships. Five participants were taking anti-depressants.

3.10. PTSD

(see EAQb, section 3)

Results of the Posttraumatic Diagnostic Scale (Foa, 1995) are presented below alongside the DSM IV criteria for PTSD (shown in italics).

A. The person has been exposed to a traumatic event in which both of the following were present.

i) The person experienced, witnessed, or was confronted with an event or events that involved actual, or threatened death or serious injury, or a threat to the physical integrity of self or others.

Table 3.32 summarise types of traumas experienced by the participants.

Table 3.32. Types of traumas experienced in addition to the abortion (s)

A	NSAK	SAK	D	NSAS	SAS	C	SC	I	T	LTI	O	Total
1	3	1	0	3	3	0	2	0	1	2	5	21

A= Serious accident D=Natural disaster
NSAK=Non sexual assault (someone known) NSAS= Non sexual assault (stranger)
SAK= Sexual assault (someone known) SAS= Sexual assault (stranger)
C= Combat SC= Sexual contact when under 18 I=Imprisonment
T= Torture LTI=Life threatening illness O=Other traumatic event
N=11

The table summarises numbers of participants who indicated that they had experienced the types of traumas listed on the PDS (Foa, 1995).

Table 3.33 summarises the traumas that were identified by the participants on the PDS as bothering them most.

Table 3.33. The trauma identified by participants as 'bothering me most'.

Abortion identified as the trauma that 'bothers me most'.	8
Other trauma identified as the trauma that 'bothers me most'.	2
Abortion and another trauma both identified as 'bothers me most'	1

N=11

The table summarises numbers of participants indicating which trauma bothered them most. The majority of participants indicated that the abortion bothered them most.

Eight participants had experienced a traumatic event prior to their pregnancy termination, six of whom reported that the abortion 'bothered me most'. Five participants had experienced one trauma and three had experienced multiple traumas. Interestingly, when completing the PDS, only two participants did not believe that the criteria set out in the PDS enabled them to class an abortion as a trauma. When informed that they could answer the form in context with the abortion, if this was appropriate to them, both participants indicated (without influence from the researcher) that the abortion was the trauma that bothered them most. Table 3.34 summarises responses to questions relating to perceived threat during the trauma.

Table 3.34. Perceived threat during the trauma that 'bothered me most'.

Perceived threat	Participants identifying abortion as 'bothering me most'.	Participants identifying other trauma as 'bothering me most'
The participant was physically injured	2	1
Some one else was physically injured	3	0
Participant thought her life was in danger	2	1
Participant felt someone else's life was in danger	8	2

N=11

The table summarises numbers of participants indicating particular perceptions of threat (listed on the PDS, Foa, 1995). The majority of participants who identified the abortion as bothering them most indicted on the revised PDS that they perceived 'someone else's life was in danger'.

Three participants did not think that the question 'was someone else's life was in danger?' could have included the foetus. However once the participants read the additional note inserted for the purpose of the present study, regarding this statement (see Chapter 2), eight participants indicated that their 'foetus' or 'baby's' life was in danger.

ii) The person's response involved intense fear, helplessness or horror.

All participants reported that they felt helpless and terrified during the trauma that 'bothered me most'.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways.

Table 3.35 summarises numbers of participants experiencing the listed symptoms. The mean score was calculated by adding together all participants' scores for each symptom (ranging from 0-3) and dividing this total by the number of participants (i.e. 11).

Table 3.35. Re-experiencing

Re-experiencing	Number	Mean score
Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.	11	2.3
Recurrent distressing dreams of the event.	7	2.0
Acting or feeling as if the traumatic event were recurring	8	2.0
Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.	9	2.7
Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.	8	2.3
Mean score	*8.6*	*2.3*

N=11.

The table summarises numbers of participants experiencing the listed symptoms and the mean score of that group of participants.

Range of scores for each item is is from 0-3, the higher score indicating more severity of symptom.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following [see list of avoidances in Table 3.36]:

Table 3.36 summarises numbers of participants experiencing avoidant symptoms. The mean score was calculated by adding together all participants' scores for each symptom (ranging from 0-3) and dividing this total by the number of participants (i.e. 11).

Table 3.36. Avoidance

Avoidance	Number	Mean score
Efforts to avoid thoughts, feelings, or conversations associated with the trauma	10	2.5
Efforts to avoid activities, places, or people that arouse recollections of the trauma	10	2.6
Inability to recall an important aspect of the trauma	6	2.7
Markedly diminished interest or participation in significant activities	10	2.2
Feeling detachment or estrangement from others	11	2.3
Restricted affect (e.g. unable to have loving feelings)	10	2.8
Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span).	10	2.6
Mean score	*9.6*	*2.5*

N=11.

The table summarises numbers of participants experiencing the listed symptoms and the mean score of that group of participants.

Range of scores for each item is is from 0-3, the higher score indicating more severity of symptom

Particular avoidances reported by participants (in Booklet A, see Appendix IV) included strong discomfort thinking of the anniversary of the expected birth, visiting or going near the place where the termination took place, and looking at photos/ pictures of foetuses. Notably, feeling detached and estranged from others was a feeling common to all.

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:-

Table 3.37. Increased arousal

Increased arousal	Number	Mean score
Difficulty in falling or staying asleep	10	2.2
Irritability or outbursts of anger	11	2.3
Difficulty concentrating	11	2.6
Hyper-vigilance	10	1.9
Exaggerated startle response.	11	2.4
Mean score	*10.6*	*2.3*

N=11.

The table summarises numbers of participants experiencing the listed symptoms and the mean score of that group of participants.

Range of scores for each item is is from 0-3, the higher score indicating more severity of symptom

All participants reported high levels of arousal, particularly in context with outbursts of anger, difficulty in concentrating and exaggerated startle response. It can also be seen from Table 3.37 that ten participants experienced hyper-vigilance and difficulty in sleeping. Eight participants reported (in Booklet A) experiencing regular nightmares as well as dreams about babies

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

All participants completed the PDS more than one month after the identified trauma. Four participants developed symptoms within 6 months of the trauma and seven experienced delayed symptoms.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Table 3.38 summarises a one-sample, 2-tailed *t*-test comparing the participants' ratings for severity of symptoms with norms of the PTSD population (Foa, 1995).

Table 3.38. Participants' PTSD symptom severity scores compared with PTSD norms (Foa, 1995)

Participants N=11	PTSD norms N=128	*t*	*df*	*p*
36.36 (5.95)	33.59 (9.96)	.314	10	.790

The data are expressed as mean values (standard deviations in parenthesis).

Results were not significantly different to the clinical norm.

As predicted these results suggest that all participants were suffering from PTSD and the severity of their symptoms were not significantly different to means of the PTSD population. Nine participants attributed their symptoms to the termination of pregnancy. Four of these participants' scores indicated severe PTSD and five indicated moderate to severe PTSD. The scores of the 2 participants who attributed their symptoms to another trauma indicated moderate to severe PTSD. It appears that the demand characteristics of the PDS Scale suggested to a minority of participants that the abortion was not a 'valid' trauma. The revised wording of the form (see Chapter 2) enabled the participants to feel able to respond to the question 'was someone else's life was in danger?' in context with the foetus.

3.11 Summary of psychometric test results

Results are summarised in context with one-sample *t*-tests. Table 3.39 summarises results of the participant's scores for the Creative Imagination Scale (CIS, Barber and Wilson, 1978); the Hospital Anxiety and Depression Scale (HADS, Zigmund and Snaith, 1983); the Powerful Others Scale (IPO, Levenson, 1981) and the Rosenberg Self-Esteem Scale (RSE, Rosenberg, 1989), compared to norms of non-clinical groups, standard deviations are shown in parenthesis.

Table 3.39. Summary table: Participants compared with non-clinical groups

	Participants			Non-clinical					
	N	**Mean**	**SD**	**N**	**Mean**	**SD**	***t***	***df***	***p***
CIS	10	24.2	(4.18)	217	20.8	(8.6)	2.57	9	.030
HADS									
Anxiety	11	15.09	(4.25)	1792	6.14	(3.76)	6.98	10	.000
Depression	11	10.27	(5.10)	1792	3.68	(3.07)	4.29	10	.002
IPO									
Internality	11	28.55	(10.86)	-	35	(7.0)	-1.20	10	.077*
Powerful Others	11	33.36	(10.16)	-	20	(8.5)	4.16	10	.002
RSE	11	20.73	(7.82)	60	29.71	(3.88)	-3.81	10	.003

The data are expressed as mean values (standard deviations in parenthesis).

The participants' scores compared to clinical groups were all significantly different with the exception of the 'Internality' subscale of the 'IPO' (Levenson, 1981), marked with an asterisk (*).

It can be seen that, with the exception of the Internality subscale of the IPO, the participants' scores were significantly different to those of the comparison non-clinical groups. Table 3.40 summarises results of the participant's scores for the Perinatal Grief Scale (PGS, Potvin et al, 1988); the Trauma Related Guilt Inventory (TRGI, Kubany, 1996) and the Posttraumatic Distress Scale (PDS, Foa, 1995) compared to norms of clinical groups, standard deviations are shown in parenthesis.

Table. 3.40. Summary table: Participants compared with relevant clinical groups.

	Participants			Clinical group					
	N	Mean	SD	N	Mean	SD	*t*	*df*	*p*
TRGI									
Global Guilt	11	3.41	(0.59)	74	2.8	(0.89)	3.4	10	.007
Guilt cognitions	11	2.76	(0.77)	74	2.1	(0.69)	2.82	10	.018
Distress	11	3.57	(0.35)	74	3.1	(0.70)	4.49	10	.001
Hindsight-bias	11	3.11	(0.67)	74	1.8	(0.90)	6.50	10	.000
Wrongdoing	11	2.15	(0.70)	74	2.5	(0.80)	-1.64	10	.132*
Lack of justification	11	2.90	(0.95)	74	2.1	(0.91)	2.79	10	.019
PGS									
Active grief	11	45.91	(3.18)	63	31.85	(10.18)	14.68	10	.000
Difficulty in coping	11	44.55	(6.76)	63	21.40	(8.32)	11.36	10	.000
Despair	11	42.36	(5.71)	63	20.51	(6.83)	12.57	10	.000
PDS									
Symptom severity	11	36.36	(5.95)	128	33.59	(9.96)	.314	10	.760*

The data are expressed as mean values (standard deviations in parenthesis).

The participants' scores compared to clinical groups were all significantly different with the exception of those marked with an asterisk (*).

The participants' scores compared to clinical groups were all significantly different with the exception of the Wrongdoing subscale of the Trauma Related Guilt Inventory (Kubany, 1996), and the PDS (symptom severity) (Foa,1995).

Table 3.41. Summary of results in context with research predictions: The nature of post-abortion distress.

Table 3.41 lists research predictions together with results.

	Research prediction: The participants will share the following characteristics	**Results**
1.	Have above average vividness of imagery.	There appeared to be no predominant level of vividness of imagery across the group. 91% of the participants indicated imaginative involvement e.g. in imagining what the baby would have looked like, imagining the foetus as a baby continuing to grow. 40% of the participants had these thoughts 'all the time'. 82% of the participants thought 'all the time' about the possibility that the foetus felt pain during the procedure. Thoughts about what had happened to the foetus after the abortion were experienced by all participants.
2.	Be sensitive to the views that others have about abortion.	The majority (73%) of the participants were sensitive to views of others about abortion and feared possibility of rejection due to having had an abortion.
3.	Be of above average hypnotic suggestibility.	The majority (80%) of participants were of above average hypnotic suggestibility and statistical analysis indicated that the participants mean scores were significantly different to reported means of college students.
4.	Have anti-abortion beliefs; Have religious beliefs that are associated with anti-abortion views.	Only a minority (18%) had strong anti-abortion views. However seven (64%) agreed strongly that the abortion felt like they had 'committed murder'. None of the participants considered themselves as strongly religious but religious / spiritual symbolism was at least moderately important to nine participants (81%) and very important to 6 (55%) participants.

5.	Have an attributional style in which they blame their character for their distress, rather than their behaviour. Have a stable, pessimistic attributional style.	73% blamed their behaviour for their distress and 91% blamed their character for their post-abortion distress. 73% of the participants blamed 'the situation', for their distress and none totally disagreed that their distress was due to 'chance'. 91% of the participants indicated a pessimistic, stable, attributional style. By contrast there appeared to be optimism about the possibility that hypnosis, as an adjunct to therapy, could help them to feel better.
6.	Have a tendency towards maladaptive, rather than adaptive, coping style.	The 3 most used coping styles were 'escape-avoidance' (91%), self-control (64%) and accepting responsibility (55%). Only one of the participants used 'social support' and none of the participants used 'positive appraisal' – the two most adaptive coping strategies.
7.	Have a perception of generally having experienced poor self-esteem prior to becoming pregnant and the abortion experience.	73% of the participants rated their self- esteem (retrospectively) lower than the mean score of college students indicating a general perception of poor self-esteem prior to the abortion experience.
8.	Have a perception of generally having experienced negative affect prior to the abortion experience.	Nearly half of the participants regarded themselves to be 'completely' confused, anxious and depressed before the pregnancy / abortion had occurred, and 64% had felt 'completely' isolated and lonely.
9.	Perceive that they have little control over events as compared with non-clinical norms.	Ten (91%) of the participants scored over the mean score of students for 'powerful others' and eight (73%) scored below the mean score of students for 'internality', indicating a general perception of little control over their lives. Statistical analysis indicated that the participants' mean scores for the Powerful Others subscale of the IPO were significantly different to mean scores of college students.

	Research prediction: The participants will have shared similar life experiences	**Results**
1.	Exposure to life stressors previous to the abortion.	All participants had experienced life stressors. Eight participants (73%) had experienced a traumatic event prior to their pregnancy/ termination. Five of these participants had experienced one trauma and three had experienced multiple traumas.
2.	Experience of previous mental health problems.	81% of the participants had received counselling in the past.
3.	A negative abortion experience e.g. *insensitive treatment by professionals involved in the abortion;* *difficulty in making the abortion decision(s);* *persuasion to either have or not to have the abortion;* *a perception of poor social support at the time of, and after, the abortion.*	 90% of the participants did not feel that they had been treated with complete sensitivity by the professionals involved in their abortion. None of the participants felt completely comfortable about their abortion decision. The majority of the participants felt the decision was never really made. 73% of the participants had experienced being persuaded either to have or not to have the abortion. 64% had been warned that they would regret their decision. None of the participants had felt consistently well supported at the time of, and after, the abortion.

	Research prediction: The participants will be sharing similar symptoms following their abortion experience, such as:	**Results**
1.	Clinically significant depression and anxiety following their abortion(s) Symptoms of anxiety and discomfort which impact on daily functioning.	73% of participants were clinically depressed according to Zigmund and Snaith's (1983) criteria. Statistical analysis indicated that there was significant difference between participants' mean scores and those of a normative sample. The majority of participants experienced nightmares, dreams about babies, panic attacks difficulty in sleeping and overwhelming thoughts that influenced their daily functioning. A number of everyday activities relating to babies were uncomfortable for the majority of participants, as were activities that had direct connection to the abortion but which could occur frequently and unexpectedly in everyday life.
2.	Feelings of guilt comparable to that experienced by a group widely accepted as having been involved in traumatic experiences (Vietnam veterans), and associated feelings of shame and self-rejection.	The participants' scores were higher than the comparison group with the exception of 'wrong doing' where the Vietnam veterans mean score were higher. 81% of participants rated 'wrong doing' lower (or as low as 'lack of justification') than other factors of guilt. Statistical analysis indicated that guilt suffered by the participants was statistically different to that suffered by Vietnam veterans. However the 'wrongdoing' subscale of the TRGI was not significantly different to the comparison group. Only 4 participants felt strongly that they deserved to feel better about the termination. Only one of the participants strongly agreed that she could accept herself for having had an abortion and seven (64%) felt strongly that they could not accept themselves for having had an abortion.

3.	Grief levels comparable to that of women who spontaneously abort.	The participants' mean scores for all subscales ('active grief', 'difficulty in coping' and 'despair') was higher than mean scores for women who had spontaneously aborted. Statistical analysis indicated that grief suffered by the participants was statistically different to the comparison group (women who had spontaneously aborted).
4.	Negative feelings directly related to having had an abortion. *Directly related to having had the abortion.* *In general.*	 Certain negative emotions (sadness, badness, regret, guilt and loss) were strongly felt by the majority of the participants about their abortion but others ('wrongness' and 'lack of relief') were less commonly experienced. 55% of participants had increased feelings of shame and irritability following their abortion.
5.	Poor self-concept and low self-esteem compared to non-clinical norms following the abortion.	Following the abortion 91% of participants had lower self-esteem scores than the mean score of college students. Statistical analysis indicated that these scores were significantly different to mean scores of the normative sample.
6.	Continued attachment to the aborted foetus.	64% perceived the pregnancy loss as a 'baby'. Three participants had given the pregnancy loss a name. Only three participants indicated that they thought of the pregnancy loss as a bunch of cells or foetus and none of these participants held this conceptualisation consistently.
7.	Dissociative experiences	91% of the participants had some experience of feeling that the termination seemed unreal and all shared a tendency to daydream whilst thinking about the abortion. 73% of participants had experienced dissociating from 'the self' who had had the termination.
8.	A perception that general health has been affected by the abortion experience	The majority of participants (64%) perceived that their physical health had deteriorated following the abortion.

9.	PTSD symptoms that meet the diagnostic criteria for Post Traumatic Stress disorder and severity of symptoms comparable to the norms of the PTSD population.	All participants met the diagnostic criteria for PTSD and nine (81%) attributed this to the abortion. Statistical analysis indicated that severity of symptoms was significantly different to the PTSD population (Foa, 1995).

Table 3.41 shows that the participants characteristically indicated high imaginative involvement rather then vividness of imagery, sensitivity to the views of others, and above average hypnotic suggestibility. They commonly did not have anti-abortion beliefs. The majority of participants tended not to blame others or chance for their distress but were more likely to blame their character and behaviour. They generally had a stable, pessimistic explanatory style and coping styles were mainly 'escape-avoidance', 'self-control' and 'accepting responsibility'. The participants commonly experienced great discomfort on exposure to reminders of the abortion and generally perceived themselves to have been isolated and suffering from low self-esteem before the abortion. Most felt they had little control over their lives.

Following the abortion, their symptoms commonly included clinical depression and anxiety, severe guilt (but not related to 'wrong-doing'), most did not feel they deserved to feel better and were experiencing low self-esteem. They experienced continued attachment to the foetus and more severe grief than women who miscarry. The majority had dissociative experiences, deterioration of physical health and all met the diagnostic criteria for PTSD.

Comparisons to non-clinical groups (Creative Imagination Scale, Hospital and Anxiety Scale, Rosenberg's Self-Esteem Scale and the Internality and Powerful Others Scale), showed statistically significant differences, with the exception of the Powerful Others subscale of the Internality and Powerful Others Scale. Comparisons to clinical groups (Posttraumatic Diagnostic Scale, Perinatal Grief Scale and the Trauma Related Guilt Inventory) showed statistically significant differences.

These results are discussed in Chapter 6 along with those of the second stage of the study.

CHAPTER 4

THE EFFICACY OF HYPNOSIS AS AN ADJUNCT TO THERAPY FOR POST ABORTION DISTRESS: METHODOLOGY

4.1 Design

This study uses a multiple-baseline time series design (Barker, Pistrang and Elliot, 1994).

In order to evaluate the impact of hypnotic interventions on the therapeutic process, anxiety, anger-hostility, somatisation and depression, as well as the participants' comfort about the abortion decision, were self-rated weekly. These ratings commenced at least 2 weeks prior to commencement of therapy in order to provide a baseline.

Outcome of therapy was evaluated by the participants' responses to questionnaires prior to therapy, one week following completion of therapy and at follow ups (approximately 3 months and 9 months following completion of therapy). Relevant psychometric tests were included in the questionnaires (see Chapter 2) as well as questions about thoughts, feelings and experiences associated with the termination of pregnancy.

In order to identify any correlation between outcome of therapy and the participants' responsiveness to hypnosis, each participant was administered a scale to measure her creative imagination, which is closely correlated to hypnotisability (Spanos, Gabora, Jarrett, & Gwynn, 1989).

The interventions were standardised and introduced systematically to evaluate impact on specific symptoms. For instance, during the first phase of therapy, each participant was

taught self-hypnosis in session one. Should the participant be experiencing PTSD symptoms, this was reported back to the participant in session two. Hypnosis was not used in this session so that any therapeutic effect attributed to receiving a PTSD diagnosis would not be confounded with any possible therapeutic effect of a hypnotic intervention. A hypnotic 'reliving' back to a happy event in the past was used in the third session. These, and the following interventions were all based on those outlined in the therapeutic protocol (see 4.4). However, as therapy progressed, the framework was used flexibly to meet the emerging needs of each participant.

Barker, Pistrang, & Elliot (1996) cite a study of six couples, in which one partner of each was suffering from schizophrenia, as an illustration of a 'multiple single case design'. This design enabled the authors (Bennun and Lucas, 1990) to identify the particular intervention that had had a positive impact on schizophrenic symptoms. As Barker, Pistrang, and Elliot (1996) suggest, single case studies can be replicated on several individuals, so that it may be possible to generalise beyond the specific participants studied to make broader claims about the efficacy of the treatment tested. Likewise, Borckardt and Nash (2002) suggest that the single-case time-series design can provide viable inferences about efficacy and, under some circumstances, mechanism of change. However, their time series design requires a substantial baseline (6-8 weeks). It was decided, therefore, that a long base line would be contraindicated for this group as it was anticipated that the pre-therapy questionnaires may evoke painful feelings as commonly observed in routine assessments for problems that involve traumatic experiences.

The therapeutic protocol was thus evaluated by a) examining the data to establish possible inferences about the efficacy of individual therapeutic interventions (Borckardt

and Nash, 2002) and b) by comparing pre-therapy ratings with post-therapy and follow-up ratings in order to evaluate overall change as well as stability of change. Reliability of change was calculated using the Reliable Change Index (Jacobson and Truax, 1991).

The project was granted approval by the joint UCL/UCLH Committees on the Ethics of Human Research.

4.2 The participants: (See also Chapter 2.2)

i) Selection criteria

Participants who met the diagnostic criteria of PTSD, as measured by the Posttraumatic Stress Diagnostic Scale (Foa, 1995) and who indicated that severe distress relating to difficulty in psychologically resolving termination(s) of pregnancy was the problem for which they required therapy, were eligible to be recruited on to this second part of the project. Six participants requested therapy of which one (referred by a psychiatrist at EGA) was eliminated from the project because it emerged that she was not suffering from post termination distress. This woman was given therapy for the problem that she presented with, but her responses to questionnaires were eliminated both from the first and second part of the study. The remaining 5 were all suffering from post–abortion distress and met the diagnostic criteria for PTSD. These participants were required to agree to complete the following:-

- Booklets C (EAQb) and D at post therapy and at 3 month and 9 month follow up (see Appendices V and VII)
- The Hopkin's Symptom Checklist (Derogatis, Lipman, & Covi, 1973) and the Comfort with Abortion Decision Questionnaire (CADQ) (Walters, 2000) (see Appendix VIII). These were to be completed on a weekly basis throughout therapy in addition to the pre therapy baseline sessions.

All participants received therapy at the Hypnosis Unit at UCL except participant 2891, who was counselled in her own home. This participant was unable to travel to the Hypnosis Unit due to a medical condition. All participants received therapy by the author of this study.

ii) Completion and attrition rate

Of the 11 participants who completed Booklets A and B, 6 did not go on to complete therapy. Demographic details of these participants are shown in Table 4.1 (repeated from Table 2.1, Chapter 2 in order to facilitate reference).

Table 4.1. Demographic details of the participants who did not continue to Part Two of the project.

Code	Age	Marital status	Children Ages in years	Family Ages in years	Occupation	Working?	Living arrangements
2112	36	Divorced	2 girls: 8 & 6 2 boys: 10 & 4	Mother: 58 Father: 59 Sister: 35	NIL	NO	Living with children and partner
1055	45	Divorced	1 boy: 17	Mother: 77 Father: deceased 1 brother 1 sister	Publishing	YES	Living with partner and her son.
1120	36	Divorced	1 boy: 4	Mother: 57 Father: 61 Brother: 31, Brothers twins: 34	Local government worker	YES	Living with mother and brother
1010	33	Single	Nil	Mother: 68 Father: deceased	Receptionist	YES	Living with partner
7808	22	Single	Nil	Mother: 55 Father: age unknown Brothers: 40,32 Sisters: 25,38	Student	NO	Partly at home partly with friends
4040	40	Single	Nil	Mother: 67 Father: 70 Brothers: 45, 43	Medical profession	YES	Living with friends

The demographic details of the participants who received therapy for the present study are shown in Table 4.2 (repeated from the Table 2.1, Chapter 2 in order to facilitate reference).

Table 4.2. Demographic details of the 5 participants who completed Part Two of the project.

Code	Age	Marital status	Children Ages in years	Family Ages in years	Occupation	Working?	Living arrangements
2891	35	Married	2 girls: 11 & 3	Mother: 54 Father: 56 2 sisters: 29 & 13	NIL	NO	Living with children and husband
1069	24	Single	Nil	Mother: 46 Father: 50 Sisters: 18,16, 4 Brothers: 14,13,5	Managerial charity work	YES	Shares a flat with a friend.
1085	23	Single	Nil	Mother: 52 Father: 52 Brother: 27	Managerial /media	YES	Living with friends
2553	37	Remarried	1 girl: 12	Mother: 62 Father: 66 Brothers: 33, 3 Sister: 35	Creative freelance.	YES	Living with husband, and daughter from previous marriage.
2314	28	Single	Nil	Mother: 67 Father: 72 Sister: 33	Skilled outdoor work	YES	Living with partner

There were no obvious demographic differences between those who entered the study and those who did not, except that the mean age of those not entering the study was older (35.3 years) than those who did (29.6 years). Reasons given by the six for not continuing to Part Two of the project are listed in Table 4.3.

Table 4.3. Reasons for not continuing to Part Two

Participant	Reason for not continuing to Part Two
2112	Complications resulting from a crisis that arose during the time therapy took place (son being taken into care) that needed intensive local support. The participant was unable to cope with the additional time commitment of therapy for her post abortion distress.
1055	Decided to withdraw after the first base line session in which she had become distressed when completing Booklet A. Changed her mind and returned to the second baseline session to complete Booklet B. Decided not to take part in the therapeutic part of the project due partly to concerns about the use of hypnosis in therapy.
1120	Unable to continue travelling to the Hypnosis Unit due to experiencing severe anxiety when travelling on the tube.
1010	Withdrew after the two base line sessions in which she completed Booklets A and B. Decided not to take part in the therapeutic part of the project. No reason given.
7808	Completed Booklets A and B but chaotic life style resulted in many missed appointments and eventual withdrawal from project.
4040	Received 3 sessions of therapy but work demands resulted in numerous missed and changed appointments. It was decided to delay therapy until work commitments settled down, during which time she became pregnant.

It can be seen that reasons were varied including matters related to domestic and life-style issues, anxiety about travel and in one case a concern about hypnosis.

4.3 Materials

i) Booklets A, B, C, and D (Appendices IV, VI, V, VII)

Four sets of questionnaires (each presented as a booklet) were devised. These were completed by the participants, prior to therapy.

- The Experience of Abortion Questionnaire: Version a (EAQa) referred to as 'Booklet A'
- A compilation of psychometric tests referred to as 'Booklet B'

(These two booklets are described in Chapter 2.)

Two further booklets, The Experience of Abortion Questionnaire: Version b (EAQb) referred to as Booklet C, and Booklet D, were completed post therapy and at follow-ups, in order to evaluate whether the overall CBT package was followed by improvement of the mental health of the participants.

- Booklet C was essentially the same as booklet A, but demographic details were not included and the tense of the verbs was changed as appropriate.
- Booklet D was essentially the same as Booklet B except that the CIS and the VVIQ were not repeated and an additional section was added in order to enable each participant to feed back evaluation of her therapy.

ii) The Hopkins Symptom Checklist (SCL-90) (Derogatis, Lipman, & Covi, 1973) (see Appendix VIII)

This symptom checklist was used to measure anxiety, depression, anger-hostility and somatic symptoms before therapy and at weekly intervals during therapy. These are four sub-scales of the Hopkins Symptom Checklist, which were selected as being the most appropriate for the present study. The Likert scale ranged from 0 and 4, the higher score indicating the most severe response. The SCL-90 was designed by the authors (Derogatis, Lipman, & Covi, 1973) to measure improvement following therapy and not as a diagnostic tool. Norms, therefore, have not been included.

iii) Comfort with Abortion Decision Questionnaire (CADQ) (Walters and Oakley, 2000)

This single–item, self-rated questionnaire was designed to monitor the participants' comfort with their abortion decision during the therapeutic process (see Appendix VIII). This was presented as a statement at the top of the SCL-90 form for participants to rate their feelings about the decision to have the abortion. Comfort level was indicated by response to a Likert scale ranging between 1 and 7, the highest score indicating the most comfort. This was scored in reverse so that the data, when presented as a graph, would follow the same convention of the other graphs in which the higher score reflected amore negative emotion.

iv) 'Most Helpful Aspect of Therapy' form (MHAT) (see Appendix IX)

Each participant was asked to fill in a MHAT form (Parry, Shapiro and Firth, 1986) at the end of each therapy session. This was returned to the therapist in an envelope that was signed over the seal and dated. Likewise, the therapist completed a similar form stating what she perceived to be the most useful aspect of the session for the client. The participants' MHAT forms were not opened until after completion of therapy.

v) 'Usefulness of Hypnosis' Questionnaire (UOH) (Walters and Oakley, 2000) (see Appendix XI)

Brief descriptions of all hypnotic interventions were typed up and given to the participant on completion of therapy. Participants were asked to comment on what the hypnotic intervention felt like and how this might have helped them. The participants were asked to rate the usefulness of each hypnotic intervention from 0 to 5, the higher rating indicating the most useful, and returned to the therapist one week following completion of therapy.

vi) Evaluation of Counselling Questionnaire (ECQ) (Walters and Oakley, 2000) (see Appendix VII)

This questionnaire included questions to examine the extent to which the participants considered the therapy to be successful; to identify what the participants felt was particularly helpful about the counselling and hypnotic interventions; and to establish whether the participant was continuing to use self-hypnosis.

4.4 Procedure

i) Baseline sessions

The weekly checklists, completed prior to the first therapy session, provided data for the pre-therapy base line. The 2 pre-therapy sessions are described in Chapter 2 (see 2.4). The first participant to be counselled (2891) had a longer baseline than the others due to domestic commitments delaying the start of therapy.

All participants who wished to receive therapy for post-abortion distress were given additional SCL-90 / CADQ forms at the second base-line sessions and were instructed to complete these at weekly intervals, immediately prior to each therapy session.

The participants returned one week following completion of therapy to complete Booklet C and D. They were then asked to return in 3 months after completion of therapy for follow-up one, and 9 months after completion of therapy for follow-up two, in order to complete these booklets again.

ii) The therapeutic protocol.

The protocol outlined below is based on a 12-session, three-phase model. Core interventions are shown in Table 4.4. Sessions that included hypnotic interventions are indicated with an asterisk. The hypnotic intervention lasted between 20 minutes and 60 minutes. Thus, some sessions (e.g. reliving the pregnancy termination procedure) were about half an hour longer than the normal one hour. If hypnotic interventions were used, the time prior to the intervention was used to orientate the client towards the focus of the intervention and the time after the intervention was used for consolidation of what was addressed in the intervention, according to the needs arising for the client at the time.

Table 4.4. Core interventions

No.	Hypnosis	Intervention
Phase One		
1	*	Teaching self-hypnosis for relaxation / expression of feelings re termination
2		Participant informed of PTSD diagnosis
3	*	Reliving a happy childhood experience
Phase Two		
4		Exploration of feelings associated with the termination
5	*	Exploratory reliving
6		Exploration of insights made / relationship issues
7	*	Reliving the abortion / abortion decision
		Exploration of feelings of grief
9	*	Mourning ritual / grief resolution
Phase Three		
10		Review of feelings / progress /insights
11	*	Consolidation of moving on (past /future)
12		Review /endings

Phase One: Sessions 1-3

In the first session the therapeutic plan was discussed with the participant, a definition of hypnosis was given that presented it as a combination of 'trance' and suggestion (Brown and Oakley, 2004). Illustrations of 'everyday trances' were given, such as being absorbed in a book. Following this explanation the participant was given opportunity to ask questions. The participant was then encouraged to describe her problem in her own words and her feelings were acknowledged.

Self-hypnosis was taught to reduce anxiety and a rationale for using self-hypnosis focussing on reduction of anxiety was given. The self-hypnosis routine was based on the participant's own imagery of a relaxing in a safe, or 'special', place to enhance the relaxation response and included suggestions to encourage optimism that the participant could achieve their identified goals. These feelings of relaxation and optimism were paired, in hypnosis, with an 'associated cue' (for example a word or small object). Participants were encouraged to practice accessing these feelings with the 'associated cue' in order to reduce hyper-arousal and build resources for the second phase of therapy (see Appendix XV).

Pragmatic matters such as the completion of weekly checklists were discussed. Whilst contracting issues regarding participating in the research study were completed in the first base line session, issues relating to confidentiality and numbers of sessions offered were confirmed once again in this first therapy session.

In the second session participants whose symptoms met the DSM IV criteria for PTSD (as measured by the PDS) were informed of this. From the second session onwards the participant was asked about her use of self-hypnosis during the previous week.

Likewise, from session two, weekly checklists were collected from each participant at the beginning of the session.

In the third session participants were introduced to hypnotic 'reliving' a happy time in the past, in order to re-experience positive feelings that may have been felt prior to the termination. A hypnotic induction, based on the 'special place' routine taught for self-hypnosis, was used to formalise the beginning of the hypnotic intervention in this and all subsequent hypnotic interventions (although the induction procedure became briefer in later sessions reflecting the participants' repeated practice).

The induction began by the therapist asking the participant to close her eyes. The therapist then gave suggestions that focussed on breathing, followed by suggestions for muscle relaxation. The therapist counted from one through to ten, timing each count with the participant's out-breath in order to further focus attention. The counting was combined with imagery that had been previously agreed with the participant (such as stepping down a staircase) in order to evoke a feeling of gradually drifting towards the 'special place'. Suggestions based on the participant's own description of being in the 'special place' were given to encourage a feeling of 'being there' (see Appendix XVII for the induction script).

Suggestions for 'reliving' a happy time were given following the participant becoming increasingly involved in the 'special place' imagery. Verbal feedback was encouraged from the participant in order to further engage her in the imagery and to enable the therapist to respond appropriately to the participant's own unique experience of being in her 'special place'. The choice of 'safe remembering' technique was selected by each participant. For example, participants could experience themselves in a safe bubble that

'transports' them back to the past (Alden, 1995) or 'watching a television screen' whilst controlling the 'replaying of a video of their life'. This first hypnotic reliving also enabled participants to experience talking in hypnosis for the first time, again in preparation for future hypnotic interventions. For instance, the participant might have been asked to verbally rate, in hypnosis, their level of relaxation whilst 'travelling back in time' and to describe how their 'younger self' looked and felt.

After this session verbal feedback about the induction procedure was obtained from the participant so that it could be adapted in any way necessary to enhance the experience for subsequent sessions.

One purpose of the first reliving intervention was to enable participants to become familiar with 'going back in time' and to try a 'safe remembering' technique before experiencing this in context with confronting painful emotions in phase two of therapy. Another purpose was to elicit feelings from the past that could be beneficial to the participant in the present. For example, should the participant have expressed feelings of isolation in context with the termination and return back to a time in which she was expressing feeling happy being with others, the therapist may have given a post hypnotic suggestion (i.e. a suggestion made in hypnosis in order to trigger a response beyond the hypnotic experience) that 'feelings of being part of the world' could be brought into the present. Likewise, an 'associated cue' might be used (see above) in order to facilitate re-experiencing the good feelings accessed in hypnosis, in the client's everyday life.

Phase Two: Sessions 4-9

The second stage of therapy involved expression of feelings, identifying links between past and present, confronting the abortion experience in order to facilitate emotional

processing (Foa and Kozak, 1986) and completing grief. The use of ego-state techniques (see below) was also introduced (Watkins and Watkins, 1997).

In session 4 the participant was encouraged to review progress in context with the use of her self-hypnosis for anxiety control and to express her current feelings about her pregnancy termination.

In session 5, following the hypnotic induction, hypnotic reliving was used to facilitate insights that may help the participant to understand her post-abortion distress in context with previous life experiences. The reliving technique used in the first phase of therapy was used again but this time, following the hypnotic induction, it was suggested to the participant that she 'go back to a time in the past that would be helpful to revisit'. Ego-state techniques (Watkins and Watkins, 1997) were used to encourage the participant to view this event from the safety of the 'bubble' or 'video screen' and questions were asked about what was happening and what emotions her 'younger self' was feeling in the scene. The therapist then suggested that the participant 'becomes' the younger self to further encourage expression of emotions. If painful feelings were expressed, it was suggested that the participant's 'older wiser self' (who was viewing the scene from the safety of the bubble or video), then joined her 'younger self' to comfort her and help her feel better. It was suggested that the participant told her younger self something that she had not heard, known or understood at the time that would help her now. Likewise, the 'younger self' was asked if there was anything she needed to do or say that would be helpful to her and was then encouraged to do or say (in hypnosis) whatever she had identified. For example, should helplessness be the emotion 'uncovered', she was encouraged to experience feeling empowered. Similarly, through the use of Socratic questioning, she may have been encouraged to reframe her cognitions about this

experience and gain new understandings. The safe remembering technique enabled the participant to 'return to the bubble' or 'fast forward the video', should she have felt overwhelmed at any point.

In session 6 the focus was on helping the participant to begin to gain meaning about her post-abortion distress in context with insights gained from the previous hypnotic interventions. Important relationships were also discussed in this session (past or present) in relation to feelings about the termination. The participant was encouraged to identify any shift of emotions. The experience of the termination experience was discussed in preparation for session 6.

In session 7 a hypnotic intervention, following an induction, was used to revisit the experience of the termination procedure, using the 'safe remembering techniques' and 'ego-state techniques' described above. In this way comfort was given to the 'self experiencing the abortion' by her 'older wiser self'. Likewise, the therapist initiated a dialogue between the 'self experiencing the abortion' and her 'older wiser self' in order to encourage insight and resolution. After the participant was alerted from hypnosis, the experience was discussed. Should the participant have needed additional exploratory work in order to make further resolution a technique was used to track the currently felt emotion, or somatic symptom, back to the past. This technique involved, in hypnosis, returning to a recent difficult feeling (or somatic symptom) and then focussing on this whilst the surroundings 'fade away'. The participant was then asked to travel back in time 'over a bridge' to a time in their life when they recognised the feeling. The purpose of this 'Affect Bridge' technique ('Somatic Bridge' if the focus is a somatic symptom) (Watkins and Watkins, 1997) is to explore past issues that may underpin present difficulties.

In session 8 the therapist made tentative enquiries about the participant's feelings towards the pregnancy loss. The therapist noted the terminology used by the participant for the pregnancy loss, i.e. whether it was referred to as a foetus, baby or child, and used the same terminology when encouraging the participant to express any possible feelings of unresolved grief. The possibility of setting up a 'mourning ritual' in hypnosis at the next session was discussed with the participant and if they wished to do this they were asked to give some thought to how they would like this ritual to be, over the following week.

The hypnotic mourning ritual in session 9 marked the last session of the middle phase of therapy. When using this procedure the participant was asked to describe the type of mourning ritual she had thought about during the week, and this was introduced following a hypnotic induction. The participant was encouraged to 'feel the baby in her arms' (or whatever imagery she had chosen to use) and was given the opportunity to complete mourning in her own individual way. The therapist prompted each stage of the mourning process with questions such as, 'what is happening now?', 'what are you feeling now?', 'is there anything you need to say right now?' etc. In the discussion following this intervention the therapist gradually addressed the reality that there was never a 'baby', but a foetus. It was felt important to consolidate this, since whilst the concept of a tangible 'baby' was useful in order to facilitate mourning, this concept, if maintained, may have colluded with maladaptive fantasising. At the end of the session it was suggested to the participant that she might mark the completion of mourning during the week, in whichever way she felt was appropriate.

Phase Three: Sessions 10-12

The third stage focussed on self-growth (including identity issues), interpersonal issues and the future in general.

In session 10, progress was reviewed and the participant was encouraged to verbalise any feelings of moving on in order to consolidate progress achieved to date. Session 10 focussed on preparing the participant for any setbacks. Symptoms, identified in phase one of therapy, were referred to and reviewed within the context of the new narrative of having psychologically resolved her abortion. The participant was also asked questions to evaluate her perceived coping expectations in situations which she had previously found upsetting. For example, she might have been asked how she would feel if confronted with anti-abortion views, and coping strategies would then be discussed. Likewise the participant might have been invited to consider whether she wished to disclose her termination to others in the future, and if so, what factors might guide her choice in this. Distinguishing between deciding not to disclose for reasons of privacy, for example, might have been contrasted with deciding not to disclose for reasons attached to shame or fear of intimidation, which may have been felt prior to therapy. In session 11 a past / future hypnotic intervention was used. In this procedure the participant was asked (after a hypnotic induction) to enter a room signifying the past where she had the opportunity to leave any feelings that no longer had a place in the present. She was then asked to enter a room symbolising the present where she could acknowledge all her new feelings of moving on and self-growth and suggestions were given to help consolidate these feelings.

In the last session (session 12) the therapy was reviewed and the participant was given the opportunity to summarise the process of her resolution. In order to facilitate this she

might have been asked what she would tell a friend in 5 years time about how she achieved her resolution, in order to consolidate a helpful 'internal narrative'. Arrangements were made in this session for the participant to return the following week to complete the post therapy questionnaires (Booklets C and D).

CHAPTER 5

THE EFFICACY OF HYPNOSIS AS AN ADJUNCT TO THERAPY FOR POST-ABORTION DISTRESS: RESULTS.

Explanatory notes:

a) The two participants who had more than one abortion were asked to complete measures listed in 5.5 in reference to 'the abortion that bothered you most'. One of these two participants (2314) made no distinction and in this case all responses to questions in both questionnaires refer generally to the two terminations. The participant who had had four terminations (2891) was not entirely clear to which termination her responses related.

b) Timing of measures:

Pre therapy: 2-4 weeks prior to therapy.

Post therapy: 1 week following completion of therapy

Follow up one (FU1): 3-4 months following completion of therapy

Follow up two (FU2): 9-12 months following completion of therapy

Follow up three (FU3): 16–18 months following completion of therapy

c) In order to show an overview of the five participants' responses, mean improvement percentages measured against pre therapy scores have been included.

d) As noted in Chapter 3, comparison with relevant clinical or non-clinical groups can be useful to indicate where the individual / subgroup score is in relation to

the normative data but this does not necessarily mean that they are significantly different from normal values.

e) The Reliable Change Index (RCI) (Jacobson and Truax, 1991) was used to calculate whether the outcome of therapy for each participant (as measured by psychometric tests) was clinically significant. The formula outlined by (Jacobson and Truax, 1991) used to calculate change is as follows:

$$RC = \frac{x_2 - x_1}{S_{diff}}$$

X_1 represents the pre-therapy score and X_2 represents the post-therapy score. S_{diff} is the standard error of the difference between the two test scores. S_{diff} can be computed directly from the standard error of measurement SE according to the following formula:

$$S_{diff} = \sqrt{(2(S_E)^2)}$$

S_{diff} describes the spread of the distribution of change scores that would be expected if no actual change had occurred. Jacobson and Truax, (1991) suggest that an RC larger then 1.96 would be unlikely to occur ($p<.05$) without actual change.

5.1 Demographics

i) Demographic information

(see EAQa, section 1)

Table 5.1 summarises age, marital status, ethnicity and numbers of children of each participant receiving therapy for the study.

Table 5.1. Demographic information: Part Two

	Age	Marital status	Ethnicity	Children
2891	35	married	White Caucasian	2 (after abortions)
1069	24	single	White Caucasian	0
1085	23	single	White Caucasian	0
2553	37	remarried	White Caucasian	1 (before abortion)
2314	28	single	White Caucasian	0

5.2 Significant life events

(see EAQa, section 17)

Prior to therapy, participants were asked to outline significant life events and memories that they believed 'may help you understand your feelings'. Responses are summarised in Table 5.2.

Table 5.2. Life events

Age	0-10 years	11-20 years	21-30 years	31-37 years
2891	Ongoing sexual abuse.	4 abortions. Father left home. Alcohol abuse. 2 rapes (1= gang rape). Eating disorder	Life threatening illness.	Life threatening illness.
1069	Looked after by different carers. Father left home.		Abortion	
1085	Over weight.	Bullied at school.	Physically assaulted by a stranger.	
2335	Grandmother committed suicide. Uncle committed suicide. Serious accident. Bullied by teacher. A serious accident Parent's absenteeism.	Bullied. Parent's divorce.	Divorced from first husband.	Second marriage / domestic violence Abortion. Father had mental breakdown.
2314		Poor relationship with parents. Physically abused by partner.	Drug and alcohol abuse. Abortion. Physically abused by partner.	

It can be seen that the majority of the participants experienced at least one trauma (as identified by the PDS, Foa, 1995), other than an abortion, and two participants (2891 and 2553) had experienced multiple traumas.

5.3 Mental and physical health

(see EAQa, section 18)

Table 5.3 summarises information about mental and physical health prior to embarking on therapy for the present study.

Table 5.3. Summary of mental and physical health history

	Previous therapy	Mental health problems	Physical health
2891	Counselling for eating disorder (a few sessions) 6 months CBT* (counselling psychologist) Psychiatric assessment (but report unavailable)	Eating disorder Ongoing depression	Chronic active hepatitis (life threatening) Asthma Clinically obese
1069	Received therapy between 18-19 years of age.	Anorexia and self-harm during teenage years	Lower back pain
1085	Counselling for panic attacks – one or two sessions whilst at university.	Panic attacks	
2553	In therapy for most of life Childhood: Father (a psychiatrist) analysed her. Received therapy at the Tavistock Clinic as a child. Other therapy includes: Adulthood: Clinical psychology Group therapy Psychoanalysis Jungian therapy Psychotherapy Referred by a psychiatrist to the present project. Psychiatric assessment: Depression / 'some question of abuse'.	Depression (taking Prozac) 'Obsessive neurosis' 'Breakdown' in late 30's Panic attacks	IBS Migraine Pre menstrual tension Breast pain and lumps Back pain
2314	Psychiatric assessment: Depression	Depression Panic attacks	General neglect of physical health

*Cognitive behavioural therapy

All participants had experienced some counselling or therapy prior to enrolling on the present project. Three participants (2891, 2553, 2314) had recurrent depression and had

been assessed, at some time in adulthood, by a psychiatrist. Two of the participants (2891 and 2553) had been referred to the project by a mental health professional and the others self-referred after having seen the project advertised in a hospital clinic.

5.4 Background to the pregnancy terminations

i) Timing, number of abortions, stage of pregnancy, whether or not a scan was seen, and professional sensitivity (see EAQa,section 2)

Table 5.4 summarises information about when and where the participants' terminations took place, the stage of pregnancy, whether or not pregnancy scans were seen by the participants, and perceptions of professional sensitivity experienced, for each termination.

Table 5.4. Details of the termination (s)

	How long ago was the termination?	Where did the termination take place?	Stage of pregnancy?	Seen a pregnancy scan?	Treated with professional sensitivity?
Termination 1					
2891	21 years	Clinic	19 weeks	*	0
1069	7 months	Clinic	8 weeks	Yes	7
1085	4 months	Clinic	6 weeks	No	3
2553	9 months	Hospital	9 weeks	No	2
2314	9 years	Hospital	8 weeks	No	6
Termination 2					
2891	22 years	Clinic	13 weeks	No	0**
2314	7 months	Clinic	17 weeks	Yes	2
Termination 3					
2891	*Participant unable to remember details*				
Termination 4					
2891	*Participant unable to remember details*				

* Could not remember *0=not at all sensitive-10=completely sensitive*

**Anaesthetised but remained fully aware.

Between them the participants had experienced 9 terminations. One participant had four terminations but was unable to give details about the third and fourth, data was thus available for only 7 of the 9 terminations experienced by the participants. The majority of the first terminations had taken place during the first trimester of pregnancy. Both second terminations took place during the second trimester. Two participants had seen

their pregnancy scan and inspection of measures taken prior to therapy appear to indicate that this did not result in higher distress than for those participants who did not see a scan.

The participants rated professional care as 'completely sensitive' for only two of the terminations experienced between them. There appears to be no pattern in which professionals were perceived to be more, or less, sensitive in either the hospitals or clinics. Although the questionnaires did not require details of the nature of any insensitive treatment experienced, verbal reports during therapy indicated that insensitive treatment included a doctor and nurse laughing and joking whilst carrying out the procedure; being subjected to an examination by a trainee nurse who was required to describe the enlarged uterus to the person training her (immediately prior to the abortion procedure); having to undress in the procedure room in front of the doctor (male) who was performing the operation; and not being forewarned of the pain involved. None of the participants had mentioned to the staff in question that these incidents had been upsetting to them.

ii) The abortion decision (see EAQa, section 7)

The table below summarises reasons given by the five participants for the pregnancy termination 'that bothered you most'. One participant chose not to respond to this question.

Table 5.5. Reasons stated for having the termination.

	Reason for having the termination
2891	Don't know
1069	Too young / broke/poor relationship with partner
1085	Nil stated
2553	Just married new husband who had left 2 children. He could not bear the idea of another one.
2314	Extreme stress, very poor mental and physical health during pregnancy

Reasons stated were varied and there appears to be no particular theme common to all five respondents.

5.5 Results of measures taken pre therapy, post therapy and at follow-ups

i) The Creative Imagination Scale (CIS) (Barber and Wilson, 1978) and the Vividness of Visual Imagery Questionnaire (VVIQ) (Marks, 1973) (see EAQb, section 5 and Appendix XVI)

CIS scores are summarised in Table 5.6 alongside related categories of hypnotic suggestibility. Possible levels of hypnotic suggestibility are high (30-40), medium high (21-29), medium low (11- 20) and low (0-9) (Barber and Wilson, 1978).

VVIQ scores and categories of the participants who completed this questionnaire are also summarised. Possible levels are 'vivid imager' (scores between 32-57), 'mid range' (scores ranging from 59-83) and 'unvivid imager' (scores ranging from 83-160) (Marks, 1973).

Table 5.6. CIS and VVIQ Scores.

	CIS		VVIQ	
Norm = 20.8	**Score**	**Category**	**Score**	**Category**
2891	24	Medium high	148	Unvivid imager
1069	18	Medium low	82	Mid range imager
1085	29	Medium high	51	Vivid imager
2553	24	Medium high	111	Unvivid imager
2314	27	Medium high	*	

* scale not administered

Participant 2314 did not complete the VVIQ due to lack of time (see 3.3). The majority of participants were of 'medium high' hypnotic suggestibility as categorised by Barber and Wilson (1978). However, there was no pattern to vividness of visual imagery that could be identified across the participants.

Consistent with findings reported in the literature (e.g. Kirsch and Council, 1992), there appears to be no correspondence between categories of vividness of imagery and hypnotic suggestibility.

ii) Hospital Anxiety and Depression Scale (HADS) (Zigmund and Snaith, 1983) (see EAQb, section 1)

Mean scores for each subscale of the Hospital Anxiety and Depression Scale (HADS) (Zigmund and Snaith, 1983) are summarised in Table 5.7. The total possible score for each subscale is 21 and a score of 8 or over for either subscale, is suggested by Zigmund and Snaith (1983) as being clinically significant. In order to show an overview of the five participant's responses, mean improvement percentages measured against pre therapy scores have been included.

Table 5.7. Hospital Anxiety and Depression Scale: Non-clinical norms compared to participants pre therapy, post therapy and follow up scores.

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
Anxiety	*Norm for non-clinical population = 6.14 (Crawford, Henry, Crombie and Taylor, 2001).*				
2891**	8	8	7	5	6
1069**	19	8	6	3	6
1085**	16	7	6	5	
2553	10	6	8	4	
2314**	16	6	8	4	
Mean improvement %		49.3%	49.3%	69.6%	
Depression	*Norm for non-clinical population = 3.68 (Crawford, Henry, Crombie and Taylor, 2001).*				
2891**	11	5*	4*	6*	3*
1069**	11	4	2	0	1
1085**	12	2	1	1	
2553	6*	5	1	6	
2314	12*	1	3	2	
Mean improvement %		67.3%	78.8%	71.2%	

* taking anti-depressant medication

** Calculations of combined anxiety and depression scores using the Reliable Change Index (RCI, Jacobson and Truax, 1991) suggested that reliable change had taken place for these participants (see Table 5.16).

The range of scores for each subscale is 0-21 and a score of 8 or over for either subscale, is suggested by Zigmund and Snaith (1983) as being clinically significant

As predicted, there was improvement on both sub scales following therapy (49% for anxiety and 67.3% for depression) and this improvement was maintained, or indeed

further improved, at follow-ups. By follow up 2 there was an overall improvement of approximately 70% for both anxiety and depression.

Of the four participants who scored over 8 for depression pre therapy, one (2314) was taking anti-depressants, as was one of the participants (2553) who scored below 8 prior to therapy. Both had ceased this medication by the end of therapy. Participant 2553 reported least overall improvement for depression but nevertheless maintained her pre treatment score (i.e. when she was taking anti-depressants), following cessation of anti-depressants. One participant (2891) began taking anti-depressants shortly before the end of therapy and her SCL-90 scores (see 5.6) revealed a sharp drop in depression just days after. It should be noted that reduction of symptoms following this medication (Cipramil) is normally expected after at least 2 weeks (British National Formulary, 1999).

Calculations of combined anxiety and depression scores using the Reliable Change Index (RCI, Jacobson and Truax, 1991) suggested that reliable change had taken place for participants 2981, 1069, 1085 and 2314 (see Table 5.16).

iii) Internality and Powerful Others Scale (Levenson, 1981)(see EAQb, section 2)

Participants' mean scores of perceived control over their lives, measured by Levenson's Internality and Powerful Others Scale (1981), are summarised below. Higher scores for 'internality' suggest greater perception of control over one's own life, whilst higher scores for 'powerful others' suggest greater perception that others have control over one's life. Mean scores of college students are shown for comparison and mean improvement percentages measured against pre therapy scores have also been included.

Table 5.8. Internality and Powerful Others Scale: Non-clinical norms compared to participants pre therapy, post therapy and follow up scores.

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
Internality *Mean scores of students= 35, Levenson, 1981*					
2891	31	38	33	30	29
1069**	41	42	47	41	41
1085**	14	29	31	38	
2553**	27	32	38	36	
2314	39	39	36	39	
Mean improvement %		21.1%	25.0%	21.0%	
Powerful Others *Mean scores of students= 20, Levenson ,1981*					
2891	39	27	26	13	22
1069	29	21	23	13	18
1085	39	15	13	11	
2553	9	8	9	12	
2314	32	24	22	13	
Mean improvement %		35.8%	37.1%	58.1%	

Possible range of scores is from 0-48 for each subscale. Higher scores for 'Internality' represent greater perception of control over life; higher scores for 'Powerful Others' indicate a perception that others have greater control over the individual's life.

Values are expressed as means of each participant's subscale scores.

** Participants achieving clinically significant change according to the RCI (Jacobson and Truax, 1991) (see Table 5.16).

Internality

The table shows that, prior to therapy, three participants scored below the mean score of college students (i.e. a non-clinical population), indicating a belief that they had little control of their lives. The two participants with lowest pre therapy scores (1805 and 2553) reported further improvement beyond therapy, reaching similar levels to the rest of the group at follow-up two. Four participants improved on scores by completion of therapy, achieving higher scores than mean scores for college students by follow up two. Calculations using the RCI (Jacobson and Truax, 1991) suggest that 3 participants achieved clinically significant change (1069, 1085 and 2553) by the end of therapy (see Table 5.16).

Powerful Others

With the exception of participant 2553, all scores were higher, prior to therapy, than mean scores of students, indicating a shared perception that others controlled their

lives. On completion of therapy all scores had improved and all participants achieved a score lower than the mean for college students by follow up two, indicating a particularly strong perception that others did not control their lives.

These results were as predicted. However, calculations using the RCI indicated that only two of the participants had achieved clinically significant change (2891 and 1085) (see Table 5.16).

iv) Perinatal Grief Scale (Potvin, Lasker and Toedter, 1988) (see EAQb,section 6)

Table 5.9 summarises each participant's combined subscales (see Appendix XIII for participants' separate subscale scores).

Table 5.9. Perinatal Grief Scale: Norms of women who have spontaneously aborted compared to participants pre therapy, post therapy and follow up scores.

Overall grief *Mean: spontaneous abortion 24.8*	**Pre Therapy**	**Post Therapy**	**Follow-up no.1**	**Follow-up no.2**	**Follow-up no.3**
2891**	43.7*	28.0*	29.3*	28.7*	26.7*
1069**	48.3*	29.0*	15.7	12.3	14.0
1085**	48.3*	24.0	11.3	16	-
2553	37.3*	30.6*	30.7*	32.3*	-
2314**	48.6*	17	22.3	17.6	-
Mean improvement %		43.1%	51.7%	52.7%	-

The data are expressed as mean values of combined subscales for each participant.

*Mean scores of subscales scored higher than mean scores of subscales for women who had spontaneously aborted.

**Participants achieving clinically significant change according to the RCI (Jacobson and Truax, 1991) (see Table 5.16)

The sum of each subscale ranges from 11 to 55, higher scores indicating the more severe grief.

Before the course of therapy, the participants' scores for the three subscales were all higher than the mean score of women who had spontaneously aborted.

Following therapy, all participants' subscale scores had, as predicted, improved and remained lower than pre therapy scores at the last follow-up. The majority of these scores were lower than mean scores for women who had spontaneously aborted, however the scores of the participants who had experienced multiple trauma (2981 and 2553) remained higher. RCI calculations (Jacobson and Truax, 1991) suggest that a clinically significant change had taken place for participants 2891, 1069,1085 and 2314 (see Table 5.16).

v) Self-esteem (see EAQa, section 5C)

Table 5.10 summarises responses to Rosenberg's Self Esteem Scale (1988). The possible range of scores is 0-40.

Table 5.10. Self-Esteem Scale: Non-clinical norms compared to participants pre therapy, post therapy and follow up scores.

Mean college students: 29.71 **	**Pre Therapy**	**Post Therapy**	**Follow-up no.1**	**Follow-up no.2**	**Follow-up no.3**
2891	18	24.5	29	25	*
1069	21	31***	28	35***	38***
1085	19	30***	32***	36***	
2553	27	32***	29	26	
2314	25	33***	29	30***	
Mean improvement %		36.8%	33.6%	36.2%	

The sum of scores ranges between 10 and 40, the higher scores indicating greater self-esteem.

* Participant did not complete this section of the booklet ** (Cheng and Furnham, 2003)

*** Mean scores of the participants are higher than non-clinical norms.

All participants achieved clinically significant change according to the RCI (Jacobson and Truax, 1991). (see Table 5.16)

Results show, as predicted, that all 5 participants had improved self-esteem scores following completion of therapy and the majority of scores were higher than the mean score for a non-clinical population (i.e. college students, Cheng and Furnham, 2003). Furthermore, all participants' post therapy results indicated significant change according to RCI calculations (Jacobson and Truax, 1991, see Table 5.16). Whilst 2 participants'

self-esteem continued to increase at follow-ups (1069 and 1085) the remaining participants showed slightly more erratic scores.

vi) Trauma Related Guilt Inventory (TRGI) (Kubany, 1996) (see EAQb, section 4).

Mean scores for the combined subscales of the TRGI rated by each participant prior to the course of therapy, on completion of therapy and follow-ups are given in Table 5.11, together with the mean score for Vietnam veterans (Kubany, 1996) (see Appendix XIV for results of sub scales). The six subscales of the TRGI are 'Global Guilt, Guilt Cognitions, Distress, Hindsight-Bias / Responsibility, Wrongdoing and Lack of Justification.

Table 5.11. Summary of Trauma Related Guilt Inventory: Clinical norm compared to participants pre therapy, post therapy and follow up scores.

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
Vietnam veterans mean score=2.4					
2891**	3.3*	1.7	1.8	2.0	2.0
1069**	3.1*	1.0	0.4	0.6	0.3
1085**	4.3*	1.0	0.6	0	
2553	2.6*	2.2	1.7	2.0	
2314**	3.7*	0.9	0.7	0.7	
Mean improvement %		60%	69.4%	68.8%	

The data are expressed as mean values of combined subscale scores for each participant.

Range of scores is from 0-4 for each item of the subscale. The higher rating indicates greater guilt.

* Combined subscale scores higher than Vietnam veterans combined subscale norms.

**Participants achieving clinically significant change according to RCI calculations (Jacobson and Truax, 1991).

Before commencement of therapy, the majority of the five participants' sub-scale scores were higher than those scored by the comparison group (Vietnam veterans) but notably three of the participants scored lower than these comparison groups for 'Wrongdoing' and 'Lack of Justification'. On completion of therapy and at follow-ups the scores of three participants were lower than the mean score of Vietnam veterans although the scores of participants 2981 and 2553 remained higher. An overview of these scores

shows a mean improvement percentage of almost 70% on scores at follow-ups one and two indicating, as predicted, improved mental health. RCI calculations (Jacobson and Truax, 1991) indicated clinically reliable change for all participants, with the exception of participant 2553's combined scores for Hindsight Bias, Wrongdoing and Lack of Justification (see Table 5.16).

vii) Ways of Coping Questionnaire (Folkman and Lazarus, 1988). (see EAQb, section 7)

Table 5.12 summarises coping styles most used by the five participants at pre therapy, post therapy, and at follow-ups.

Table 5.12. Coping styles used most by each participant

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
2891	SC, EA,	D, SSS, PR	D, SC, EA	D, SC, AR, PR	D, EA, AR,
1069	SC, EA, PPS	SC, PPS, PR	SC, PPS, SSS, PR	PPS, SSS, PR	SSS, PR
1085	EA, AR, CC	SC, SSS, PR	*	D, SSS, PR	-
2553	SC, EA, PPS, CC	SC, PPS, CC, SSS	SC, PPS, SSS, AR, PR	SC, PPS, CC, SSS, AR, PR	-
2314	SC, EA, AR	PPS, CC, SSS, PR	PPS, CC, SSS, PR	PPS, AR, CC, PR	
Total	**EA x 5 SC x 4 PPS x 2 CC x 2 AR x 2**	**SSS x 4 PR x 4 SC x 3 PPS x 3 CC x 1 D x 1**	**PPS x 3 SSS x 3 PR x 3 SC x 3 D x 1 EA x 1 (responses from 4 participants only)**	**PR x 5 AR x 3 PPS x 3 SSS x 3 D x 2 SC x 2**	-

* did not respond

D=Distancing *SC=Self-Control* *SSS=Seeking Social Support*
EA=Escape–Avoidance *PPS=Planful Problem Solving* *PR=Positive Reappraisal*
AR=Accepting Responsibility *CC=Confrontive Coping*
Values are expressed as total numbers of participants using the coping styles indicated.

Before the course of therapy, it can be seen that the most commonly used coping styles were 'escape-avoidance' and 'self-control' and that none of the five participants were using the two most adaptive coping styles (Folkman and Lazarus, 1988), 'social support' and 'positive reappraisal'.

Responses following completion of therapy showed that none of the participants were using 'escape-avoidance' but four were using 'social support' and 'positive appraisal', and these coping styles continued to be used by the majority of participants at follow-up one. Interestingly, by follow-up two, all participants were using 'positive reappraisal'. As predicted, the participants were using more adaptive coping styles on completion of therapy and beyond.

viii) Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995)(see EAQb,section 3)

Table 5.13 summarises types of traumas listed in the PDS (Foa, 1995) as examples of traumatic experiences. Those checked by the participants on the PDS are indicated. The Foa scale does not require respondents to indicate numbers of occasions when each type of trauma occurred.

Table 5.13. Types of traumas experienced by the participants.

	A	NSAK	NSAS	SAS	SC	LTI	Other	Total
2891			x 1	x 2	x 2	x 2	Abortion	7
1069				x 1	x 2		Abortion	3
1085	x 1	x 1			x 1		Abortion; Parents almost divorcing	5
2553	x 2	x 1	x 1		x 1		2 family members committed suicide; Domestic violence	8
2314	x 1		x 1		x 1		Abortion	4
Total	**4**	**2**	**3**	**3**	**7**	**2**	**8**	**27**

A= Serious accident
NSAS= Non sexual assault (stranger)
SAS= Sexual assault (stranger)
TI=Life threatening illness
NSAK=Non sexual assault (someone known)
SAK= Sexual assault (someone known)
SC= Sexual contact when under 18
O=Other traumatic event

The table summarises numbers of the types of traumas listed on the PDS (Foa, 1995) that were experienced by the participants.

All participants had experienced sexual contact under the age of 18 with someone at least 5 years older than them at the time. Participants 2891and 2553 experienced the greatest numbers of types of traumas. Table 5.14 summarises the trauma identified by the participants as bothering them most at the time of responding to the PDS.

Table 5.14. The trauma identified by participants as 'bothering me most'.

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
2891	Rape and abortion	CSA	CSA	CSA	CSA
1069	Abortion	Abortion	Abortion	Abortion	Abortion
1085	Abortion	Abortion	Abortion	Assault	-
2553	Multiple	Multiple	Abortion	Domestic violence	-
2314	Abortions	Abortions	Abortions	Abortions	

CSA: Childhood Sexual Abuse

The majority of participants indicated that the abortion bothered them most, however responses were more varied by follow-up 2.

In spite of intensity of feelings about the pregnancy termination(s) indicated on the Perinatal Grief Scale (Potvin et al 1988) and Trauma Related Guilt Inventory (Kubany, 1996), to which participants responded in context with the termination, only 2 of the participants (1069 and 2314) consistently responded to the abortion 'as the trauma that bothers me most' prior to therapy and at subsequent follow ups.

Figure 5.1 shows pre-therapy, post-therapy and follow-up scores for both symptom severity and numbers of symptoms endorsed, presented in graph form. The figure is similar in format to those suggested by Foa (1995) to report client progress.

As predicted, all participants reported a reduction in severity of PTSD symptoms following therapy and participants 1069 and 1085, the least psychologically complex participants, were free of all PTSD symptoms by the end of therapy. Only one participant (2553) scored above the mean non-PTSD score (Foa, 1995) for symptom severity by her final follow up. These results reflect RCI calculations (Jacobson and Truax, 1991) which suggest that participant 2553 was the only one who did not achieve clinically significant change.

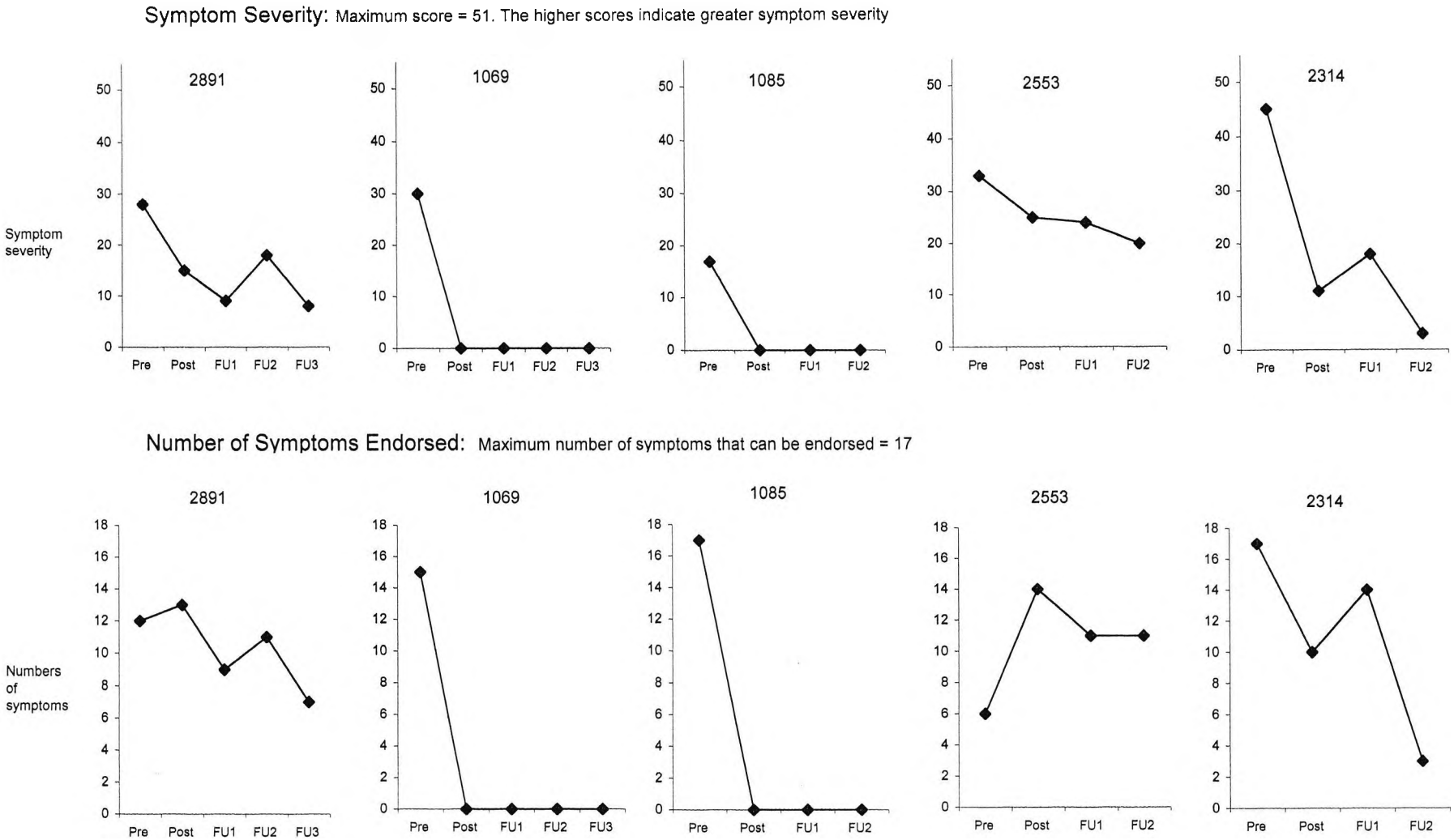


Figure 5.1. Posttraumatic Diagnostic Scale (Foa, 1995)

Unexpectedly, two participants experienced an increase in number of symptoms post therapy but it should be noted that, in spite of this increase overall, severity scores remained lower that pre therapy. Moreover, all of the participants endorsed fewer symptoms than the mean number scored by Foa's (1995) non-PTSD subjects, by their final follow up. However, the limitations of comparing the participants' mean scores with the mean of the comparison group should be noted.

Notably, least improvement following therapy in PTSD symptoms was reported by the 2 participants whose life history included greatest numbers of traumas (2891 and 2553). Indeed, participant 2553 experienced more symptoms following therapy and at follow-ups than prior to therapy. However, whilst her symptoms increased in number there was nevertheless a reduction in symptom severity and, as stated above, the number of symptoms she endorsed by her final follow up was less than the mean number scored by non PTSD subjects (Foa, 1995). This finding was consistent with the predictions.

ix) Overview of improvement of measures following therapy.

Table 5.15 summarises numbers of participants who achieved improvement on pre therapy measures. In order to review progress over time, numbers in brackets refer to numbers of participants who achieved improvement on their last recorded score. The participants whose scores remained the same as the previously recorded score, are also identified.

Table 5.15. Improvement summary table: Improvements of scores at post therapy (from pre therapy), at follow-up one (from post therapy) and follow-up two (from follow-up one).

Measure	Post Therapy	Follow up 1	Follow up 2
Hospital Anxiety and Depression Scale			
Anxiety	4, 1= (4^)	5 (3^)	5 (5^)
Depression	5(^)	5 (4^)	4, 1= (2^)
Internality and Powerful Others Scale			
Internality	4(^)	4 (3^)	2, 2= (2^)
Powerful Others	5(^)	4, 1= (2^)	5 (4^)
Perinatal Grief Scale	5(^)	5 (5^)	5 (3^)
Self Esteem Scale	5(^)	5 (2^)	4 (4^)
Trauma Related Guilt Inventory	5(^)	5 (4^)	5 (1^)
Posttraumatic Diagnostic Scale			
Symptoms endorsed	3(^)	4 (5^*)	4 (4^*)
Severity of symptoms	5(^)	5 (2^*)	5 (4^*)
Total numbers of measures summarised	45	45	45
Number of improved measures	41	42	39
Number of maintained measures	1	1	0
Number of measures not showing improvement	3	2	6
Number of measures showing improvement since last recorded	41 (91%)	30 (67%)	29 (64%)

* includes 2 participants who scored zero from post therapy onwards. ^ score improved since last recorded score
= the same as the previous score.

The summary table shows that on completion of therapy all participants improved on their scores for depression, 'powerful others', grief, self esteem and trauma related guilt. At follow up one 67% of psychometric test results showed improvement beyond the post therapy results and at follow up two 64% of test results showed improvement on follow up one results. These results suggest that regardless of actual values of scores, there was not only a general continued improvement of mental health immediately on completion of therapy, but also at 3 months and 9-12 months beyond.

x) Clinical significance of post therapy results.

The data was examined to establish whether results were clinically meaningful on completion of therapy. The Reliable Change Index (RCI) was used to analyse data (Jacobson and Truax, 1991) and results are summarised in Table 5.16.

Table 5.16. Reliable Change Index (RCI) calculations (Jacobson and Truax, 1991).

The table below shows Reliable Change Index calculations for pre- and post-therapy differences.

	2891	**1069**	**1085**	**2553**	**2314**
HADs anxiety and depression combined)					
Pre	19	30	28	16	28
Post	13	12	9	11	7
RCI	*2.26**	*6.77**	*7.14**	*1.88*	*7.89**
TGRI HB+W+LJ					
Pre	9	8.3	7	7	11.1
Post	5	2.9	3.57	6.7	1.3
RCI	*3.67**	*4.96**	*3.57**	*0.28*	*8.9**
TGRI GG+GC+D					
Pre	10.6	10.5	9.3	8.7	11.2
Post	5.0	5.3	2.8	6.2	1.8
RCI	*10.9**	*10.2**	*12.7**	*4.90**	*18.43**
PDS: Severity of symptoms					
Pre	28	27	30	33	45
Post	15	0	0	25	11
RCI	*2.47**	*5.13**	*5.70**	*1.52*	*6.46**
RSE					
Pre	18	21	19	27	25
Post	24.5	31	30	32	33
RCI	*2.81**	*4.32**	*4.76**	*2.16**	*3.46**
PGS(combined subscales)					
Pre	43.7	48.3	48.3	37.3	48.6
Post	28	29	24	30.6	17
RCI	*3.74**	*4.6**	*5.79**	*1.59*	*7.52**
Internality					
Pre	31	12	14	27	39
Post	38	30	29	32	39
RCI	*0.93*	*2.4**	*2.0**	*0.67**	*0*
Powerful others					
Pre	39	29	39	9	32
Post	27	21	15	8	24
RCI	*1.41**	*0.94*	*2.8**	*0.12*	*0.94*

Pre and post therapy data are expressed as mean values of scores for the psychometric tests listed.
*RCI values > 1.96 indicate a reliable change at the 5% significance level.

RCI calculations of the HAD Scale scores (test-retest reliability .91 for the total score, see Chapter 4) indicate that reliable change had taken place for 4 of the 5 participants. Subscales of the TGRI were calculated in 2 separate clusters, in line with test-retest reliability of the scale (between .73 and.75 for Hindsight bias / Responsibility, Wrongdoing and Lack of Justification and between .84 and .86 for Global Guilt Cognitions and Distress, see Chapter 4). All but one of these results suggested clinical reliability of change. Reduction in numbers of PTSD symptoms reported on the PSD Scale (test-retest reliability .74, see Chapter 4) were clinically significant for three participants and reduction of symptom severity scores were clinically significant for four of the participants. All Rosenberg Self-Esteem scores (test-retest reliability .82, see Chapter 4) indicated a significantly reliable change. Data suggests that Perinatal Grief scores (test-retest reliability .59 and.66 over the 3 subscales, see Chapter 4) were clinically meaningful for four of the five participants. Clinically reliable change had been indicated post-therapy for Internality subscale scores for three of the participants The Powerful Others subscale post therapy results showed a clinically reliable change for two participants. Test-retest reliability over both subscales is between .66 and .73 (see Chapter 4).

Overall, the majority of post-therapy scores indicate clinically significant change.

xi) Outcome of therapy and hypnotisability

Overall improvement percentages measured against scores taken prior to therapy for the Hospital Anxiety and Depression Scale (Zigmund and Snaith, 1983), Internality and Powerful Others Scale (Levenson, 1981), Perinatal Grief Scale (Potvin et al, 1988), Self Esteem Scale (Rosenberg, 1988) and Trauma Related Guilt Inventory (Kubany, 1996) were calculated for each participant. These scores are presented in Table 5.17 to review

individual participant's overall progress. Hypnotic suggestibility scores are included for comparison and ranked order of improvement is shown in brackets.

Table 5.17. Overall outcome related to hypnotic suggestibility

		% of overall improvement		
		Compared to pre therapy scores	*Compared to post therapy scores*	*Compared to follow-up 1*
	CIS* score	**Post Therapy**	**Follow-up no.1**	**Follow-up no.2**
2891	24(3=)	32.6 (4)	34.7 (3)	37.5 (4)
1069	18 (5)	41.7 (3)	53.9 (2)	65.8 (2)
1085	29 (1)	67.4 (1)	81.8 (1)	93.4 (1)
2553	24 (3=)	21.5 (5)	29.1 (5)	18.5 (5)
2314	27 (2)	49.9 (2)	34.3 (4)	45.2 (3)

*CIS: Creative Imagination Scale (Barber and Wilson (1978). Ranked order in parenthesis.

Numbers in brackets refer to ranking of participants according to % improvement Overall improvements relate to combined improvements of the Hospital Anxiety and Depression Scale, Internality and Powerful Others Scale, Perinatal Grief Scale, Self Esteem Scale and the Trauma Related Guilt Inventory.

On visual inspection of the data, contrary to predictions, there appears to be no consistent pattern in which CIS scores related to outcome. For instance, participant 1069 (with the lowest CIS score) achieved the second most improved scores at follow-ups one and two. The greatest overall improvement of scores on completion of therapy was made by participant 1085 and 2314, both of whom had the highest CIS scores.

xii) Previous mental health related to outcome of therapy

As predicted, the participants with a history of mental health problems (i.e. 2891, 2553 and 2314) showed least improvement on the psychometric tests over time. These participants all had a history of depression and were the only participants to have been assessed by a psychiatrist at some time in their lives. Furthermore, 2891 and 2553 had experienced multiple ongoing trauma since early childhood, which distinguished their trauma history from those of the other participants.

xiii) Factors related to the termination(s) in context with outcome of therapy

Another observation is that both 2891 and 2314 had more than one termination, experienced the first of these 21 years and 9 years ago respectively and had terminations at a more advanced stage of gestation (19 and 17 weeks respectively). This was in contrast to the other participants whose terminations took place just 4-9 months before commencement of therapy and were between 6-9 weeks gestation. Notably the participant who made the most improvement on the psychometric tests, began therapy sooner than any of the others following her termination.

xiv) Outcome of therapy related to normative samples

A surprising result was that a number of the participants' scores following therapy showed not only an improvement measured against their own previous score, but were superior in some instances (for example improvement in 'internality' and 'powerful others' scores), to norms for college students. Likewise, with the exception of 2891 and 2553, the participants' scores following therapy for 'perinatal grief' were lower than the mean scores for women who had experienced a miscarriage, and scores for 'trauma-related guilt' were lower than norms for both Vietnam veterans and college students.

xv) PTSD symptoms, hypnotic suggestibility and identified traumas.

Table 5.18 summarises percentage improvement of symptom severity scores measured against pre therapy scores using the Posttraumatic Stress Diagnostic Scale (see Figure 5.1). CIS scores are shown for comparison and ranked order of improvement is shown in brackets. The trauma identified by the participants as that which 'bothers you most' for each of the Posttraumatic Stress Diagnostic Scales (Foa, 1995) completed are included.

Table 5.18. PTSD symptoms, percentage improvement and hypnotic suggestibility

	A				B
	Post Therapy	**Follow-up 1**	**Follow-up 2**	**Follow-up 3**	**CIS**
2891	46.4% (4) Rape and abortion	68.0% (3) CSA*	36.0% (5) CSA*	71.4% (2) CSA*	24(3=)
1069	100%(1=) Abortion	100% (1=) Abortion	100% (1=) Abortion	100%(1) Abortion	18(5)
1085	100% (1=) Abortion	100% (1=) Abortion	100% (1=) Assault		29(1)
2553	24.0% (5) Multiple	27.2 (5) Abortion	39.4% (4) Domestic violence		24(3=)
2314	75.6% (3) Abortion	60.0% (4) Abortion	93.3% (3) Abortion		27(2)

CSA (Childhood Sexual Abuse)

CIS (Creative Imagination Scale).

Values in parenthesis indicate ranked order of overall therapeutic improvement at post-therapy and at follow-ups, compared to pre-therapy scores (A) and CIS scores (B).

Although two of the three participants showing the greatest improvement over time obtained the highest CIS scores, visual inspection of the data indicates that, contrary to predictions, there is generally no consistent pattern in which outcome was related to hypnotic suggestibility. It can also be seen that the least improvement post-therapy and at follow-up 2 was made by (2891 and 2553), both of whom had experienced multiple trauma from early childhood and did not consistently identify the abortion as the trauma that bothered them most.

5.6 Therapeutic process

i) Interventions used

Table 5.19 summarises, and briefly describes, interventions used for each participant. Hypnosis interventions are indicated by*.

Table 5.19. Summaries of interventions used for each participant

Participant 2891

Session	Hypnosis	Intervention
Phase 1: Stabilisation		
1*		Self-hypnosis taught
2	*	Participant informed of PTSD diagnosis / Ego strengthening
3	*	Reliving a happy childhood experience
Phase 2: Systematic uncovering		
4	*	Exploratory reliving / safe remembering [re-visits abuse aged 5 years]
5		Review of feelings
6	*	Exploratory reliving / safe remembering [to gang rape at 16 years]
7	*	Re-parenting / self- nurturance
8		Reappraisal of guilt' wasn't my fault'
9	*	Future rehearsal - to rehearse self protection
10	*	Future rehearsal - to rehearse assertiveness with mother and sister
11		Reflection on current feelings
12	*	Reliving to experience self healing following first abortion and gang rape
13	*	Reliving to reframe childhood abuser as weak
14	*	Reliving to 14 years –rape and first abortion experience following this
15		Relationship with mother
16	*	Ego strengthening / self healing
17	*	Reliving gang rape and second abortion
18	*	Reliving gang rape and second abortion experience
19	*	'Affect bridge' from 'inner badness' to childhood abuse at 5 years
Phase 3: Interpersonal and intrapersonal development		
20		Coping strategies / future orientation
21	*	Anger with mother expressed. Released pressure / anger
22	*	Mental calmness / disposal of 'inner rubbish' / letter to mother
23	*	'Affect bridge' / resolution of guilt when with abuser at 5 years.
24		Depression and anger with husband expressed
25	*	Future rehearsal – coping strategies
26		Stress management
27	*	Review of progress
28	*	Past / future – moving on

Participant 1069

Session	Hypnosis	Intervention
Phase 1: Stabilisation		
1	*	Teaching client self-hypnosis and anxiety control
2		Client informed of PTSD diagnosis
3	*	Reliving a happy childhood experience
Phase 2: Systematic uncovering		
4		Explored feelings about abortion – decision / relationship with mother.
5	*	Exploratory reliving - to 14 years old – feels 'used' by family.
6	*	Reliving the experience of her abortion
7		Explored feelings of grief
8	*	Mourning ritual
Phase 3: Interpersonal and intrapersonal development		
9	*	Accessing past feelings of youthfulness and rehearsing in future context
10		Preparation for possible future set-backs.
11	*	Past / future intervention to consolidate progress
12		Overview of therapy and progress made

Participant 1085

Session	Hypnosis	Intervention
Phase 1: Stabilisation		
1	*	Self-hypnosis taught for anxiety control
2		Client informed of PTSD diagnosis
3	*	Reliving a happy childhood experience
Phase 2: Systematic uncovering		
4		Explored feelings associated with abortion
5	*	Exploratory reliving- to being bullied at school
6	*	Reliving the experience of her abortion
7		Explored anger relating to her partner
8		Explored identification with the foetus and grief for foetus.
9	*	Mourning ritual
Phase 3: Interpersonal and intrapersonal development		
10		Moving on. Reviewed progress made.
11		'Anniversary' imminent. Client reports recent nightmares
12	*	'Re-scripting' nightmares
13	*	Past / future intervention to consolidate progress

Participant 2553

Session	Hypnosis	Intervention
Phase 1: Stabilisation		
1	*	Teaching client self-hypnosis and anxiety control
2		Client informed of PTSD diagnosis / relationships
3	*	Reliving a happy childhood experience
Phase 2: Systematic uncovering		
4		Review of feelings since last session, feelings re termination
5	*	Exploratory reliving
6	*	Explored relationships. Short hypnosis for headache /PMS symptoms
7	*	Reliving the abortion decision
8		Explored feelings of grief
9	*	Grief. Re-lived a childhood accident and grief of not having 'a proper family'
Phase 3: Interpersonal and intrapersonal development		
10	*	Past / future intervention to consolidate progress
11		Overview of therapy and progress made

Participant 2314

Session	Hypnosis	Intervention
Phase 1: Stabilisation		
1	*	Teaching self-hypnosis and anxiety control / relationships with parents & partner
2		Client informed of PTSD diagnosis / relationships with parents and partner
3	*	Reliving a happy childhood experience/ relationships with parents and partner
Phase 2: Systematic uncovering		
4		Explored feelings associated with her abortion- decision / humiliation /concern re foetus feeling pain.
5	*	Uncovering reliving - guilt re ex partner expressed
6	*	Reliving the experience of her abortion
7	*	Second reliving of her abortion Reports stopping taking ant-depressants
8	*	Reliving to explore a past relationship and feelings of guilt
9		Feels low following stopping antidepressants – future orientation
10	*	Ego strengthening: Overcoming obstacles that prevented her feeling better about herself (guilt and anxiety re parents and ex-partner)
11	*	Mourning ritual
Phase 3: Interpersonal and intrapersonal development		
12		Reflects on progress to date
13	*	Hypnosis for headache: Imagery of clay head sculpture
14		Makes further links between past and future/ makes sense
15	*	Ego strengthening (related to work): Strong bright light and a symbol of a rock
16	*	Past / future intervention to consolidate progress
17		Reflects on growing self assertiveness and owning feelings
18		Talks of re- energised creativity

* Hypnotic intervention

The length of hypnotic interventions varied between approximately 20 minutes and 60 minutes. Some of the protocol interventions were occasionally combined. For example, in the case of two participants (1069 and 2314), an exploratory reliving intervention led to uncovering feelings about significant relationships, which provided an opportunity for this topic to be addressed in the same session. Participant 2314 coped well when discussing issues relating to grief and felt ready to complete the mourning ritual in the same session, and for participant 1085 the last 2 interventions were combined in order to bring the ending of therapy within the date that she needed to finish.

During the course of therapy, three participants (2891, 2314 and 2553) received additional interventions that addressed somatic symptoms (headaches and pre menstrual symptoms respectively). Therapy for participant 1085 included an intervention to address a repetitive nightmare and for participant 1069 therapy included an intervention

to help her access 'youthful feelings' that she had not felt since her termination. Therapy for participant 2314 included a second revisiting of her termination experience in order to complete resolution. Ego-strengthening techniques were also used to help her overcome obstacles that were preventing her from feeling better about herself (following cessation of antidepressants) and to help her cope with difficult feelings emerging about work relationships.

Therapy for participant 2891 included a number of additional interventions that addressed the traumas she had experienced, in addition to her terminations. In order to help this participant cope comfortably with emerging feelings, several ego strengthening sessions were included and a hypnotic re-parenting intervention enabled her to begin the process of self-nurturance. Some of the additional hypnotic interventions were brief. Several hypnotic interventions were also included to help her reinforce coping strategies (including assertiveness skills).

ii) Hopkin's Symptom Checklists (see Figures 5.1a –5.4b)

Baseline

Three participants (2891, 2553, 2314) completed baseline responses to the SCL-90 for 4 weeks prior to therapy. Participant 1805 and 1069 completed only three and two weeks baseline respectively due to various restrictions imposed by their work places, and thus it was necessary to start therapy as soon as possible. Baselines were generally stable within one point of the 5-point SCL-90 scale over the weeks these were completed. However, participant 2314 showed a downward trend for all subscale baselines and 2553 showed a downward trend for all subscales except for anger – hostility.

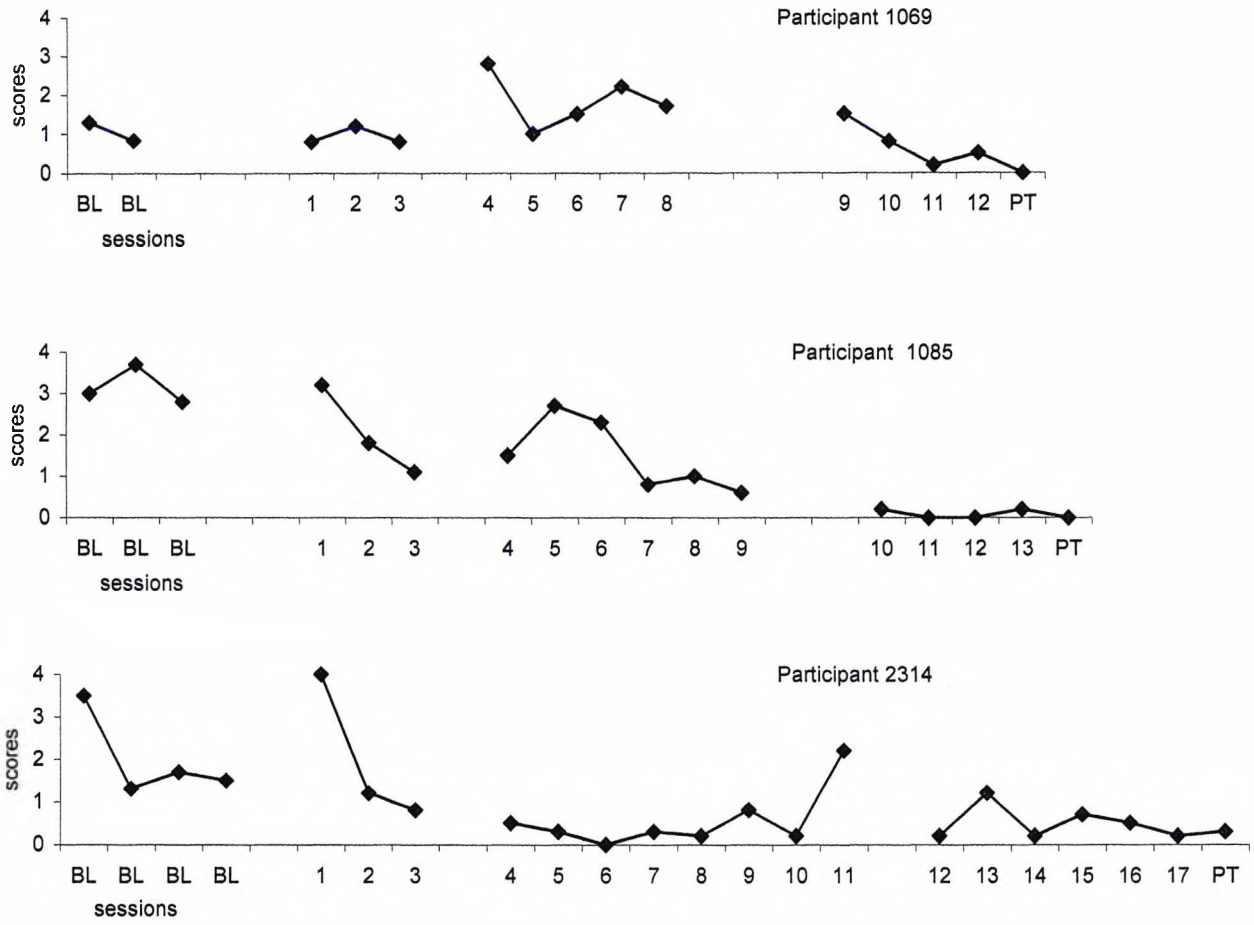


Figure 5.2a. SCL-90 scores: Anger - Hostility

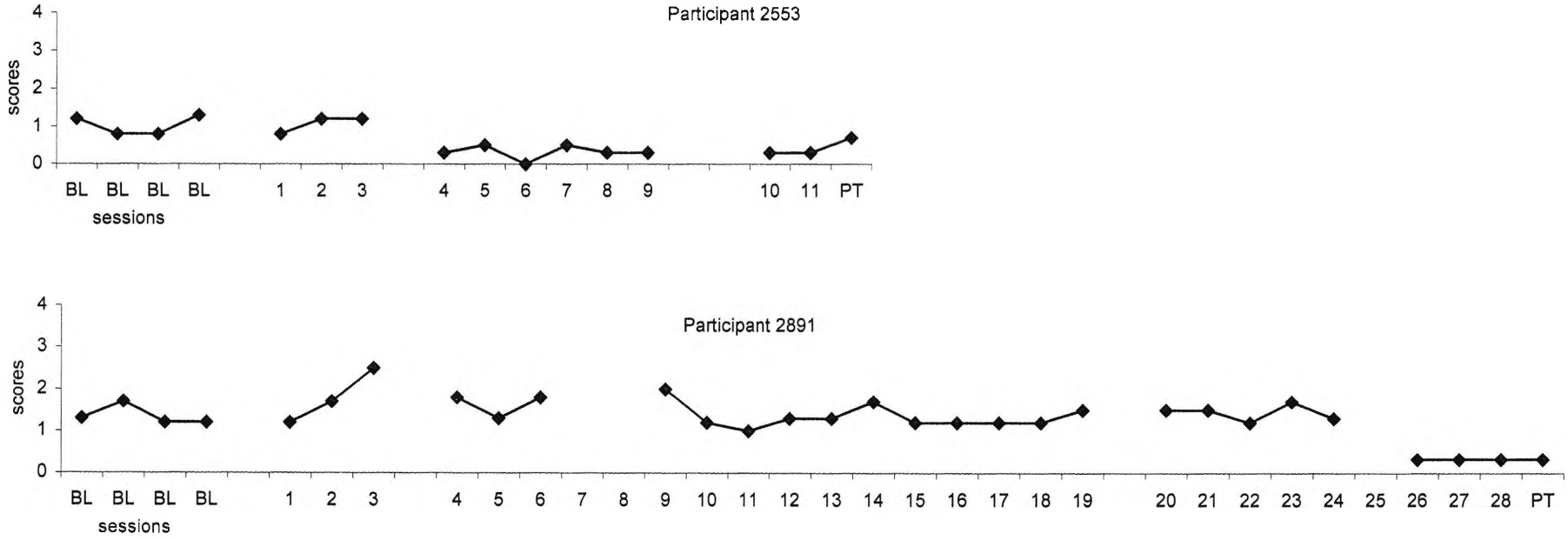


Figure 5.2b. SCL-90 scores: Anger - Hostility

NB: Participant 2891 did not complete checklist for sessions 7, 8 and 25

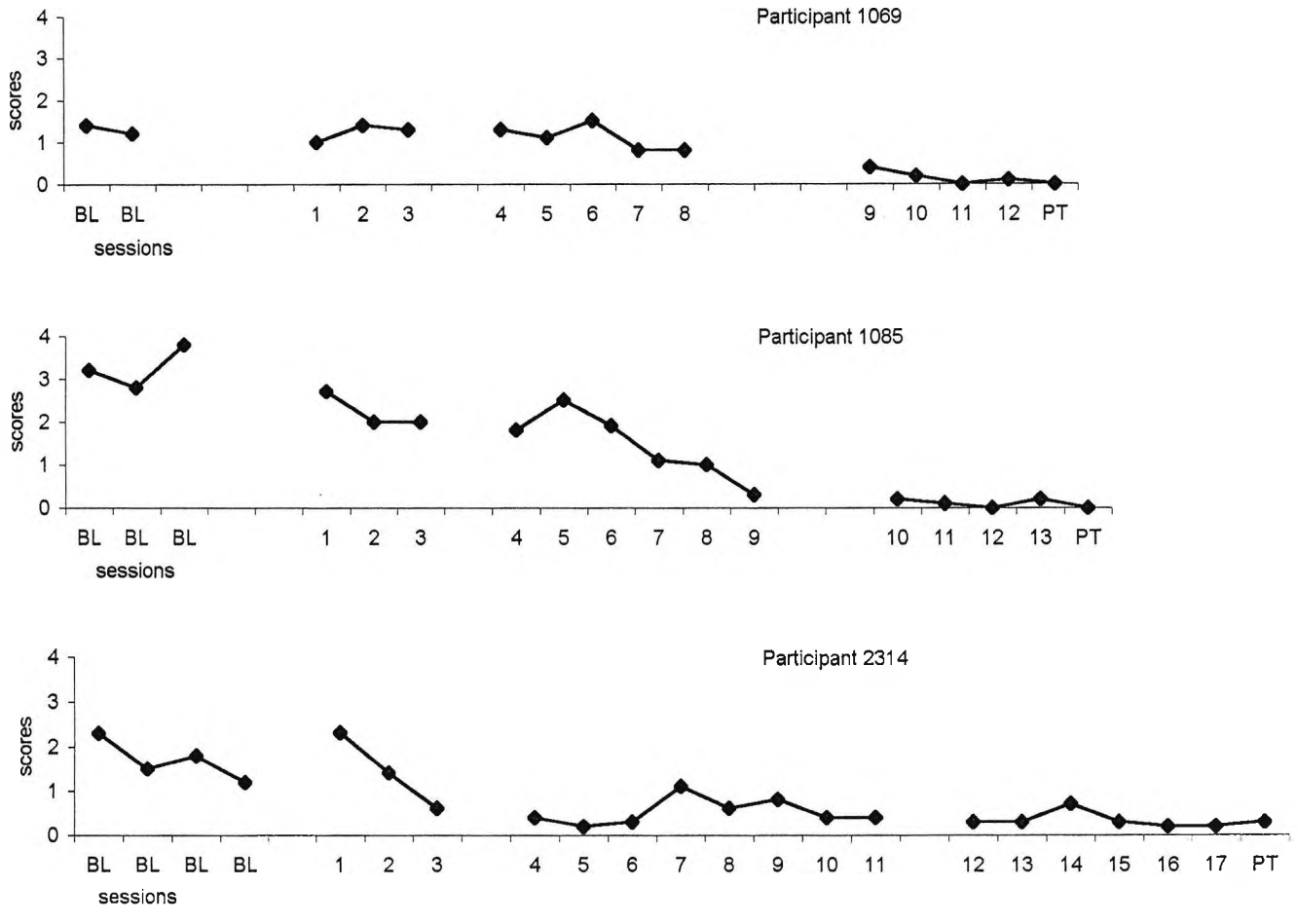


Figure 5.3a. SCL-90 scores: Somatisation

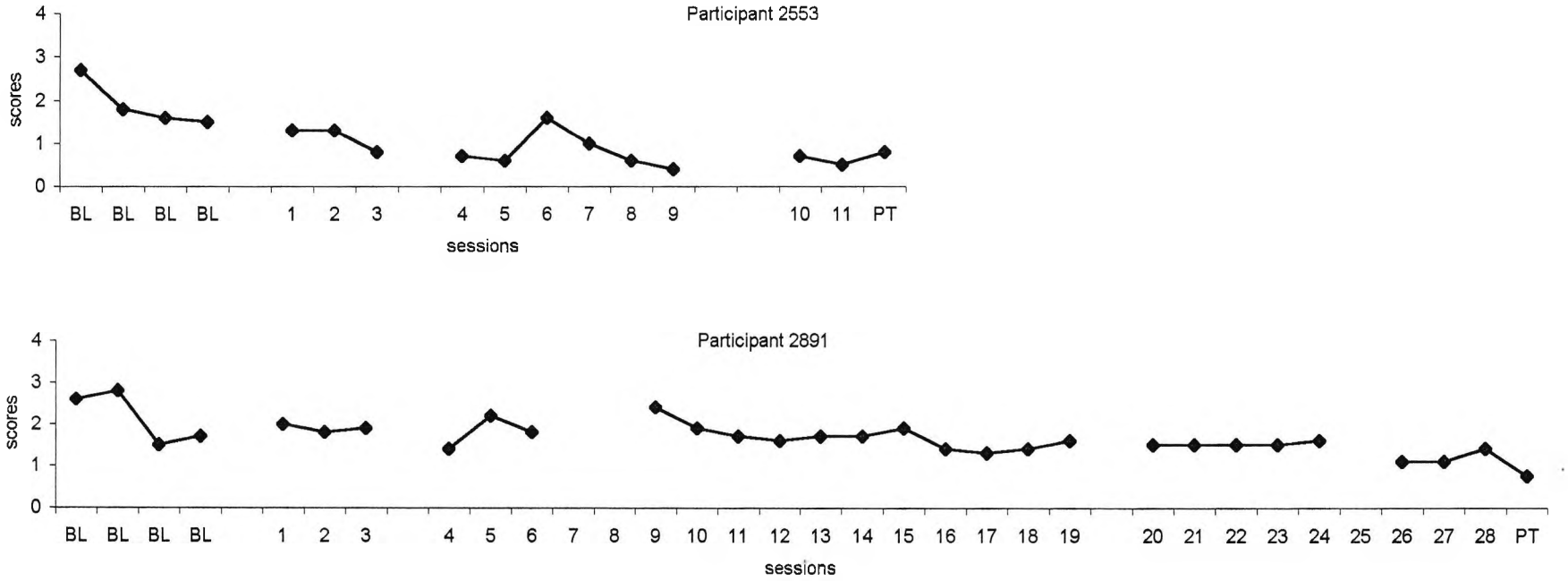


Figure 5.3b SCL-90 scores: Somatisation

NB: Participant 2891 did not complete checklist for sessions 7, 8 and 25

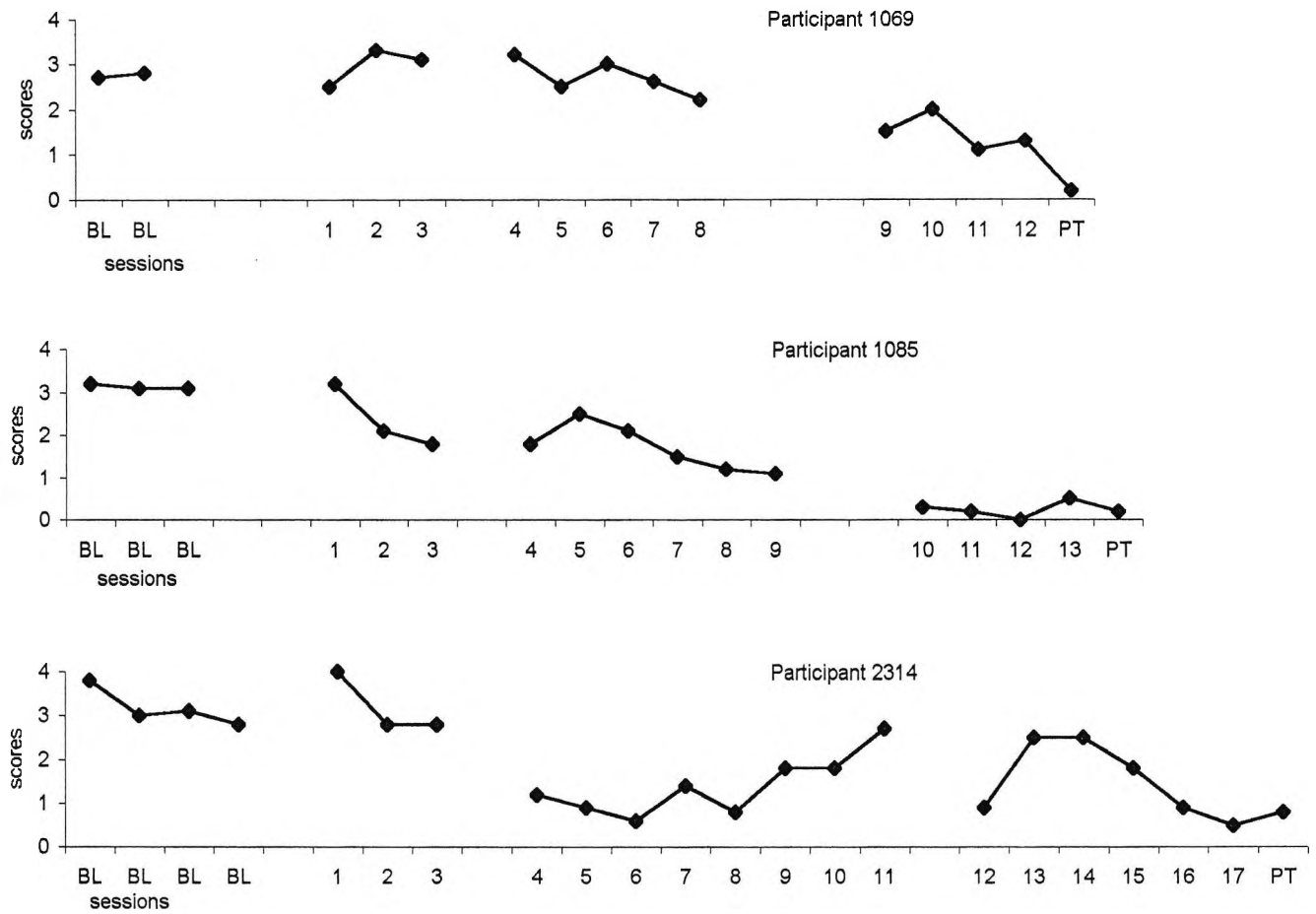


Figure 5.4a. SCL-90 scores: Depression

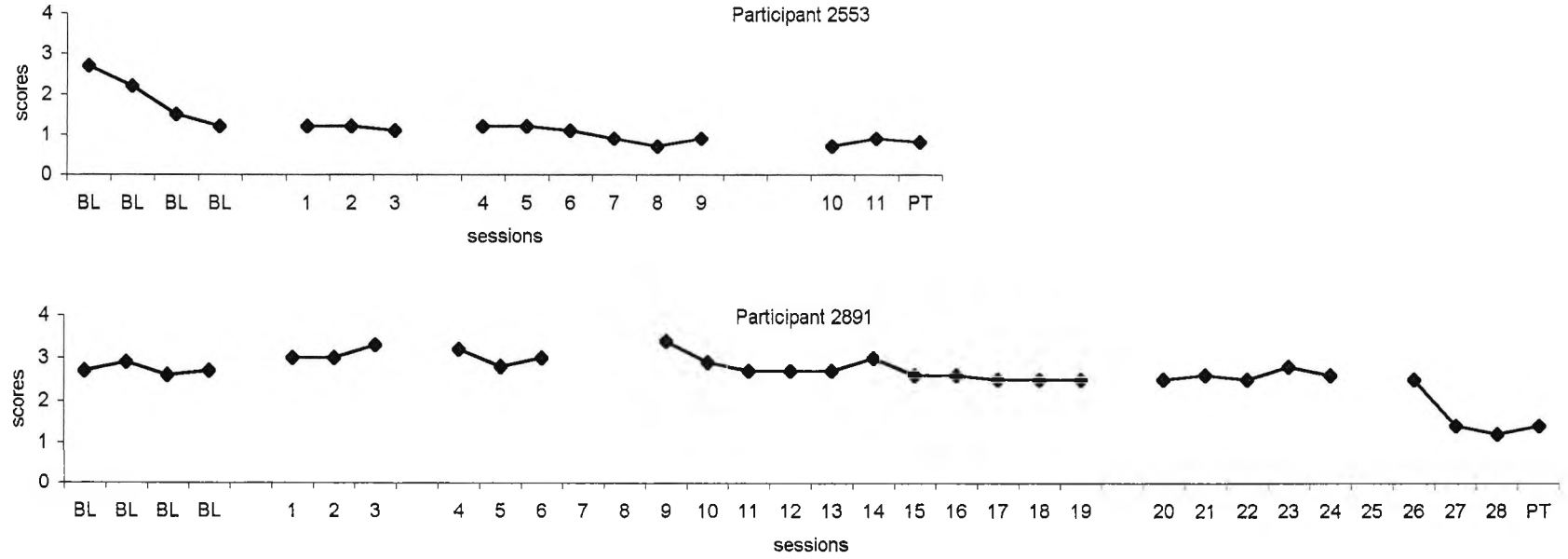


Figure 5.4b. SCL-90 scores: Depression

NB: Participant 2891 did not complete checklist for sessions 7, 8 and 25

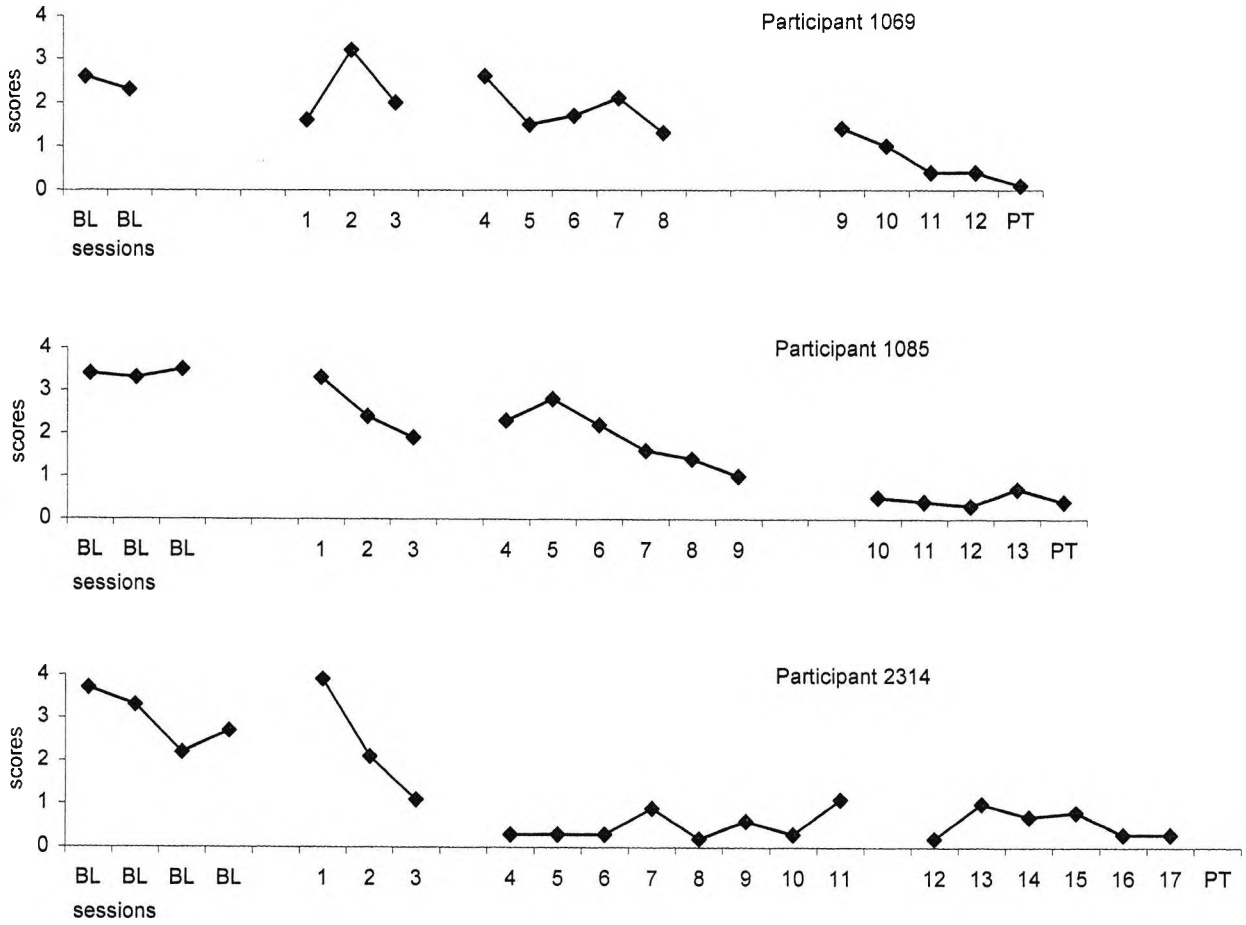


Figure 5.5a. SCL-90 scores: Anxiety

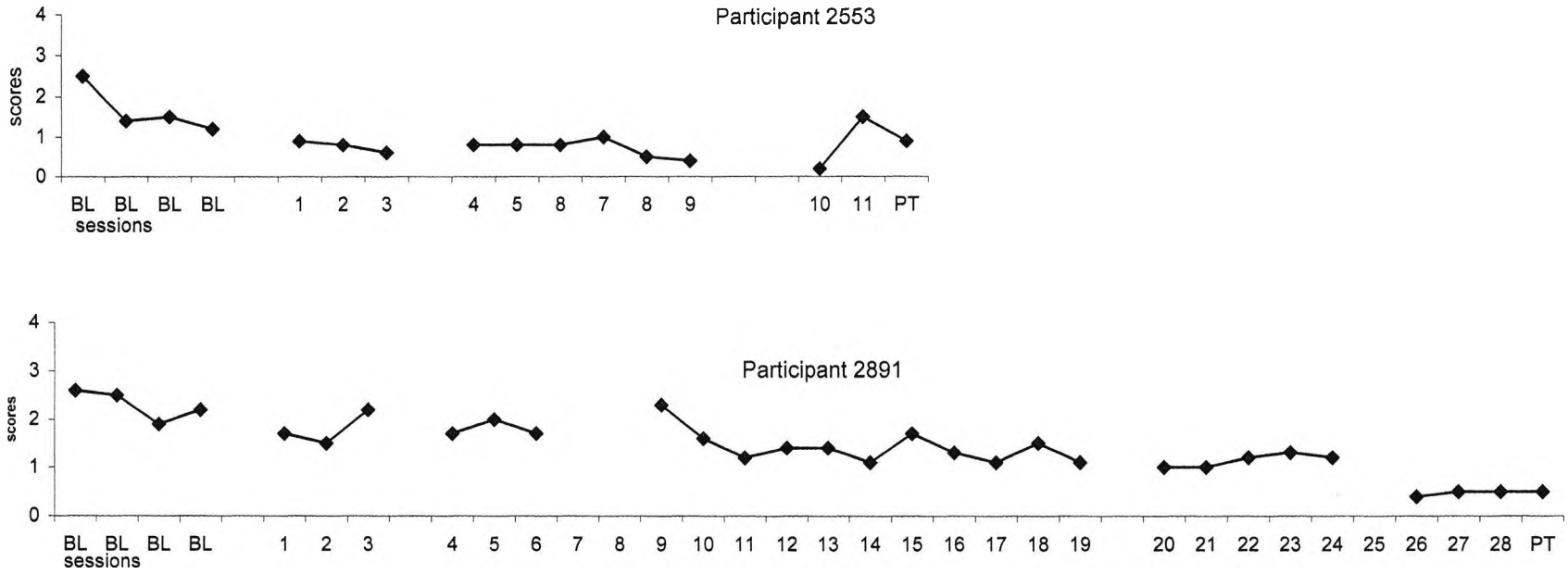


Figure 5.5b. SCL-90 scores: Anxiety

NB: Participant 2891 did not complete checklist for sessions 7, 8 and 25

Phase one

In phase one, i.e. the stabilisation phase of therapy focussing on anxiety reduction, participants 2314, 1085 and 2553 showed an overall reduction in subscale scores measured against base line. Participants 1069 and 2891 showed less improvement although their anxiety scores were generally lower than at baseline.

Phase two

By the end of phase two, four of the participants' subscale scores were, almost without exception, lower than both their base line and phase one scores, however, participant 2891 showed clear improvement only on the anxiety subscale.

Phase three

For participants 1069 and 1085, there was continued improvement during phase three. Participant 2553 did not show any marked improvement beyond phase two and participant 2314 maintained, rather than improved, scores for somatisation and anxiety, and her scores for hostility and depression peaked at the beginning of this phase. The scores of 2891 dropped markedly over the last four weeks of therapy – coinciding with taking antidepressants at this time.

Visual inspection of figures 5.2 -5.5 showed that overall, 2553 and 2891 made least improvement during the course of therapy (which corresponds to results of the psychometric tests) and most improvement was shown by 1069 and 1085 who scores generally declined (in spite of some peaks) throughout therapy (which also corresponds to the psychometric tests). Participant 2314 made most of her progress during phase one.

Contrary to the research predictions it was not possible to identify a pattern common to all participants, in which particular interventions were followed by greater or lesser change as measured by the SCL-90 scores.

iii) Comfort with Abortion Decision Questionnaire (CADQ)

Figures 5.6a and 5.6b show, with the exception of participant 2553 (whose mid-point scores were unchanged throughout therapy), that all participants felt more comfortable about their decision to have an abortion following therapy. Greater comfort with the abortion decision for 1069 and 1085 appeared to take place by the end of the middle phase of therapy. For 1069, 2314 and 2891, it can be seen that the process of resolving feelings about the abortion decision started to take place following the addressing of unresolved issues concerning important relationships. For 1069, this involved addressing feelings of being conditionally loved (and used) by her mother; for 1085, distrust of her partner emerged as the focus; 2314 resolved feelings of humiliation and guilt about a past relationship (and to feelings of humiliation and guilt regarding her abortion experience); 2891 addressed feelings of being controlled by her mother and sister and the terror of being trapped (and let down by females present in the house at the time) during a gang rape and fear experienced during the subsequent abortion.

iv) The 'Most Helpful Aspect of Therapy' (MHAT)

At the end of each session all participants identified what they felt was the most helpful event in the session, and wrote this down on the MHAT form.

MHAT responses in context with SCL-90 scores

SCL-90 responses, completed one week following the intervention, did not always reflect comments written on the MHAT. For example, one participant (1069) wrote on the MHAT

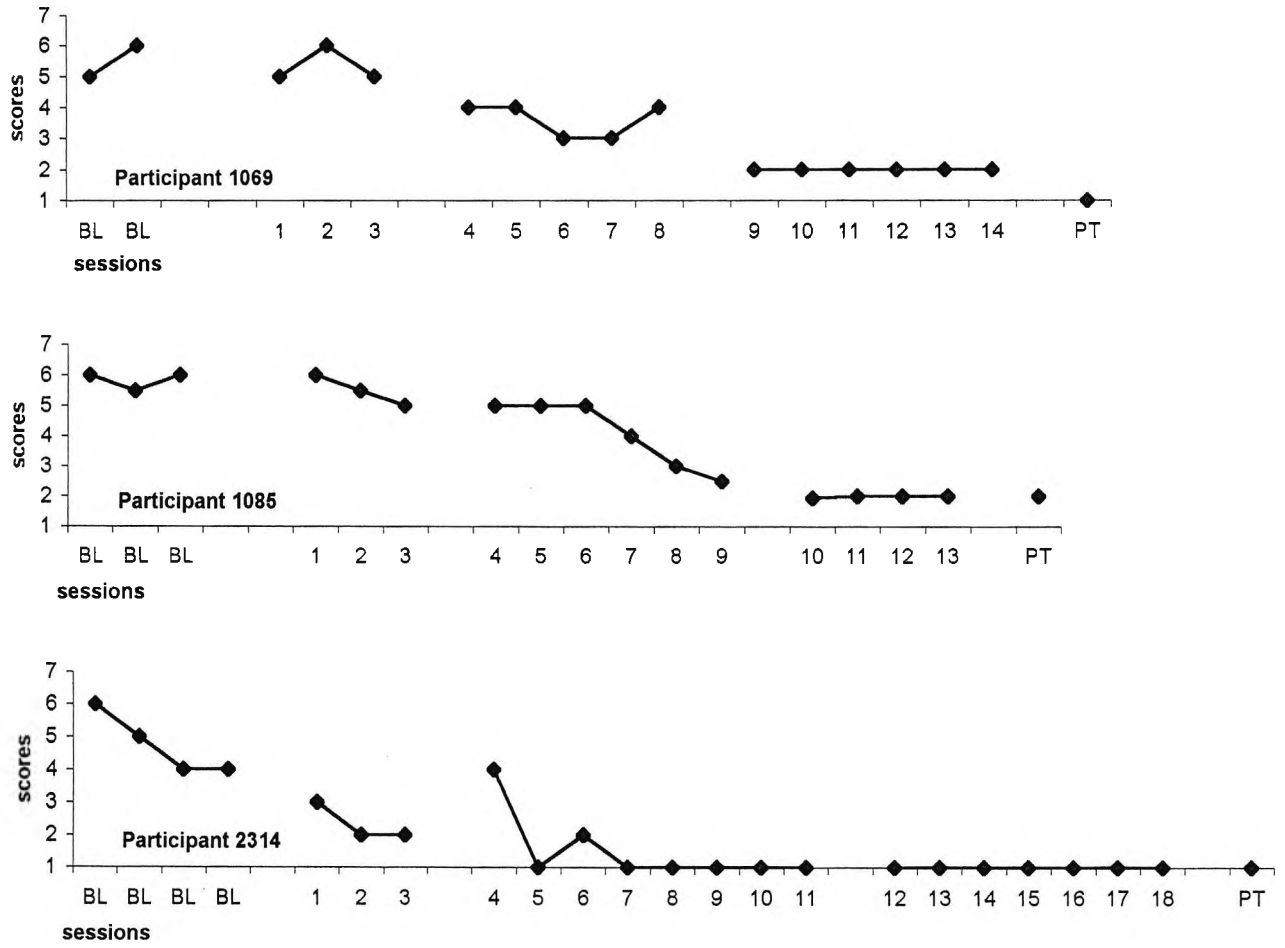


Figure 5.6a. Discomfort with the abortion decision.

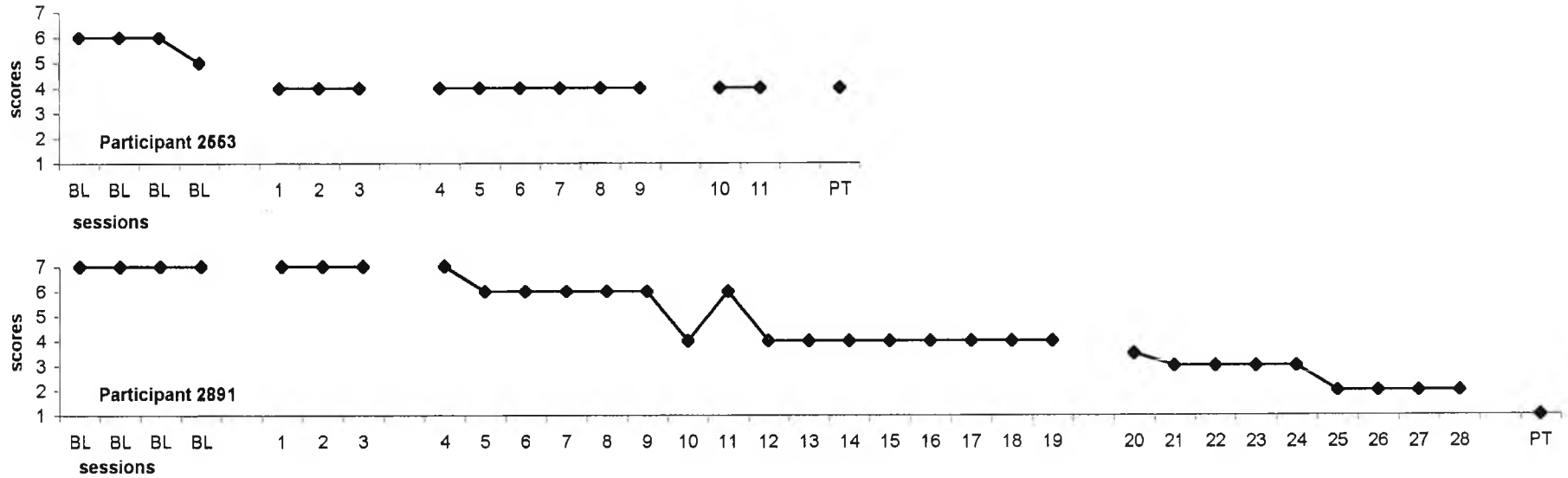


Figure 5.6b. Discomfort with the abortion decision.

form after the first session, that she was feeling *'extremely relaxed with a strong sense of well being'*. However, this was followed by a sharp increase of SCL-90 scores. Furthermore, whilst MHAT comments illustrated that participants viewed the emergence of strong feelings in sessions as helpful, such sessions were sometimes followed by higher SCL-90 scores (e.g. 1069 session 2; 1085 session 5; 2314 session 11).

On visual inspection of the data there appears to be no consistent link between comments made on the MHAT and SCL-90 scores apart from improvements following the PTSD diagnosis. Information gathered from the MHAT forms may thus be most useful in tracking subjective evaluation of progress in relation to interventions used.

v) Participants' evaluations of the hypnotic interventions

Comments made by the participants suggest that, overall, the hypnotic interventions were helpful in reliving unresolved situations in order to experience achieving resolution in retrospect; in gaining insights, for example in making links between unresolved issues that may not previously have been seen as connected; in experiencing empowerment and in engaging emotionally in consolidation of progress. Ego state techniques were frequently reported as being helpful, for example in facilitating empowerment and in facilitating insight through seeing past events from new perspectives.

All participants made positive comments about exploratory hypnotic reliving interventions. The hypnotic suggestion made for this intervention ('Go back to a time that would be helpful for you to revisit in order to understand your feelings / the pain you are feeling now / to move on') was deliberately vague in order to ensure that the participant did not censor out any associations that they may have felt were unconnected

to their termination. All participants relived a time that elicited unresolved feelings and this gave them the opportunity to resolve the situation retrospectively. For example participant 2891 re-experienced her grandfather's kindness, which she didn't feel she deserved until her 'older self' told her 5-year old self that *'It wasn't your fault'*. Participant 1069 relived feeling angry and trapped at being 'used' by her family as a carer for the younger family members, 1085 returned to unresolved feelings about being bullied at school, 2553 to being abandoned on the hard shoulder of a motorway by her father at 6 years old and 2314 to a holiday when she began to notice that she was losing confidence. Participant 2891 made reference to a safe remembering technique (seeing events from the safety of being inside a protective bubble (Alden, 1995), *'When I was in my bubble I remember cutting myself with a razor. I did it cos no one cared or was there. Because I was hurting too much and I needed to feel hurt. I understand these urges now.'* (2891). Each of the participants was able to introduce into these relivings an appropriate resolution, facilitated by ego state techniques.

Four participants explicitly made reference to positive feelings, such as empowerment, evoked by communication between their 'Older Wiser Self' and 'Younger Self' (i.e. facilitated by ego state therapy techniques). For example, *'I gave myself all the strength and comfort I needed'*, and *' .....nice to know I had the power to make myself better.'*, (1069) and *' [My] 'Older Self' was very comforting to [my] 'younger self.''* (1085). Insights gained from ego state reliving interventions were also evident e.g., *' ...seeing myself as a child and seeing how innocent I was.'* (2891), and *'[I was] able to look at [the] situations through the eyes of 'the adult me' and realise how immature and childish the children who had bullied me were.'* (1085).

Reliving aspects of the termination appeared to be helpful in a variety of ways. Three participants commented that the reliving had elicited feelings about their terminations which revealed links to important, yet difficult, relationships. For example, *'I was in the clinic after the termination feeling disgusting and terrible. My older self comforted me and pushed mom away. I didn't need my mom and she didn't mind'* (1069), *'Knowing how special he was.....I needed to know that it was alright to still love him* [father of the aborted baby]*'* [2891- of her first abortion] and *'.....letting go - not being held back by my parents' pain....'* (2553). Another participant (1085) wrote that it was helpful to remember the time just before the procedure which she had previously been unable to remember, and to experience her 'older self' comforting her younger self whilst going through the abortion procedure. Likewise, participant 2314 commented that she found the intervention helpful in acknowledging how difficult the time was and to realise that she had made the right decision.

Some comments described resolutions made within reliving interventions e.g. *'To revisit a time when I was happy and to resolve things with my ex-partner. It is something that has caused me a lot of pain, hypnosis left me with a sense of calm'* (2314). The hypnotic mourning ritual also enabled resolution, for example one participant writing on the MHAT form what she had felt helpful in a session commented, *'Hypnotism to say 'Goodbye', in my terms. Had not previously done this. I can move on!'* (1085), *'[The] ritual of leaving [the] baby in a beautiful, safe place. To be able to think of [the] baby somewhere beautiful as opposed to remembering the operation which used to feel so barbaric.'*(2314) and *'I gave [the baby] to [my aunt] who took it from me for safekeeping. It gave a sense of closure, relief, calm, helped feeling accepted.'* (1069).

An hypnotic intervention towards the end of therapy provided symbolic closure and this was identified by all participants as helpful, for example, *'[I] felt I could work on this as this would help me feel good and not trapped in poor self image.'(1085), 'I very much feel I have been held back in the past by insecurities and low self esteem.'*(2314), *'[Helpful] to separate myself from the past- not being locked in other people's darkness and my own pain.'* (2553) and *[helpful] leaving negatives in the past and taking positives with you.'* (1069).

vi) Participants' evaluations of non-hypnotic interventions:

Non hypnotic interventions that were evaluated as being helpful included being given useful information, discussing and planning coping strategies, talking about feelings, providing an opportunity to consolidate increased self awareness and insights, and an acknowledgement of progress.

Greatest improvement on SCL-90 scores following session two (informing participants of the PTSD diagnosis), was made by the three participants (2891, 1085 and 2314) who commented on the MHAT forms that the PTSD diagnosis was helpful, for example, *'Knowing there is a recognised condition for how I feel – PTSD'* (1085), *'I have an illness – I might not be mad.'* (2891) and *'I was surprised and relieved to learn that symptoms are treatable.'* (2314). In contrast, participant 1069 (who felt 'unworthy' of the diagnosis) showed an increase in her SCL-90 scores following this intervention.

Three participants (1069, 2553 and 2314) commented that acknowledging and reviewing progress was helpful. Participant 2553 commented that it was helpful to see the SCL-90 graphs and to review the feelings she had at the start of therapy in her final session. She wrote on the MHAT at the end of this session that it was helpful

'*discussing measurable progress, graphs, returning to initial statements etc, validating feelings of progress*'.

Most participants remarked that it was helpful to discuss coping strategies that could be used in stressful relationships with significant others. For example participant 1069 wrote that '*talking about work and family and using work strategies at home*,' was helpful.

Participants 1069 and 2553 stated that talking about painful feelings was helpful, whilst 1085 appreciated being 'given permission' to express some positive things about having had the termination. Normalisation of feelings was identified as helpful in context with information given about the possible range of emotional reactions following an abortion (2314) and in context with being abused as child (2891).

Some statements illustrated increasing self-awareness. For example, participant 1085 found that it was helpful to identify her fear of loneliness and discuss this in context with the meaning that her foetus had for her. Likewise, participant 2314 found it useful to identify, and discuss, her loss of confidence in decision making since her abortion, *'It's important to remember that decisions aren't always wrong because they might cause pain initially'* (2314). Participant 2891 commented that she found it helpful to learn to be more aware of a distinction between feelings of stress and depression. Discussing the pragmatics of starting a creative project was helpful for participant 2314, who realised that she always felt better when she was being creative. Participant 2891 alluded to a growing belief in her discovery (during therapy) that the abuse she experienced as a child was not her fault and stated on the MHAT, *'When I was young I coped as best I could with what I had.'* (2891).

vii) Usefulness of Hypnosis (UOH)

On completion of therapy participants were given a form on which each of the hypnotic interventions they had experienced were briefly, and factually, described, for example, '*You went back to a happy time when you were 3 or 4 years old. You were playing in your garden wrapped in net curtains*'. Participants were invited to evaluate each intervention on a rating scale from 1 (not at all helpful) to 5 (very helpful). Table 5.20 summarises mean UOH ratings alongside CIS scores, and overall improvement of psychometric tests (presented in percentages).

Table 5.20. UOH related to outcome of psychometric tests and hypnotic suggestibility

	Mean UOH score *	CIS score	Post Therapy**	Follow-up no.1**	Follow-up no.2**
2891	3.8 (4)	24(3=)	32.6 (4)	34.7 (3)	37.5 (4)
1069	4.9 (1)	18(5)	41.7 (3)	53.9 (2)	61.0 (2)
1085	4.4 (2)	29(1)	67.4 (1)	81.8 (1)	93.4 (1)
2553	3.5 (5)	24(3=)	21.5 (5)	29.1 (5)	18.5 (5)
2314	4.2 (3)	27(2)	49.9 (2)	34.3 (4)	45.2 (3)

*Values refer to means of combined ratings indicated on the Usefulness of Hypnosis (UOH) form. Values in parenthesis indicate ranked order of helpfulness, perceived overall.

** Values refer to overall improvement of psychometric tests presented as percentages. Values in parenthesis indicate ranked order of overall therapeutic improvement

CIS (Creative Imagination Scale) scores. Ranked order in parenthesis.

The table shows that the two participants who made the most progress, as measured by psychometric tests, also rated the helpfulness of hypnotic interventions higher than the 3 participants who made least improvement. There appears to be no consistent pattern in the way in which CIS scores relate to how helpful the participants found the hypnotic interventions. For instance, the two participants (1069 and 1085) who found the hypnotic interventions most helpful, scored the lowest and highest scores respectively on the CIS. The mean ratings of scores for each hypnotic intervention ranged between 4.0 and 4.8. The intervention which was rated most highly by the participants was the mourning ritual / grief resolution (mean rating 4.8).

viii) Subjective 'realness' of the hypnotic experience.

The table below summarises number of UOH comments that included reference to the hypnotic experience feeling 'real'. No request had been made to the participants to comment on how 'real' the experience of hypnosis felt in order to avoid influencing their comments.

Table 5.21. 'Realness' of the hypnotic experience according to comments made on UOH forms.

	Numbers and % of hypnotic interventions feeling 'real' *	Mean score of hypnotic interventions feeling 'real'**	Mean score of UOH***	CIS score****
2891	8 (47.1%)	4.3	3.8	24
1069	0	0	4.9	18
1085	3 (42.9%)	4	4.4	29
2553	0	0	3.5	24
2314	3 (27.3%)	4.7	4.2	27

*Values expressed as numbers of hypnotic interventions during the course of therapy that felt real. Values in parenthesis refer to % of all hypnotic interventions experienced by the participant that felt real.

** Values presented as mean scores of all 'realness' ratings.

***Usefulness of Hypnosis form. Values represent mean scores.

****Creative Imagination Scale. Values represent total scores.

Results show that the two participants with the highest CIS scores (1085 and 2314) both commented that they experienced some hypnotic interventions as feeling 'real'. However, of the two participants scoring the same CIS score (2891 and 2553), statements on the UOH form indicated that one (2891) experienced 47.1% of hypnotic interventions as feeling 'real' whilst the other (2553) made no reference at all to 'realness'. Nevertheless it should be noted that participant 2553 twice commented on the 'powerfulness' of the interventions. It did not appear that there was any pattern in which some interventions were experienced as feeling more 'real'.

Interestingly, there was only one mention of the 'realness' of the hypnotic experience in the MHAT forms (i.e. completed at the end of each therapy session) (1069, session 3).

ix) Overall review of UOH comments

UOH comments were, generally consistent with the MHAT comments. However, each participant's UOH form showed a style of response that had some tendency to focus on particular aspects of the therapeutic process. For instance, comments by participant 1085 frequently alluded to ways in which the hypnotic interventions facilitated opportunity for resolution, for example, '*Once I had stood up to the bullies I felt great, as if I had released a pain that had been in my memory.*' Likewise, '*I had not given myself the opportunity to say 'goodbye' and had not felt I was able to until this point*', and, on reliving the termination, '*I was able to share the pain and therefore accept comfort from my older self*'.

Participant 1069 alluded to insights gained following hypnotic interventions. Some responses focused on insights that helped her to accept feelings that she had felt that she should not have had. For example, in reference to reliving the abortion experience, she commented, '*I got to see that I was brave and that it was OK to feel like that and be upset*', and comments about the intervention in which she relived feeling guilty about her anger when looking after her small cousins, she reported, '*I was doing a job I wasn't supposed to do and it was OK to be cross*'.

Participant 2314 noted the emotional challenge of some of the hypnotic interventions and remarked upon the physical response she experienced in hypnosis when reliving her termination, '*I felt my heart begin to beat faster and I had a lump in my throat*'. She put this into context with a sense of release when she had confronted her anxieties '*leaving some of the pain behind*' and also remarked upon things that she managed to achieve in hypnosis that led to resolution. For example, in reference to a reliving intervention in

which she resolved guilt attached to leaving her ex-partner, she wrote, '*Very sad but it felt good to say things I had been unable to say at the time.*'

Comments made by participant 2891 frequently revealed how vivid the hypnotic interventions were for her. For example, in commenting on feelings of empowerment when confronting her abuser in hypnosis, she wrote '*It was the first time I felt in control of X [abuser] and not guilty*', and when rehearsing, in hypnosis, being assertive with her mother and sister reported on the UOH, '.....*I felt, like, this is me, listen to me for once*'. She also showed that an ego strengthening hypnotic intervention continued to help her beyond the session, '*My ray of light still shines, so it worked! Even though sometimes I still feel bad*'. The 'realness' of hypnotic experience was also evident in a comment referring to reliving the gang rape, in which she wrote '*Scared. I found it hard to believe I was an adult and not me at the time*..... *The shower* [imagery to wash away feeling dirty] *helped*'.

Participant 2553, reported that the hypnotic interventions were helpful in gaining control over her body and also indicated that hypnosis helped to '*reconnect herself*'. Other comments also made reference to dissociative feelings for example, '[the hypnotic intervention] *gave me back a sense of myself and of being inside myself, not locked out*', and '*I slightly resisted the hypnosis, feeling part of myself stay outside and second guess*'. This reference to 'resistance' as well as comments such as, '*I don't remember this session much but it was painful and unresolved*' [session addressing relationship with husband and fear on realising that she was pregnant], and '*I'm not sure, hard to remember. Just aware of constant deep grief*', reflected her UOH ratings which were lower than those of all other participants.

x) Participants' evaluation of the therapy.

On completion of therapy, participants were asked to complete an 'Evaluation of Counselling Questionnaire' (see Appendix XII). Table 5.22 summarises their responses.

Table 5.22. Summary of responses to the 'Evaluation of Counselling Questionnaire':

The responses below relate to the evaluation form given to the participants on completion of therapy (see Appendix XII).

1. Do you consider that the main problem(s) you resolved at the end of counselling remains resolved?
Not at all slightly moderately mostly completely

Participant	2891	1069	1085	2553	2314
	completely	completely	completely	mostly	completely

2. If not 'completely' please give brief details in the space below about what is unresolved and how this might affect your life.

2553*	It taps into underlying depression, fear and grief that continues to affect my life.

* Only completed by participant 2553.

3. Was there any aspect of the counselling that you now feel was particularly *helpful* to you?

2891	Talking in great detail in hypnosis
1069	The opportunity for closure / reference. Relaxation techniques.
1085	Hypnosis
2553	Hypnosis - because of it being through subconscious happening at unanalysed unarticulated level. Structural sense of progress.
2314	That it was specifically related to the termination.

4. Was there any aspect of the counselling that you now feel was unhelpful to you?

2891	No
1069	No!
1085	No
2553	I became aware of hypnosis techniques and part of my mind followed it instead of succumbing.
2314	No

5. Were there any hypnosis sessions that you now feel were particularly helpful to you?

2891	Going back to situations in part. Bubble*, bridge**.
1069	Can't remember – maybe taking the kidney bean [foetus] to xxxx's [aunt's] – sticks in my head.
1085	All were helpful – it was a process rather than an individual session!
2553	The one where I put my feelings in the fire and they made fireworks that people could look at, instead of looking at me.
2314	Hypnosis to relieve bruxism and headaches, and also to remember aspects of my childhood (although I found it uncomfortable at the time).

* Safe remembering technique (Alden, 1995)
** Safe remembering technique (Watkins and Watkins, 1997)

6. Were there any hypnosis sessions that you now feel were particularly unhelpful to you?

2891	Can't remember
1069	No!
1085	[left blank]
2553	[left blank]
2314	No

7. Overall how would you rate the success of your therapy?

Not at all slightly moderately very extremely

2891	1069	1085	2553	2314
extremely	extremely	extremely	very	extremely

8. Do you use self-hypnosis techniques?

Never occasionally sometimes fairly often frequently

2891	1069	1085	2553	2314
never	occasionally	sometimes	sometimes	frequently

9. If you use self-hypnosis at all please indicate what sort of purpose you use this for. Please indicate how useful you find this self-hypnosis.

Not at all slightly moderately very extremely

1069	very	Relaxation and at times of stress- recent work issues!
1085	very	Relaxation
2553	very	Relaxation. To deal with pain and panic.
2314	extremely	To relieve tension in jaw. To help sleep and to help with confidence.

Responses indicate that the participants perceived the therapy to be helpful. Notably, the participant (2553) who made least improvement on the psychometric tests nevertheless regarded her therapy as 'very' helpful – however this was in contrast to all the other participants who rated their therapy as 'extremely' helpful. Four of the participants were continuing to use self-hypnosis.

5.7 Summary of results in context with research predictions

i) Psychometric tests

Table 5.23 summarises the outcome of therapy in context with results of psychometric tests, the participants' hypnotic suggestibility and psychological history. The impact of hypnotic interventions on particular symptoms is also summarised.

Table 5.23. The efficacy of hypnosis as an adjunct to therapy for post-abortion distress: Summary of results in context with research predictions

The overall CBT package will be followed by improvement of the mental health of these participants:-	
Improvement of mental health	**Observed by:**
Improved scores on the psychometric tests	Results of psychometric tests taken before, on completion, 3-4 months later and again 9-12 months later, indicate that the therapeutic package was followed by improvement of mental health for all participants. Measures taken 9-12 months following therapy showed further improvement for the majority of participants. Most post-therapy scores were clinically significant according to RCI calculations (Jacobson and Truax, 1991)
which will relate to the participants' hypnotic suggestibility	There appears to be no consistent pattern in which CIS scores related to outcome.
and to the psychological history of the participant, such as previous experience of trauma	Least overall improvement was achieved by the three participants who had a history of depression, and the two participants who experienced multiple trauma showed the lowest improvement of all.

During the course of therapy the addition of particular hypnotic interventions will be followed by improvement of the participants' symptoms:-		
	During the course of therapy participants will:	**Results**
1.	Experience a reduction of anger-hostility, anxiety, depression and somatisation in response to particular hypnotic interventions.	There appeared to be no pattern common to all participants, in which particular interventions were followed by greater or lesser change as measured by the SCL-90 scores.

2.	Experience increased comfort with the abortion decision in response to particular hypnotic interventions.	All participants felt more comfortable about their decision to have an abortion following therapy. There appeared to be a pattern in which this took place following addressing unresolved issues about how the decision was made and important relationships but no particular hypnotic intervention could be identified from which this resulted.

The table above refers to results of psychometric tests taken before commencement of therapy, on completion of therapy, 3-4 months beyond completion of therapy and again at 9-12 months following completion of therapy. It indicates that the therapeutic package was followed, as predicted, by improvement of mental health for all participants and furthermore that the majority of post-therapy scores showed clinical significance according to RCI calculations (Jacobson and Truax, 1991).

Moreover, measures taken 9-12 months following therapy showed further improvement for the majority of participants. Also, as predicted, it would appear that outcome was mediated by previous psychological history since least overall improvement was achieved by the three participants who had a history of depression (2891, 2553 and 2314), and the two participants who experienced multiple trauma showed the lowest improvement of all (2981 and 2553). However, contrary to predictions, outcome of therapy did not appear to be related to hypnotic suggestibility.

ii) Process of therapy

Contrary to predictions, there appeared to be no pattern in which particular interventions were followed by change. It would appear that the two most psychologically complex participants (2981 and 2553) responded least to interventions, as measured by the SCL-90 The curve on the SCL-90 graph was very similar for participants 1085 and 1069 indicating a similar response to the overall package for these less complex participants.

For 3 participants (1069, 1085 and 2314), interventions which involved resolution of feelings about significant relationships, appeared to be associated with increased comfort with the abortion decision, however, it was not possible to reliably identify specific improvements that resulted from particular interventions

Comments written on the MHAT form did not appear to relate to SCL-90 scores but were helpful in identifying the subjective value of hypnotic techniques such as reliving and ego state techniques which were found to be useful by all. Results of the UOH suggest that the participants who rated the hypnotic interventions as being most helpful also made the most progress and that the hypnotic mourning ritual was generally the most highly rated of all hypnotic interventions. Visual inspection of data shows that hypnotic suggestibility does not appear to be associated with perceived 'realness' of the hypnotic interventions.

All participants rated the overall therapy, and the hypnotic interventions, as helpful, Four participants perceived their problem, for which they attended therapy, to be 'completely' resolved and the fifth (2553) rated her problem as being 'almost' resolved. This participant (who had experienced therapy during periods throughout her life), knowing that therapy for the project would involve approximately 12 sessions, had planned from the beginning to receive therapy elsewhere on completion of the 12 sessions.

Overall, whilst the therapeutic package appeared to be successful in improving the mental health of the participants, and the hypnotic interventions were perceived by the participants to play a part in this improvement, it was not possible to reliably identify specific hypnotic interventions that were responsible for particular improvements.

CHAPTER 6

DISCUSSION

This study had two main foci. The first was to investigate the psychological characteristics of a group of participants who identified themselves as suffering from severe emotional distress following pregnancy termination, and the second was to systematically examine a therapeutic package in which hypnosis was used as an adjunct to therapy for this problem. The following discussion will examine the results presented in chapters 3 and 5, and then consider these in context with a model of hypnosis. Finally, suggestions for further study will be made and overall conclusions will be summarised.

6.1 The nature of post- abortion distress

i) Suggestibility

Of particular interest to the present study was the examination of the participants' hypnotic suggestibility. This has not been investigated in previous studies of post-abortion distress. As predicted, results showed that the majority of participants were of above average hypnotisability, as measured by the Creative Imagination Scale (Barber and Wilson, 1978), which correlates with non-hypnotic suggestibility (Spanos, Gabora, Jarrett, & Gwynn, 1989). Spanos (1986) has identified a type of individual who tends to score high on hypnotisability scales and who is particularly sensitive to 'nuances in interpersonal communication, social empathy and cooperativeness'. The discomfort felt by the participants on exposure to anti-abortion comments would appear to reflect the particular interpersonal sensitivity that Spanos suggests is characteristic of suggestible individuals.

Another consideration is that this particular sensitivity to social cues may have influenced the participants' evaluation of the treatment they received by the health professionals involved in their abortion procedure(s). The majority of participants felt that they had not been treated with complete sensitivity, but would less suggestible individuals possibly have evaluated similar experiences as satisfactory? The questionnaires did not require the participants to describe their insensitive treatment therefore it is not known what the participants specifically regarded as 'insensitive'. However, the participants who went on to experience therapy in part two of this study described some worrying examples of lack of concern shown by professionals (see 5.4). None of these participants had mentioned to the staff in question that these incidents had been upsetting to them, perhaps characteristic of the 'socially cooperative individual' described by Spanos (1986), as well as the participants' 'self-control', a coping strategy used by over half of the participants (see (vi) below).

Visual inspection of CIS data showed that the majority of participants were of above average hypnotisability and statistical analysis indicated that the participants' were significantly higher in hypnotisability than a non-clinical group. Furthermore the general profile of the participants, as demonstrated in responses to Booklet A, would suggest that the group had a general tendency towards a characteristic suggestibility.

ii) Imaginative involvement

Whilst vividness of visual imagery is, to some extent, related to imaginative involvement (Kirsch and Council, 1992) these two constructs are not identical and the relationship between hypnotisability and vividness of imagery has tended to be weak (de Groh, 1989). In the present study the Vividness of Visual Imagery Questionnaire (Marks, 1973) was included to examine whether vividness of visual imagery was a

characteristic associated with levels of grief. However, in contrast to Johnson and Puddifoots' findings (1998), the participants showed no particular pattern of high vividness of imagery (although it should be remembered that only 7 of the 11 participants completed this questionnaire).

Imaginative involvement can be described as total immersion or absorption in an activity, involving the shutting out of external stimuli, and is a major characteristic of the hypnotic experience (Hilgard, 1970). This is a very different experience to 'seeing in the mind's eye', the task that participants are asked to perform when responding to the VVIQ (Marks, 1973). The majority of participants taking part in the present study indicated a considerable capacity to become totally involved in their inner experiences, for example, 'staring into space thinking about it all', an involvement that suggests more interaction with imagery (Heap and Aravind, 2002) and absorption in a constant flow of mental patterns involving visual, auditory, olfactory, gustatory, and somatosensory modalities (Damasio, 1999). Thus, imaginative involvement is more an ability to become highly absorbed in a range of images that are '*experienced*', rather than just observed. Absorption in painful images associated with the abortion may have therefore been a factor that maintained the participants' post-abortion distress. However, when used therapeutically (i.e. in hypnotic interventions) this same ability may have been a factor that facilitated involvement in hypnotic imagery which, in turn, promoted resolution and change (see section 6.2).

iii) Empathy, fantasy, guilt and grief

In reviewing the results of this study it would appear that empathy and fantasy are inextricably enmeshed with feelings of guilt and grief. The majority of participants showed a tendency towards fantasising, a characteristic associated with complicated

grief (Rando, 1991). It would appear that the participants experienced a disturbing internal reality in which a constructed relationship with the foetus may have underscored their high levels of grief and trauma-related guilt. Indeed, the participants' levels of grief (as measured by the Perinatal Grief Scale, Potvin, Lasker and Toedter, 1988) were significantly higher than women who had miscarried. Furthermore, their scores for the subscale of 'despair', a form of grief that is associated with serious long-lasting psychological effects (Potvin et al., 1988), were particularly high. One explanation for this is that the combination of the knowledge that the abortion was something that the woman had consented to herself, an ability to empathise with her aborted foetus, and a fantasised relationship with the foetus might have combined to create a potent mix of emotions.

Moreover, the participants' scores for trauma-related guilt (as measured by the Trauma Related Guilt Inventory, Kubany, 1996) were significantly higher than those of Vietnam veterans, with the exception of 'Wrongdoing'. Indeed, the majority of participants scored 'Wrong doing' lower than all other factors related to guilt. This appears to indicate that in spite of such intensity of guilt and grief the participants did not believe that abortion is wrong, reflecting responses to Booklet A which also showed that the majority of participants did not have anti-abortion views. Yet, paradoxically, seven of the participants strongly agreed that they felt like they had committed a murder (and none strongly disagreed with this statement). These results reflect the need to be aware that guilt is not one construct, i.e. that it was possible for the participants to experience guilt cognitions, a global feeling of guilt and feelings of regret about the abortion, whilst still retaining a belief that abortion is not wrong. This is an important finding, firstly, since it challenges the pro-life assumption that women suffering from distress following an abortion feel guilty because they have acted against their beliefs and maternal

instincts (Spekhard and Rue, 1992). Secondly, this finding should alert therapists to fully explore the specific nature of any guilt expressed by women experiencing post-abortion distress. Similarly, therapists should make no assumptions about religious beliefs and post-abortion distress since results suggest that whilst the participants were commonly not very religious they nevertheless saw religious symbolism as important.

These results reveal a highly complex picture of post-abortion distress, and a conflict between the participants' intellectual acceptance of abortion in general and, at a more emotional level, their inability to come to terms with having personally had an abortion, so that it continued to *feel* wrong. It may be hypothesised that an ability to be involved in fantasies about 'how things could have been', might effectively have blocked the development of comfortable self-representations of having had an abortion, especially when low self-esteem, low self-efficacy and possibly a history of previous negative life events were present.

iv) The abortion decision

None of the participants felt comfortable about their abortion decision and almost all found that the decision was extremely difficult to make. It has been noted earlier in this study that ambivalence about an abortion decision has been associated with post-abortion distress (Major and Cozzarelli, 1992), however, imaginative involvement and suggestibility have not been previously considered in context with ambivalence. The process of decision-making inevitably involves imagining possible outcomes. For suggestible women considering an abortion, this might involve absorption in both positive and negative imagery of having, and not having, the abortion. For some women, it may be speculated that this may result in confusion and difficulty in making the final decision. Thus, any negative post-abortion feelings that arise following the

abortion may be interpreted as proof that a mistake had been made and this 'proof' is further consolidated by selective attention to any positive representations of having the baby generated in the decision-making process, thus evoking feelings of regret.

Oakley and Frasquilho (1998) suggest that hypnotisability reflects a flexibility of cognitive style in which individuals switch easily between analytic (or rational) and holistic (or emotional) thinking styles. Arguably, these switches of thoughts may represent different 'parts' (or representations) of themselves. It might be speculated, therefore, that women in the present study were conflicted about their abortion decision, due to a capacity to move back and forth between evaluating their decision from conflicting perspectives. This might further explain the confusion that the majority of participants experienced in the decision-making process, and the inevitability that the final decision would therefore not feel 100% 'right'.

Another finding in the present study was that the majority of participants had experienced being persuaded either to have or not to have the abortion. The participants' generally higher than average suggestibility may have evoked feelings of uncertainty when this conflicted with their own intuitions. Therapy for post-abortion distress may thus need to focus on enabling a woman to review her decision in context with 'the part of her' who believes this to be the right decision and to enable this part to feel more resilient to other influences.

v) General mood and attributional style

Ratings of general mood revealed a tendency towards stability of negative affect, both before and after the abortion, but was commonly perceived by the participants to be intensified following the abortion. The participants' self-esteem was significantly lower

than a non-clinical population (Cheng and Furnham, 2003) as measured by Rosenberg's Self Esteem Scale (1989), and retrospective ratings prior to the abortion showed that they regarded their self-esteem to have been low even prior to the abortion. The participants' bias towards a stable attributional style and general pessimism about feeling better may have predisposed them towards depression (Abramson, Seligman and Teasdale, 1978). Likewise, the majority of participants blamed their characters for their post-abortion distress, suggesting an attributional style which has also been found to increase vulnerability towards depression (Janoff-Bulman, 1979).

The participants' responses to the questionnaires commonly presented a general sense of hopelessness. It was therefore interesting to note that all participants indicated at least some hope that hypnosis could help them feel better and four felt this strongly. Whilst this optimism about hypnosis was generally fairly moderate and was inevitably biased due to the participants' prior knowledge that hypnosis would be offered as an adjunct to therapy as part of this project, it nevertheless indicates an overall optimism that hypnosis could reverse their hopelessness. This finding accords with researchers who have found that the context of hypnosis influences expectations, a finding that has implications regarding therapy for post-abortion distress since expectations have been shown to increase responsiveness to suggestion (Kirsch, 1991; Gandhi and Oakley, in press).

vi) Coping style and perceptions of social support

Results indicated that coping by 'seeking social support' was rarely used and 'positive appraisal' was not used at all by the participants. Arguably, these adaptive coping styles would have provided some protection from post-abortion distress. However, as predicted, results indicate that the participants commonly used maladaptive coping

styles, particularly that of escape-avoidance. An avoidant coping style has also been associated with a tendency to fantasise (Aspinall and Taylor, 1992) which also has some correlation with hypnotic susceptibility (Rhue and Lynn, 1988). Coping by self-control (64% of participants) may have reflected the control needed to cope with everyday events that evoked reminders of the abortion. It is possible that this coping style would have disguised their post-abortion distress, so that others would have been completely unaware of the mental turmoil being experienced.

There was a common tendency for the participants to expect and receive little support following the termination of pregnancy. The participants generally regarded themselves to be lonely and isolated both prior and after the abortion and this appeared to be compounded by a pattern of limiting disclosures to very few (Major and Gramzow, 1999). The decision to tell others about the abortion is likely to have involved a process in which some evaluation was made of who could be trusted, supportive, non-judgemental etc, thus the abortion may have brought into sharp focus unsatisfactory aspects of relationships with partners, family and friends, bringing to light a number of unresolved issues, both past and present.

The conclusion reached by the majority of participants was that very few of their closest friends or family members could be trusted to respond helpfully, which sadly may have been an accurate assessment (Major and Gramzow, 1999). Nevertheless, it would appear that keeping the abortion secret, albeit a possibly well-judged decision, may have been a factor which increased the sense of isolation experienced by the majority of participants following their abortion. Furthermore, in line with Major et al (1990) participants in the present study perceived that they had little control over their lives, as measured by the Internality and Powerful Others Scale (Levenson, 1981), suggesting

that low perception of self-efficacy, and their perception of lack of support, were factors that may have increased their risk of poor post abortion adjustment. It should be noted however, that whilst statistical analysis of the data did not show any significant difference between the participants' and college students' Internality scores, their scores for Powerful Others was significantly greater. This may reflect the characteristic 'disempowerment' described by the five women who subsequently received therapy, who spoke of their anger at having to seek permission for their abortions from medical doctors, and their humiliation in having to depend on various administrative and medical staff to arrange and carry out the procedures.

vii) PTSD and dissociation

Responses to the PDS allowed close examination of the particular symptoms of PTSD following abortion, which previous larger studies have not reported. The majority of the participants responded to the PDS (Foa, 1995) identifying the abortion as the trauma that bothered them most and, as predicted, all participants met the DSM IV criteria for PTSD. Results indicated that symptom severity was not statistically different to the PTSD population norm. All had experienced events that they perceived to be traumatic, prior to the abortion(s). It would appear that symptoms of increased arousal such as irritability and outbursts of anger were a particular problem for the participants and it may be speculated that such symptoms reflected unresolved issues concerning particular relationships tested by the abortion.

In line with the participants' generally escape-avoidant coping style, avoidant symptoms of PTSD appeared to be common to all. The symptoms which Foa (1995) lists within the 'avoidance' category of the PDS, are representative of the types of dissociation suggested by Holmes et al (1995). For example, amnesia is representative of

'compartmentalisation'. However, whilst all participants rated avoidant symptoms highly, only 6 participants experienced amnesia and visual inspection of the data failed to identify any pattern which may explain this. Also representative of compartmentalisation (Holmes et al, 2004) was the feeling of being 'two different people' (one who accepted the abortion and the other who could not) experienced by the majority of the participants and pretending not to have had the abortion (experienced by half of the participants). These dissociative coping strategies may have been used either consciously or unconsciously. For example, coping with events which are traditionally associated with celebration, such as the birth of a friend's baby etc, may demand verbalising socially appropriate clichés such as 'What a beautiful baby', and exposure to innocent remarks made by others such as 'How could anyone hurt them?', that may cause the most intensely painful feelings. So, in order to cope, the woman manages to convince herself, at least temporarily, that she did not have an abortion. Damasio (1999) asserts that whilst it is possible, with great control, to block the externalisation of feelings, the 'private, mental experience of emotion', the 'internal milieu', can never be blocked, a description highly pertinent to women suffering from post-abortion distress who find ways of functioning, but know that the painful feelings are never far away.

The other symptom of dissociation suggested by Holmes et al (2004) is that of detachment (e.g. 'spacing out'). Symptoms listed in the PDS representative of detachment fall mainly within the section headed 're-experiencing' (although 'lack of concentration', listed under 'increased arousal', may also suggest 'detachment'), which all participants in the present study appeared to experience as indicated by their responses to the PDS. Brewin et al's Dual Representational Theory (1996), an explanatory model of PTSD, has relevance here (see 1.8). From the perspective of this model, non-conscious (non-verbal) 'situationally accessible memories' (SAMs) are

dissociated from consciousness but can be triggered by internal or external cues (Brewin et al, 1996). In the case of post-abortion distress, results of the present study would indicate that a number of external cues might be responsible for activating the SAMs (such as hearing the word abortion, hearing a debate about abortion, a picture of a foetus, etc) and result in a multi-modal, highly distressing 're-experiencing' of an aspect of the abortion experience.

A criticism of the PDS may be that it does not always adequately reflect language used by clients to describe PTSD symptoms, such as 'spacing out' or 'staring into space'. Additional statements in Booklet A of the current study, however, were phrased to relate directly to the termination, using everyday language to describe detachment, and results indicated that all participants experienced dissociative symptoms such as staring into space in a day dream, or feeling that the termination seemed unreal (symptoms representing detachment). These unreal feelings experienced at the time of the termination are indicative of dissociation. According to Marmar, Weiss and Metler (1997), dissociation at the time of a trauma is predictive of PTSD, a theory that is clearly relevant to participants in the present study.

Overall, these results suggest that the participants shared a tendency to dissociate and that this may have served as a maladaptive coping or 'defence' mechanism (Cardena, 1994). As with imaginative involvement and fantasising, dissociative characteristics may thus have served to maintain, as well as contribute to, the development of post-abortion distress. However, this characteristic might also be conceptualised as a talent that could be employed in the use of hypnotic techniques to support appropriate CBT interventions (described by Holmes et al, 2004) designed to treat PTSD.

Assessment of PTSD thus provided insight into the severity of the participants' symptoms and illustrated the extent to which they were, in some ways, partially disengaged from life. Moreover, when PTSD symptoms are put in context with results of other psychometric tests, it is clear to see that the participants were suffering extreme psychological distress and that in many cases this suffering was taking place in total isolation without even their closest friends or family being aware. These findings would suggest that theorists (e.g. Russo, 1997), who construct abortion as a benign event that simply serves the purpose of dealing with an unwanted pregnancy, have failed to acknowledge the complexity of the problem and do not represent the experiences of the possible thousands of women in the UK alone that may be suffering from post-abortion distress, a point of view that may lead to further isolate those women affected.

6.2 The efficacy of hypnosis as an adjunct to post-abortion distress.

i) The process of therapy

No clear pattern could be identified in which particular interventions were followed by symptomatic improvement across all 5 participants. However, a pattern did emerge (as illustrated by the SCL-90 graphs) in which the processes of change for the 2 least psychologically complex participants (1085 and 1069) were similar, showing a gradual decline in symptoms throughout therapy with scores that peaked during the second phase of therapy (following confrontation of the most painful aspects of their distress). Similarly, a pattern emerged in which the 2 *most* psychologically complex participants showed least change over the course of therapy. These participants (2891 and 2553) had both suffered multiple trauma and showed symptoms of complex PTSD which may have explained some of the particular difficulties they experienced which were more resistant to change, such as extreme lack of trust (2553) and severe dissociative symptoms (2891) (van der Kolk and McFarlane, 1996). Participant 2314 showed most improvement

during the first phase of therapy. It should be noted, however, that there was a considerable increase in her anger-hostility and anxiety scores following week one, possibly linked to a crisis with her partner. If these scores were eliminated, a less dramatic picture of progress in phase one would have emerged.

Interestingly, two of the three participants whose SCL-90 scores showed least change during the middle phase of therapy (2314 and 2553) were both taking anti-depressants during this phase (during which painful issues were addressed). One hypothesis might be that this medication suppressed affect and prevented these participants from engaging with the same heightened emotions as experienced by 1069 and 1085. Likewise, the SCL-90 graphs of participant 2891 (by far the most psychologically complex participant) showed little change during the middle phase of therapy, perhaps reflecting her lifetime's habit of dissociating from painful feelings (Dolan, 1991) in order to psychologically survive the multiple traumas that she had experienced throughout her life (ongoing childhood sexual abuse, childhood neglect, rape and gang rape, and 4 abortions).

The process of change did not appear to be linked to hypnotic suggestibility, for example, the 2 participants who made most progress attained both the highest and lowest CIS scores of the group. It should be noted, however, that the lowest scoring participant (1069) was highly motivated and very enthusiastic about using hypnosis - a mindset conducive with responsiveness to hypnotic suggestion (Kirsch, 1985). Furthermore, whilst her scores were generally low on the CIS (Wilson and Barber, 1978) (indicating that the majority of suggested scenarios felt 'a little the same' or 'between a little and much the same'), she rated the relaxing scenario as 'almost exactly the same'. Given that all hypnotic interventions began with an induction involving imagery of a relaxing

scene, to which she was highly receptive, this may have primed her to respond to the suggestions that followed.

Symptom scores cannot prove that the intervention immediately prior to change was the *sole, major* or even *contributing* factor leading to change, or whether it had any relevance at all. Certain mental processes might, for example, take longer to change in response to interventions than others. For instance participant 2981, following an hypnotic reliving in session 4 to being abused at five years old, was able to begin to *think* that the abuse was not her fault but it was only after session 13 that she was able to *feel* that it was not her fault. This session enabled her to experience, in hypnosis, confronting her abuser, seeing him as weak and expressing her anger towards him. Given findings of recent neuroimaging studies (e.g. Szechtman et al.,1998), it could be speculated that this evoked very similar brain functioning to actually having experienced this scenario. Although it is never possible to actually change history, it may be that this hypnotic technique triggered basic perceptual levels of brain functioning so that newly constructed (helpful) representations were particularly robust.

A further consideration is that the phased approach to the treatment of PTSD used in this study is based on the premise that the person should have sufficient resources at their disposal before the therapist attempts to address the trauma (Rothschild, 2005). Therapy was thus initially focused on reduction of symptoms. When feelings that had previously been too painful to confront were addressed in phase two of therapy (Dolan, 1991), it had been anticipated that the participants' SCL-90 scores were likely to increase somewhat, as was the case with 1085,1069 and 2314. Therefore it could be argued that a *rise* in scores at various stages of the therapeutic process may paradoxically illustrate the

effectiveness of an intervention, reflecting successful engagement of painful (but manageable) emotions.

The MHAT forms completed by the participants at the end of each session did not consistently reflect SCL-90 scores. The participants had, without exception, reported positive aspects of the sessions on the MHAT, but progress, as indicated on the SCL-90, did not always follow. The addition of a rating scale on the MHAT to indicate *degree* of helpfulness might have helped to some extent, but it may be speculated that written feedback from the participants, albeit in a sealed envelope and labelled only with a code number, might nevertheless have been influenced by the participants' knowledge that the therapist would be examining these responses. Nevertheless, the MHAT forms provided a rich source of information about how interventions were perceived, as well as identifying what the participant considered to be the main focus of the therapeutic session. Completing the forms also seemed to help the participants' clarify their own thoughts and seemed to be a contributing factor in the participants' construction of narratives in which they could explain, and consolidate, their recovery.

It would appear that what took place within the hypnotic interventions was regarded by the participants as central to the process of psychologically resolving their abortions and provided markers of progress, almost as if constructing an alternative account of history. Indeed, participants frequently referred to the hypnotic interventions as if the imagined scenarios had actually happened, for example, they might say, 'I was thinking about when I comforted my younger self……', or ' When I was confronting those bullies…..' , 'When I was in my bubble…….'.

These comments illustrate a 'virtual reality' type of experience created by hypnotic suggestion (Walters and Oakley, 2003). An example of this was an image of a 'shining light', arrived at by the therapist eliciting, in hypnosis, one participant's (2891) imagery of how she would like to replace her 'rotten core', something she believed that she had always had. This seemingly simple 'ego-strengthening' intervention, involving imagery of a shining light to 'heal her rotten core' had a profound effect on her and continued to do so throughout the remaining therapy and at follow-ups too. One reason for this may have been that the imagery had been arrived at within a hypnotic context, thus making it more emotionally meaningful at a holistically 'felt' level. Indeed, the participant visibly squinted and complained that the light was hurting her eyes, evidence of activation of a very basic perceptual process, all of which contributed to the experience feeling so real (Brown and Oakley, 2004).

Indeed, all participants had commented in the therapeutic sessions that certain interventions had felt real. However, this was noted by only 3 of the participants when responding to the UOH form. The UOH form was designed to obtain feedback from the participants without influencing their responses and thus it had been decided not to ask any direct questions. In retrospect, it may have been helpful to have included a rating scale to enable participants to indicate the extent to which each hypnotic intervention felt real so that this could have been more adequately related to hypnotisability. It would appear, on inspection of the CIS scores and UOH comments, that there was no clear pattern in which the realness of the hypnotic intervention related to hypnotisability, however the limitations of the data available to assess this should be noted.

The UOH was helpful in identifying the variety of ways in which the participants responded to the hypnotic interventions and, as observed in responses to the MAHT forms, illustrated the development of the participant's narrative of change. It was also

clear that each participant had responded to the core hypnotic interventions used as part of the therapeutic protocol in a unique way (see Table 5.18, Chapter 5).

Difficulties with close relationships emerged, without exception, for all five participants, reflecting the general feeling of lack of support and trust they had all indicated in response to Booklet A. An interesting observation was that the 4 participants who, by the end of therapy, were able to feel more comfortable about their decision to have their abortion (s) achieved this following interventions in which therapy addressed unsatisfactory relationships with significant others. Moreover, it was evident that participant 2553 (who indicated at the end of therapy that she still felt uncomfortable about her abortion decision) had experienced serious marriage problems throughout the course of therapy. Furthermore, this participant had commented that she had become 'aware of the hypnotic techniques', and found this had prevented her from 'succumbing' indicating that she had perceived that the therapist might have been using techniques that were not meant to be transparent, a comment which may have reflected issues relating to trust.

The possible link between difficult close relationships and comfort with the abortion decision was unexpected, but it would appear that a theme running through all difficult relationships experienced by the participants had been a feeling of being badly hurt and let down by a significant other who they had felt should have cared for them, a feeling that was possibly linked to identification with the aborted foetus.

ii) Outcome of therapy

All participants showed an improvement of mental health as measured by psychometric tests on completion of therapy, the majority of which were clinically significant

according to the Reliable Change Index calculations (Jacobson and Truax, 1991) and four showed increased improvement at the first follow up. These results did not appear to show any pattern in which improvement was linked to hypnotisability. A pleasing result was that by the second follow-up 4 participants had made further improvement on their follow-up one results. Four participants had continued to use self-hypnosis, at least sometimes, mainly for relaxation (see Table 5.21). Whilst it may be speculated that self-hypnosis may have been helpful in achieving continued improvement, it is not possible to establish this with any certainty. For example, one possible explanation of their continued improvement could be that increased reintegration into life by the end of therapy was followed by an increasing number of positive experiences which created further opportunities for even further positive experiences.

Another possibility is that the use of hypnotic 'future rehearsal' interventions in phase three of therapy gave the participants the opportunity to experience the future 'in advance'. This may have helped to increase expectations that a desired future could be achieved and sustained. This focus towards the future is regarded by Yapko (1992) as an essential goal in therapy for depression in order to change the depressed client's characteristically stable and pessimistic thinking style (e.g. 'I will never feel better') to *un*stable and thus more optimistic (e.g. 'This feeling will pass').

A surprising result was that some post therapy scores were superior to those of norms for college students. There would appear to be no explanation for this, however, it could be speculated that the participants were feeling so relieved to have felt better following therapy that they rated the scales with a particularly positive bias. Least improvement on the psychometric tests appeared to be made by the participants who had a previous long-term history of depression. Two of these participants had experienced more than one

abortion. The participants who made most improvement had experienced their abortions more recently than the other three. Although the small numbers involved in this study make these findings difficult to generalise, it may be speculated that the longer the problem is left untreated the more intractable it becomes.

Results indicated that all 5 participants were suffering from PTSD. It should be noted, however, that participants 2553 and 2891 had not consistently identified the abortion as the trauma that had affected them most (see Table 5.14) and PTSD symptoms experienced by these two participants showed less improvement than the other three. Nevertheless, both participants 2553 and 2891 had indicated extreme distress about their abortion(s). For example, participant 2891 found it very difficult to initially acknowledge that she had had an abortion, possibly as she realised that this might inevitably lead to the disclosure that she had had 4 abortions, a secret she had kept from others throughout her life and something she had felt painfully shamed by. Indeed 2553 indicated on the revised PDS that she had not realised that the questions asked could be related to an abortion. Furthermore, she felt unable to complete answering the additional questions relating to this, i.e. whether 'someone's' life was in danger could have related to a foetus, possibly due to the painful feelings this evoked. Thus both 2553 and 2891 demonstrated the extent to which their abortions 'bothered them' but this was not adequately reflected on the PDS. Measures, such as the PDS, would thus appear to be limited in the extent to which they can provide an accurate picture of PTSD related to abortion.

Nevertheless it seemed that the participants found it helpful to know that their symptoms indicated PTSD. The comments below were written on the 'Most Helpful Aspect of Therapy' form:

'I have an illness - I might not be mad'.

'I tell myself, give yourself a break, you've got PTSD'

'At first it was difficult to accept but it makes me feel it's a nice compact diagnosis, like there is an end to this'.

These comments suggest that informing the participants of the PTSD diagnosis was helpful therapeutically (Dolan, 1991). However, it should be noted that anti-abortion activists have used the PTSD diagnosis of severe distress following an abortion strategically by encouraging litigation against the doctors who perform abortions (Lacey, 3rd August, 1997), a strategy to discourage doctors from providing an abortion service. It was argued earlier (see Chapter 1) that abortion politics prevent women from receiving help that they need. Similarly, if therapists are reluctant to provide information about PTSD for fear that a client might be encouraged to use this strategically, yet another helpful strategy available to those suffering from less contentious traumas is denied for women suffering from post-abortion distress.

Following therapy, all participants experienced a reduction in the overall severity of their PTSD and 3 participants showed a reduction of specific symptoms endorsed. However, participant 2553 indicated on the PDS an increase of PTSD symptoms on completion of therapy. Inspection of this participant's data failed to establish an explanation for this. Indeed, her ratings for other psychometric tests showed that these had all improved by completion of therapy, which revealed incongruence when compared to both her PTSD scores and her general evaluation of therapy which she rated as 'very' successful and similarly indicated that she regarded her problem as 'mostly' resolved.

6.3 The Integrated Model of Hypnosis (IMH) and post-abortion distress

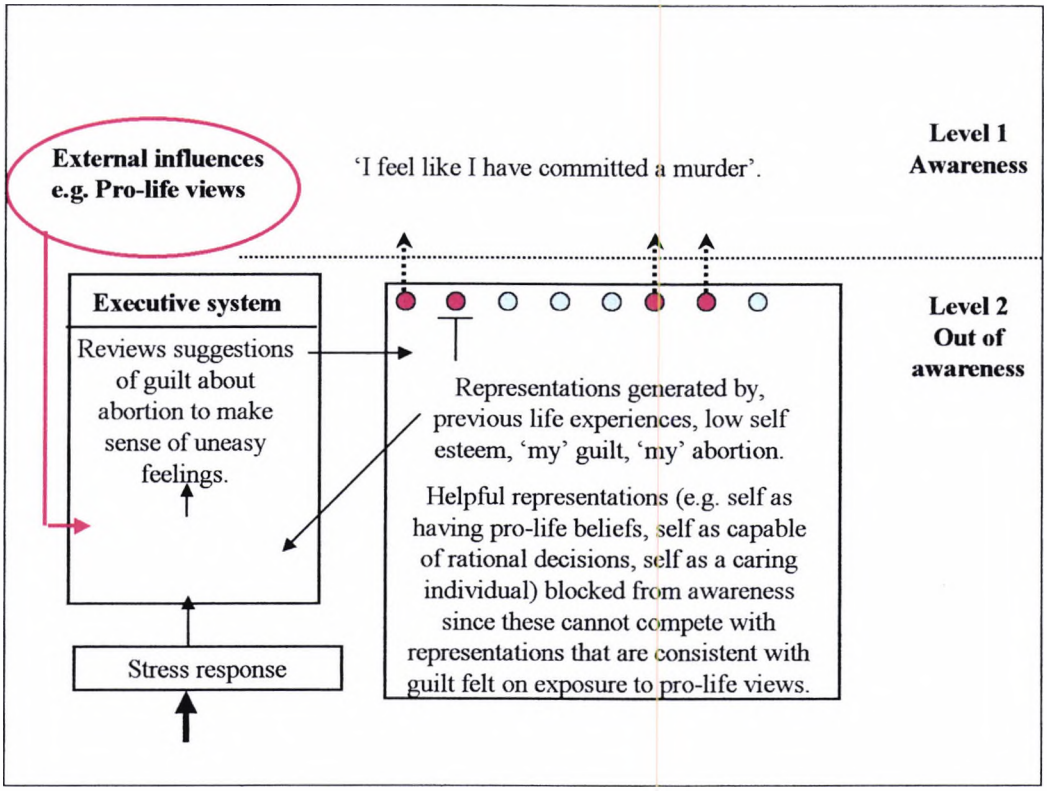
i) Using the Integrated IMH to understand the participants' post-abortion distress

It was suggested in the introduction that the IMH (Brown and Oakley, 2004), might be useful to understand the nature of post-abortion distress. This model is now reviewed in the light of results discussed above.

Of particular note was that the majority of the participants did not believe that abortion was wrong but they nevertheless experienced high levels of guilt. One way of explaining this within the IMH is that whilst a woman may have a conscious awareness of her pro-choice views on abortion, total acceptance of other women's decisions to have an abortion, and may have expressed acceptance of her own abortion, her above average suggestibility may nevertheless result in anti-abortion views having an influence on her, even if these do not fit with her self-view.

According to the model (see Figure 6.1), one way that psychological discomfort may arise is that ruminations on pro-life opinions act as suggestions that by-pass critical awareness in consciousness, and directly influence the executive system, i.e. out of awareness. Pro-life opinions, for example, suggesting that abortion is 'bad', may thus activate a search in Level Two for stored representations and associative memories that make most sense of this. This search could activate representations of the woman's own abortion as well as a search for representations of the self as 'bad' to correspond to the 'badness' of abortion as suggested by pro-life views. Given that the participants commonly perceived themselves to have low self-esteem, representations of feeling bad about oneself are likely to be active. Once a match is found, and the spreading activation of associations stabilised (Rummelhart & McClelland, 1986), a new

representation may have become constructed in Level Two in which 'my guilt' is associated with 'my abortion'.



Red circle = selected representations Blue circle =non-selected representations

Figure 6.1. Using the IMH to understand the participants' post-abortion distress.

The conscious experience of this activity in Level One might be a feeling of unease on exposure to a baby, which is further interpreted as 'I am feeling guilty about my abortion' or 'I feel like I have committed a murder' (a feeling experienced by over half of the participants). However the source of guilt (the linking of pro-life opinions of abortion to one's own self-view of 'badness') is not fed through to consciousness, since this does not accord with the self - representation of being a person with pro-choice views.

Brown and Oakley (2004) describe the effect of suggestion on basic perceptual systems, which may also be useful to explain how the participants' generally above average suggestibility may have contributed to the discomfort they experienced on exposure to reminders of the abortion. This is now examined in context with a situation that the majority of participants found extremely uncomfortable about, i.e. seeing a photograph of a foetus in a magazine.

The discomfort of stumbling across a picture of a foetus, perhaps on turning over a page in a magazine, may be explained by the picture activating a complex network of associations (out of conscious awareness) such as those of aborted foetuses; the woman's own aborted foetus; and representations of the abortion, of herself as a murderer, of the foetus feeling pain, of the participant's own experiences of being treated badly, of a painful abortion procedure etc. All of these associations would be accompanied by activated physiological responses, such as those involving the amygdala (Rothschild, 2005) and stress hormones which further influence the selection of 'best-fitting' representations in Level Two. A simplistic interpretation of this process is that the system stabilises once the search has matched pro-life assertions about foetal pain with representations of the self as a bad person resulting in the woman consciously experiencing despair and attributing this despair to having caused her foetus to suffer a painful death.

Cognitive models such as the IMH challenge pro-life assumptions that feelings of guilt represent evidence that abortion is wrong. Rather, it can be argued that feelings about an abortion may be the result of an exceptionally complex process involving a multitude of legacies of life experiences, not only multitudes of permutations of thoughts, feelings and behaviours, but complex physiological responses too. Furthermore, contradictory to

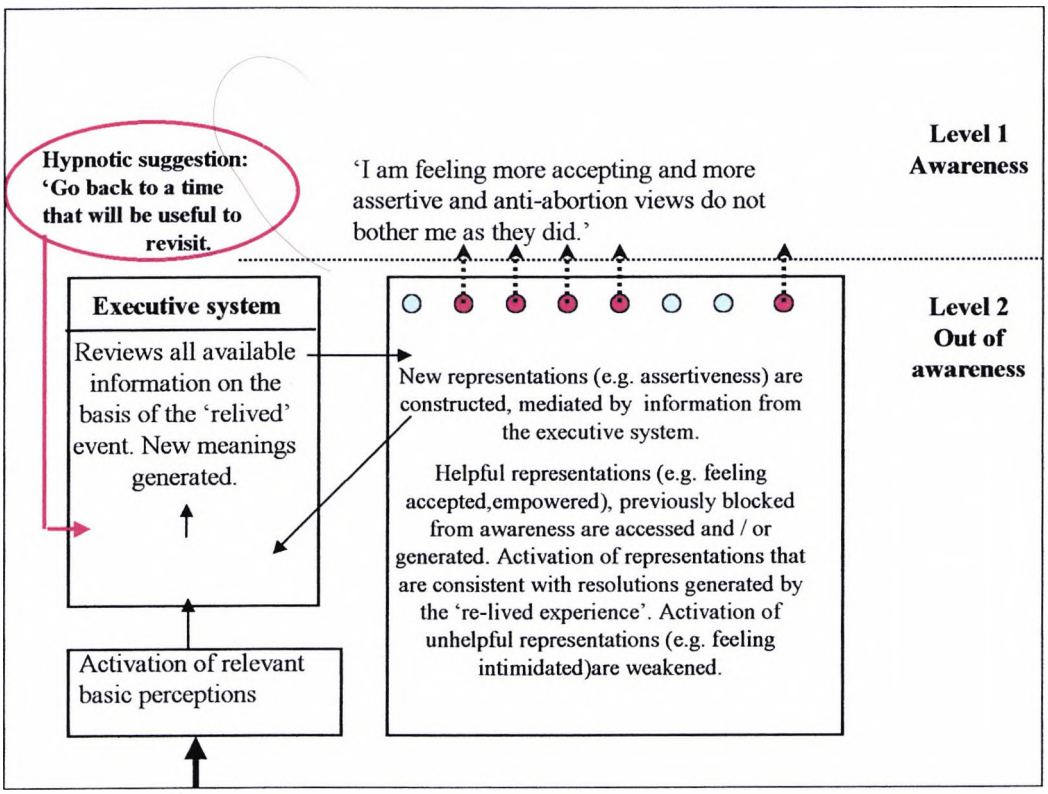
pro-choice views on post-abortion distress, this highly complex process does not need to imply any underlying psychological pathology.

The IMH could also account for post-abortion distress from an evolutionary perspective. It may be helpful to first put this in context with a stress model. Stress management training (e.g. Palmer and Dryden, 1995) teaches clients to reduce the fight or flight response and clients are informed that this is generally an inappropriate reaction since the stressor is likely not to be life threatening. It is explained that the fight or flight response is a very powerful drive influencing thoughts, emotions and behaviours, a primitive response designed to ensure individual survival and, ultimately, the survival of the species.

Post-abortion distress could similarly be explained by suggesting that pregnancy hormones initiate a powerful response that influences thoughts, feelings and emotions - a primitive mechanism to ensure the pregnancy survives. If the abortion decision is stressful, the stress response also influences thoughts, feelings and emotions. Moreover, above average suggestibility may increase responsiveness to internal cues resulting from this hormonal activation. The fight and flight response and maternal instincts arising from hormonal activity do not facilitate rational judgement. Should the pregnancy be aborted, pregnancy hormones will diminish but thoughts, feelings and behaviours evoked when they were present may have become habitual and cause considerable confusion and distress. Yet, just as a stress response does not necessarily indicate that a perceived threat is life threatening, in a similar manner, post-abortion distress does not have to indicate that the abortion was a mistake (or wrong).

ii) The IMH and the participants' process of change

One way that the IMH might explain the process of change experienced by the participants is that the hypnotic suggestions facilitated a highly efficient search for all relevant or pertinent representations which provided the opportunity to *experience* resolution. This process is illustrated in Figure 6.2.



Red circle = selected representations Blue circle =non-selected representations

Figure 6.2. The IMH and the participants' process of change.

The figure shows how participant 1069, in response to the suggestion inviting her 'To go back to a time that would be helpful to revisit', went back to being a teenager and re-experiencing all the feelings of being used and taken for granted that she had felt at the time, a process likely to have also involved basic perceptual activations (Brown and Oakley 2004). On being encouraged by the therapist to articulate her feelings to her 'Older Wiser Self' (OWS), her OWS was able to acknowledge her 'Younger Self's' (YS) anger and support her YS to confront her family and be retrospectively assertive

with them. The figure illustrates how change is *experienced* in Level One, rather than just understood at a cognitive and / or emotional level, following the construction of novel representations in Level Two, of feeling empowered. It could be speculated that evidence of these representations was the participant's report (in the following session) of feeling more assertive with her family, which also helped her to feel less reliant on her family's approval of her abortion and to feel accepting of herself. This process was assisted by suggesting she went 'Forward in time', to practise this assertiveness and 'Notice the difference', a suggestion which may have consolidated these representations, and made them more readily accessible, in Level Two.

One important aspect of such interventions is that they facilitate resolution of issues that may have underpinned the client's distress but may not have otherwise have come to light so speedily. Another important consideration is that this type of hypnotic intervention enables the therapist to become a 'witness' to past events. This may have considerable impact on the therapeutic relationship since the 'rewriting of history' is likely to include representations in Level Two of the therapist's unconditional acceptance. Indeed, experiencing unconditional acceptance appeared to be a feeling that all five participants lacked in childhood relationships with significant others. Participant 1085, responded to the suggestion inviting her to 'Go back to a happy time before you had your problem', by finding herself at a childhood birthday party indulging herself in eating party food. This memory may have been arrived at through activation of associations triggered by responsiveness to the words 'happiness', 'childhood' and 'problem'. Thus, the spreading activation of associations (Rummelhart & McClelland, 1986) in Level Two resulted in the most meaningful representation available and presented the therapist with an opportunity to address issues the participant had raised in previous sessions that, as a plump child, she had never felt attractive enough for her

mother. The intervention thus involved validation of the participant's childhood enjoyment of the delicious food and included making further suggestions to enjoy 'all the good feelings attached to the experience' in order to invoke an experience of retrospective unconditional acceptance and consequently a newly constructed representation which influences feelings experienced in Level One, and one that may have contributed to feeling more self-acceptance about her abortion too.

Such interventions may have helped the participants, all of whom had problems in trusting others, to be able to trust the therapist sooner than might otherwise have been possible. Indeed, when using hypnosis in therapy the therapist's own focus of attention may in itself be enhanced resulting in a 'virtual reality' experience of being 'there' with the client, an experience which may facilitate heightened empathy (Wickramasekera and Szlyk, 2003). In addition, the presence of a constant flow of information drawn from the therapist's long-term memory as well as the structure of therapeutic framework, provides the therapist with an opportunity to respond highly sensitively to what the client is experiencing. As such, it is suggested here that the therapeutic process, particularly when it feels as if 'something is happening', is similar to what Casement (1995) describes as the therapist's 'resonance' with the client, a process representative of communication in Level Two between therapist and client.

It is suggested that the hypnotic interventions used in this study thus involved the complex interweaving of psychological theories, an openness to working with the unexpected, keeping in mind the broader picture, and paying attention to the detail of the here and now. This process involves the therapist moving back and forth between critical evaluation of available knowledge (Level One) and intuition (Level Two). Ego-state techniques necessitated the use of counselling skills (rather like those used in

couple or group work) that can enable ego-states (or resilient and vulnerable self-representations in Level Two) to communicate and make resolutions. Contrary to the common, but erroneous, concept of hypnosis, the use of hypnosis described in this study is not the use of forceful commands to invoke change such as 'You will no longer be upset when you see a baby in a pram', rather it is the setting up of scenarios within hypnosis so that the client can experience change.

Participant 2891, in response to being asked in the penultimate session if she believed that she could have achieved similar progress without the use of hypnosis, answered:

> *'No, I don't think it would have worked. I think you really need to be there in the situation. I couldn't have talked about it so much as I did doing it like that. I felt it was happening like a film'.*

> *'It feels like my brain has done a somersault, it's come back down where it should be - it was ajar before..... ...I can't describe it - never felt like this in my life. I don't know how I coped before'.*

It is interesting to speculate whether what this participant is describing is a fundamental change occurring in Level 2 (See Figures 1.1, 1.2 and 1.3), a process that seems to transcend the verbal and one that may only adequately be described in the metaphorical language of the type used by this participant. Furthermore, it may be useful to consider this process of change within the evolutionary model of post-abortion distress described above. For instance, this participant's progress may be conceptualised as her success, at a fundamental level, to reappraise the threat that she had continued to feel following her multiple experiences of childhood abuse, and also to re-evaluate her abortion decisions

so that her distress was no longer interpreted as evidence that she should feel ashamed of these decisions.

6.4 Research methodology

As Elliot (1984) suggests, therapists need to pay close attention to the detail of how clients experience change in order to design effective therapeutic models. The use of subjective reports is valuable in this respect and much can be gleaned from the careful observation of a few clients, not only in their actual responses but also in the process of responding. For example, reactions to the pre-therapy assessment questionnaires in the present study ranged from feelings of distress (2891, 2553) to relief (1085,1069, 2314), and participant 2891's dissociative symptoms resulted in some difficulty and confusion with the reversed questions. Both participants 1069 and 1805 completed their questionnaires with considerable composure, and commented on how surprised they were that the questions related very much to their feelings. Others also expressed a feeling of relief on realising that their feelings were not unique and 1085 said that the questions had provided words for emotions that she had been unable to articulate.

Not only did the questionnaires trigger various emotions but, in view of the participants' above average suggestibility, it is possible that the questions possibly conveyed suggestions to the participants which influenced their conceptualisation of their distress. Sometimes the participants' use of language about the weekly checklists suggested they were not responsible for their responses. For example 2891 sometimes said, 'The checklists have changed this week'. This may have suggested compliance or a need to please the therapist, but another consideration is that, particularly in the initial stage of therapy, that it was difficult to own feeling better if the participant was still feeling emotionally attached to the foetus. Mcleod (1994) suggests that a disadvantage of using

self-report measures is that they can present a distorted picture, however, on balance it would seem that the self-report questionnaires provided richer data than was possible with objective measures alone.

Woolfe (1996) writes:

> *Counselling psychology can be seen as a reaction to the somewhat mechanistic view of human beings inherent in more traditional psychological paradigms based upon a conventional model of science and the techniques of scientific investigation'. (p. 9)*

Kidner (1993) similarly suggests that a purely objective approach to researching hypnosis in therapy may simply not be possible by scientific measurement alone, a possibility that could effectively prevent its wider use. It was hoped that a time series design, albeit with a shorter baseline than that recommended by Borckardt and Nash, 2002 (see Chapter 4) might have provided a solution to this dilemma and enable inferences to be made about the efficacy of the therapeutic protocol examined in this study. However, a limitation of this study was that it was not possible to disentangle the components of therapy sufficiently succinctly to assess the effectiveness of the hypnotic interventions.

The endless variables that could affect therapeutic outcome are, indeed, frequently discussed in the literature (e.g. Kidner, 1993; Mcleod, 1994). Experimental hypnosis studies typically use scripts and tight protocols in order to ensure consistency of hypnotic interventions. Indeed, hypnosis has been shown to be an effective research tool in understanding clinical problems such as psychogenic pain (Derbyshire, Whalley, Stenger, and Oakley, 2004) and a meta-analysis of the use of hypnotic and non-hypnotic techniques in pain management has supported the efficacy of hypnotic techniques in pain management (Montgomery, DuHamel and Redd, 2000). Such research may inform

clinical practice about *techniques* but makes no claims to be measuring '*therapy*' for psychogenic pain. Therapy for most psychological problems, however, is not a pure science (Woolfe, 1996). Legg (1998) describes the concept of therapy as both an art and science by comparing therapeutic skills with those of a jazz musician who uses knowledge of basic chord sequences to be able to improvise. The dilemma of carrying out clinical research facing practitioners as a whole (not only those who use hypnosis adjunctively), would appear to reflect the difficulty in finding scientific methods that adequately address the art of therapy.

In the present study, utilising the participants' own imagery and insights was of central importance to the therapeutic framework examined and any conclusions drawn from a study that, for example, confined the use of hypnosis to scripts and a rigid protocol in order to control variables, would say little about the actual potential of hypnotic interventions. Indeed, the use of hypnosis scripts in therapy is more akin to the lay use of hypnosis in therapy (or 'hypnotherapy'), and thus more frequently associated with non-psychologically informed, and therefore limited, approaches. Furthermore, research findings have shown that individuals are more likely to develop new ideas if these are discovered by the client (Legg, 1998) and this is likely to be true when insights are made within hypnotic interventions too. Similarly, whilst the protocol could have been used more inflexibly, this would have said little about the potential of the hypnotic interventions for adaptation in response to the participants' needs, as these arose in therapy – a process that will inevitably be unique for each person.

A limitation of the study was the small number of women taking part. This was due to the difficulty in recruiting participants, reflecting a reluctance of women to participate in studies on abortion as noted by Barnard (1990). However, comments made by

professionals in response to the study are interesting to note. For example, one GP contacted in connection with the study, asked: *'Doesn't hypnotherapy lay the person open to bad influences and the devil?'* and suggested that it was wrong to reach a resolution about abortion without guilt and confession. On another occasion the manager of a counselling service said '*abortion is a very sensitive area and hypnosis raises concerns about being intrusive- something that is done to you.*' A counsellor working for an abortion charity that provides post-abortion counselling commented, '*we understand psychological difficulties after an abortion to be part of a process, rather than an event, which would seem incongruent with the service you are proposing*'. All these responses illustrate commonly held misconceptions about hypnosis.

Whilst there was some encouraging willingness on behalf of several organisations to display posters and leaflets about the present study it became clear that those who were likely to have influenced dissemination of information included administrative officers (who had control over the display of posters and leaflets), clinic receptionists (who made decisions about putting telephone calls through to GP's), counsellors, doctors, psychiatrists and psychologists, all of whom may have had their own, often ill-informed, views on hypnosis. Any of these professionals may thus have influenced the opportunity for clients to make their own decisions about whether or not they would have liked to be involved in the project.

Another limitation of the study was that the psychometric tests sometimes necessitated slight changes of wording to make them appropriate to the problem. In the case of the Perinatal Grief Scale (Potvin, Lasker and Toedter, 1988) this simply involved exchanging the word 'miscarriage' with 'abortion'. However, the PDS involved a more substantial change (see Chapter 2). Whilst this sacrificed the validity of the scale, it

nevertheless seemed more important to ensure that the PDS fairly represented the participants' particular problem, which the original wording may not have been able to do. The PDS was selected for use with the present study because the questions elicited useful data about symptoms, however it was not ideally suited to trauma related to an abortion.

One obvious solution is the development of a specifically tailored measure of PTSD related to abortion, e.g. 'Post Abortion Syndrome' (Spekhard and Rue, 1992). However, this would result in the labelling of women and a humiliating diagnosis that would conflict with a woman's right to retain privacy about an abortion. Another consideration is that, whilst it would seem essential for therapists to be aware of the possibility that a woman who has experienced an abortion could be suffering from PTSD, there is a danger that pro-life activists could use this possibility to restrict abortion provision.

The participants taking part in the study were selected on the basis that they were suffering from post-abortion distress. The recruiting of an appropriately matched control group (e.g. women with similar demographics who have had abortions but have not developed post-abortion distress) was considered when designing the study but was not possible in the timeframe available. Thus it was decided to use normative data (clinical and non-clinical) to compare results. It is acknowledged that the absence of a control group within the study places some limitation on the interpretation of results. The characteristics of women suffering from post-abortion distress identified here cannot, for example, be used to reliably predict particular groups of women that might be considered at greater risk. In considering a matched control group it should also be noted that limitations in abortion research suggest that it is not possible to reliably

ascertain what is demographically typical of women suffering from post-abortion distress (see Wilmouth, Alteris, and Bussell, 1992).

The small number of participants taking part in the second part of the study should also be noted. However, 'collections' of experimental case studies can be a highly appropriate way to empirically examine therapeutic protocols (see Borckardt and Nash, 2002; Barker, Pistrang, and Elliot, 1996). It is, indeed, hoped that the study can continue so that results from testing the protocol with further cases can be accrued over time.

The design of the study could, perhaps, be improved by shortening the questionnaire booklets. This could be done by further examining any possible overlapping of questions by eliminating those asked in section 5 of Booklet A which alluded to emotions that are also addressed in the psychometric tests in Booklet B. It may also have been helpful to have asked the participants to respond to the SCL-90 at the baseline assessment session and also at follow-ups. This was not originally felt to be necessary as the intention was to use the SCL-90 to monitor change throughout therapy (Derogatis, Lipman, & Covi, 1973), however, in retrospect this could have been used to provide baseline and follow-up data too.

6.5 Future research

The present study would suggest that further investigation into the hypnotic suggestibility, fantasy proneness and imaginative involvement of women suffering from post-abortion distress is warranted. Examination of data from a larger number of women, prior to their abortion, plus following up adjustment to the abortion six months later, could determine with more confidence than is possible from the present study, whether above average hypnotic suggestibility, fantasy proneness and imaginative

involvement increases vulnerability to post traumatic stress disorder following abortion. Whilst recruitment of participants would predictably be restricted by the difficulties that have been identified in doing abortion research alluded to above, a larger initial target group would improve final sample size. Furthermore, collecting data from a group who had not self-selected on the basis of experiencing post-abortion distress, might establish whether in some cases above average hypnotisability, fantasy proneness and imaginative involvement may also be associated with satisfactory psychological adjustment following abortion and whether the experience of dissociation at the time of the abortion might be another factor in predicting post-abortion distress.

Another possibility is that the basic therapeutic protocol under examination in the present study could be adapted for use with two groups, one of which received the same interventions (such as the mourning ritual) without hypnosis. If numbers were sufficiently large and the psychological profiles of the women in both groups evenly matched, such a study might be helpful in establishing whether the addition of hypnosis improved outcome, a consideration that could not be addressed in the present study.

A further possibility would be to evaluate a pre-recorded self-hypnosis tape which could include future rehearsal techniques that enable the participants to experience coping well with the abortion, ego-strengthening suggestions and suggestions to promote resilience to anti-abortion comments. By comparing post-abortion adjustment of these women to a control group of women who did not receive the tape, it would be possible to establish whether this simple strategy could help towards the prevention of post-abortion distress.

6.6 Concluding statement

Research carried out to investigate the efficacy of treatment for PTSD has resulted in recommendations to use a combination of cognitive interventions and exposure techniques (Roth and Fonargy, 1996). However, as Roth and Fonargy point out, studies have, on the whole, been small in scale and it is still difficult to draw definitive conclusions. Whilst it is not disputed that these methods can, and do, lead to recovery, it should be remembered that such protocols, even when applied by the most competent therapists, do sometimes serve to worsen the problem (Rothschild, 2005). Yet the successful use of hypnosis in managing exposure to trauma (as part of a protocol to treat PTSD) based on numerous case reports, can only achieve official categorisation as 'a promising but not fully supported, efficacious intervention' (Cardena, 2000), since insufficient well-designed studies exist to make stronger claims. The present study has attempted to address this short fall.

The results of the first part of the present study suggest that women who experience severe psychological difficulties following an abortion may share characteristics such as above average hypnotisability (significantly different to the norms of a non-clinical group), and a tendency towards fantasy proneness and imaginative involvement. Furthermore, results have indicated that symptoms of severe post-abortion distress may be categorised as posttraumatic stress disorder and that symptom severity is not statistically different to the general PTSD population (Foa, 1995). However, the small number of participants taking part in this study, and the self-selected nature of the group of participants examined make it difficult to generalise from these results.

In the second part of the study a therapeutic protocol for treating post-abortion distress was examined that combined the use of hypnotic techniques with CBT and

psychodynamic theories. It was evident from subjective feedback and psychometric tests that the therapeutic protocol was followed by improved mental health of all five participants who received therapy and that improvement continued to increase beyond therapy. Moreover, the majority of post-therapy psychometric measures showed reliable clinical change (Jacobson and Truax, 1991) and overall progress was sustained at 16–18 months following completion of therapy. Whilst results suggest that this therapy was successful, and that the addition of hypnosis was regarded by the participants as a central part of this success, the small number of participants involved prevents generalisation or stronger claims to be made.

As noted in the introduction to this study, very little investigation has taken place to establish effective psychologically informed therapeutic frameworks for treating this distressing clinical problem. It is hoped that the framework presented might provide one such possibility and that this study will contribute towards an increased understanding of the nature of post-abortion distress and stimulate thoughtful and sensitive consideration of the very complex issues involved.

A particularly striking finding has been the especially severe level of distress experienced by the participants and the unique difficulties that they faced in coping with everyday life, mostly it would appear, in isolation and with little or no support. It was stated in the introduction to this study that each year an estimated 5,500 women may develop psychological difficulties following an abortion (Paintin, 1997). It is suggested that women affected, social psychologists and therapists might all benefit from understanding the problem from the perspective of a psychological model that is not driven by undercurrents of abortion politics.

REFERENCES:

Abramson, L.Y., Seligman, M. E. P. & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87,* 49-74.

Adler, N. E. (1992). Unwanted pregnancy and abortion: Definitional and research issues. *Journal of Social Issues, 48,* 19-35.

Adler, N., David, H., Major, B., Roth, S., Russo, N., and Wyatt, G. (1990). Psychological responses after abortion. *Science, 248,* 41-44.

Alden, P. (1995). Back to the past: Introducing the 'bubble'. *Contemporary Hypnosis, 12,* 59-68.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition.* Washington, DC, American Psychiatric Association.

Arthur, J. (2003). Beware of meaningless studies by anti-choice researchers *Pro-choice press,* Autumn / Winter http//www.prochoiceactionnetwaoprk-canada.org/cmaj-study.html

Ashurst, P. (1990). Abortion is a human issue, *GP,* 5th October.

Aspinall, L. and Taylor, S. (1993). Effects of social comparison direction, threat, and self-esteem on affect, self-evaluation, and expected success. *Journal of Personality and Social Psychology, 64,* 708-722.

Bagarozzi, D. A. (1994). Identification, assessment and treatment of women suffering from post traumatic stress after abortion. *Journal of Family Psychotherapy, 5,* 25-54

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review, 84,* 191-215.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37,* 122-147.

Barber, T. X., Spanos N. & Chaves, J. (1974). *Hypnosis: Imagination and human potentialities,* New York: Pergamon.

Barber, T. X. & Wilson, S. C. (1978). The Barber Suggestibility Scale and the Creative Imagination Scale: Experimental and clinical applications. *American Journal of Clinical Hypnosis, 21,* 84-108.

Barker, C., Pistrang, N., & Elliot, R. (1994). *Research Methods in Clinical and Counselling Psychology*. Chichester: John Wiley and Sons.

Barnard, C. A. (1990). *The Long-Term Psychological Effects of Abortion*. Portsmouth, NH: Institute for Abortion Recovery and Research.

Bates, B. L. (1993). Individual differences in response to hypnosis. In Rhue, J. W., Lynn, S. J., and Kirsch, I. (Eds.), *Handbook of Clinical Hypnosis*, pp. 23-54. Washington: American Psychological Association.

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Beck, A. T. & Beck, R.W. (1972). Screening depressed patients in family practice – a rapid technique. *Post-graduate Medicine, 52,* 81-85.

Beck, A. T., Rush, A. J., Shaw, B. J., and Emery, G. D. (1979). *Cognitive Therapy of Depression: A Treatment Manual*. New York: Guilford Press.

Bennun, I., and Lucas, R. (1990). Using the partner in the psychosocial treatment of schizophrenia: A multiple single case design. *British Journal of Clinical Psychology, 29,* 185-192.

Black, J. (2004, April 20th) *My Foetus.* Channel Four.

Bonano, G. (2004). Loss, Trauma and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59,* 20-28.

Borckardt, J. & Nash, M. (2002). How practitioners (and others) can make scientifically viable contributions to clinical-outcome research using the single time-series design. *The International Journal of Clinical and Experimental Hypnosis, 50,* 114-148.

Bracken, M.B., Klerman, L., & Bracken, M. (1978). Coping with pregnancy resolution among never-married women. *Journal of Orthopsychiatry, 48,* 320-334.

Bradshaw, Z. & Slade, P. The effect of induced abortion on emotional experience and relationships: A Critical review of the literature *Clinical Psychology Review, 23,* 929-958.

Bremner, Southwick, Brett, Fontana, Roesenheck, Charney 1992;

Breslau, N. (1998). Gender differences in trauma and posttraumatic stress disorder. *Journal of Gender Specific Medicine, 5,* 34-40.

Breslau, N., Chilcoat, H.D., Kessler, R.C. & Davis, G.C. (1999a). Previous exposure to trauma and PTSD effects of subsequent trauma: results from the Detroit Area Survey of Trauma. *American Journal of Psychiatry, 56,* 902-7.

Breslau, N., Chilcoat, H.D., Kessler, R.C., Peterson, E.L. & Lucia, V.C. (1999b). Vulnerability to assaultive violence: further specification of the sex difference in post-traumatic stress disorder. *Psychological Medicine, 29,* 813-21.

Breslau, N., Davis, G.C. & Andreski, P. (1995). Risk factors for PTSD related traumatic events: A prospective analysis *American Journal of Psychiatry, 153,* 529-535.

Brewin, C. R., Dalgleish, T. & Joseph, S. (1996). A dual representation theory of post-traumatic stress disorder. *Psychological Review, 103,* 670-686.

Brien, J., and Fairbairn, I. (1996). *Pregnancy and Abortion Counselling,* London: Routledge.

Brom, D. Kleber, & Defares, P. (1989). Brief psychotherapy for posttraumatic stress disorders *Journal of Consulting and Clinical Psychology, 57,* 607-612.

Brown, D. (1985). Pseudomemories: The standard of science and the standard of care in trauma treatment. *American Journal of Clinical Hypnosis, 37,* 1-2.

Brown, R. (2002a) *An integrative cognitive theory of suggestion and hypnosis,* Unpublished PhD thesis, University College London.

Brown, R. & Oakley, D. (2004). An integrative cognitive theory. In M. Heap, R. Brown and D. Oakley (Eds.) *The Highly Hypnotisable Person* East Sussex: Brunner-Routledge, pp152-186.

Bryant, R.A., Guthrie, R.M., Moulds, M. L., Nixon, R. D. & & Felmingham, K. (2003). Hypnotizability and posttraumatic stress disorder: A prospective study. *The International Journal of Clinical and Experimental Hypnosis, 51,* 382-389.

Bryant, R. A. & Mallard, D. (2003). Seeing is believing: The reality of hypnotic hallucinations. *Consciousness and Cognition, 12,* 219-230.

Burns, D.D. (1989). *The Feeling Good Handbook.* New York: William Morrow and Co.

Campbell, S. (1989, February 3rd). Quoted by H. Franks, *The classroom nightmare.* The Times.

Carlson, E.B. & Rosser-Hogan, R. (1991). Trauma experiences, posttraumatic stress, dissociation, and depression in Cambodian refugees. *American Journal of Psychiatry, 148,* 1548-1551.

Cardena, E. (2000). Hypnosis in the treatment of trauma: A promising, but not fully supported, efficacious intervention. *International Journal of Clinical and Experimental Hypnosis, 48,* 221-234.

Casement, P. (1995). *On Learning from the Patient.* London: Routledge.

Cheng and Furnham (2003) Attributional style and self-esteem as predictors of psychological well being *Counselling Psychology Quarterly, 16,* 121-130.

Chu, J.A. & Dill, D. L. (1990). Dissociative symptoms in relation to childhood physical and sexual abuse. *American Journal of Psychiatry, 147,* 887-892.

Cohen and Roth (1984). Coping with abortion *Journal of Human Stress, 10,* 140-145.

Cohen, S. & Wills, T. (1985). Stress, social support and the buffering hypothesis. *Psychological Bulletin, 98,* 310-357.

Coleman, P. K., and Nelson, E. S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. *Journal of Social and Clinical Psychology, 17,* 425-442.

Condon, J.T. (1987). Altered cognitive function: a shift towards primary process thinking *British Journal of Medical Psychology, 60,* 329-34.

Cozzarelli, C., Major, B., Karrasch, A., & Fuegen, K. (2000). Women's experiences of and reactions to antiabortion picketing, *Basic and Applied Social Psychology, 22,* 265-276.

Crandall, C. S., and Moriarty, D. (1995). Physical illness stigma and social rejection. *British Journal of Social Psychology, 34,* 67-85.

Crawford, H. J. (1994). Brain dynamics and hypnosis: Attentional and disattentional processes. *International Journal of Clinical and Experimental Hypnosis, 42,* 204-32.

Damasio, A. (1999). *The Feeling of what Happens.* London: William Heinemann.

Dana, M. (1984) *Abortion and the emotions involved.* For B.S.S. Channel 4 and The Women's Therapy Centre, London, N7 6LA.

Day, E. (2004, April 11th) *Catholic leader supports televising of 'devastating' abortion.* The Sunday Telegraph.

David, H. B. (1985) Post-abortion and post-partum psychiatric hospitalisation. In *Abortion: Medical Progress and Social Implications, 115,* 150-161, CIBA Foundation Symposium.

Davidson, J. & Smith, R. (1990). Traumatic experiences in psychiatric outpatients *Journal of Traumatic Stress, 3,* 459-475.

Davis, M. H. (1994). *Empathy: A Social Psychological Approach.* Wisconsin: Brown and Benchmark.

De Groh (1989) Correlates of hypnotic susceptibility. In N. P. Spanos & J.F. Chaves (Eds.), *Hypnosis: The Cognitive-behavioural Perspective,* 32-63, Buffalo, NY: Prometheus Books.

Deacon, B.J. & Abramowitz, J.S. (2004). Cognitive and behavioural treatments for anxiety disorders: A review of meta-analytic findings. *Journal of Clinical Psychology, 60,* 429-441.

Degun-Mather, M. D. (1997). The use of hypnosis in the treatment of post-traumatic Stress disorder in a survivor of multiple childhood trauma. *Contemporary Hypnosis 14,* 100-104.

Derbyshire, S. (1995, Autumn). Do fetuses feel pain during abortion? *Abortion Research Notes,* 57.

Derbyshire, S.W.G, Whalley, M.G., Stenger, V.A., Oakley, D.A. (2004). Cerebral activation during hypnotically induced and imagined pain. *NeuroImage, 23,* 392-401.

Derogatis, L.R., Lipman, R. S. & Covi, L. (1973). SCL-90, an outpatient psychiatric rating scale-preliminary report. *Psychopharmacology Bulletin, 9,* 13-28.

Dolan, Y. (1991). *Resolving Sexual Abuse*. New York: Norton.

Dunbar, F. (1967). A psychosomatic approach to abortion and the abortion habit. In H. Rosen, (Ed.), *Abortion in America*, Boston: Beacon Press, pp. 22-31.

Elliott, R. (1984). A discovery-orientated approach to significant change events in psychotherapy: Interpersonal process recall and comprehensive process analysis. In Rice, L. N., and Greenberg, L. S. (Eds.), *Patterns of Change: Intensive Analysis of Psychotherapy Process*, 249-86. New York: Guilford Press, pp249-86.

Ellison, M. (1999, August 10th). *Abortion cuts crime says study* The Guardian.

Erikson, R. (1993). Abortion trauma: Application of a conflict mode. *Pre and Perinatal Psychology Journal, 8,* 33-42.

Evans, B.J. (2003). Hypnosis for posttraumatic stress disorders *Australian Journal of Clinical and Experimental Hypnosis, 31,* 54-73.

Ffrench, C. (2000). The meaning of trauma: Hypnosis and PTSD. *Australian Journal of Clinical and Experimental Hypnosis, 28,* 188-199.

Foa, E. B., and Kozak, J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20-35.

Foa, E. (1995). Posttraumatic Stress Diagnostic Scale. USA: *National Computer Systems, Inc.*

Foa, E. Dancu, C. Hembree, E., Jaycox, L. Meadows, E. & Street, G. (1999). A comparison of exposure therapy, stress inoculation training, and their combinbation for reducing posstraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology, 67,* 194-200.

Folkman, S., and Lazarus, R. S. (1988) *Manual for the Ways of Coping Questionnaire.* Palo Alto, California: Consulting Psychologists Press.

Frasquilho, F., and Oakley, D. A. (1997). Hypnotizability, dissociation and three factors of eating behaviour. *Contemporary Hypnosis, 14,* 105-111.

Friedman, M. (2000). PTSD diagnosis and treatment for mental health clinicians. In M. Scott & S. Palmer (Eds.) *Trauma and Post- traumatic Stress disorder.* London: Cassell.

Fromm, E. (1992) An ego-psychological theory of hypnosis. In Fromm, E. & Nash, M. (Eds.) *Contemporary Hypnosis Research* New York: The Guildford Press.

Gandhi, B. and Oakley, D. A. (2005). Does 'hypnosis' by any other name smell as sweet? The efficacy of 'hypnotic' induction depends on the label 'hypnosis' *Consciousness and Cognition.* (In press)

Greer, H. S., Lal, S., Lewis, S. C., Belsey, E. M., and Beard, R. W. (1976). Psychological consequences of therapeutic abortion: King's termination study 111. *British Journal of Psychiatry, 128,* 74-79.

Gruzelier, J. (1998), A working model of the neuropsychophysiology of hypnosis: A review of evidence. *Contemporary Hypnosis, 15,* 5-23.

Hadley, J. (1996). *Abortion: Between Freedom and Necessity*. London: Virago.

Halligan, S.L. & Yehuda, R. (2000). *The National Center for Post-traumatic Stress Disorder: PTSD research quarterly, 11.*

Heap, M. & Aravind, K. (2002) *Hartland's Medical and Dental Hypnosis*, Fourth Edition Edinburgh: Churchill Livingstone.

Heap, M., Brown, R. J. & Oakley, D. A. (2004). High hypnotisability: Key issues. In M. Heap, R. Brown and D. Oakley (Eds.) *The Highly Hypnotisable Person* East Sussex: Brunner-Routledge, pp3-29.

Herman, J. L. (1992). *Trauma and Recovery*. New York: Basic Books.

Hilgard, J. R. (1970). *Personality and Hypnosis: A Study of Imaginative Involvement*. Chicago: University of Chicago Press, pp45-79.

Hilgard, E.R. (1979). Divided consciousness in hypnosis: The implications of the hidden observer, In Fromm and R.E. Shor (Eds.) *Hypnosis Developments in Research and New Perspectives,* 2nd edition, 45-79, New York: Aldine.

Holen, A. (1993). *The North Sea oil rig disaster.* International handbook of traumatic stress syndromes New York: Plenum Press.

Holmes, E.A., Brown, R.J., Mansell, W., Fearon, R.P., Hunter, E.C.M., Frasquilho, F. & Oakley, D.A. (2005) Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clinical Psychology Review, 25*,1-23.

Horowitz, M. J., Wilner, N. & Alvarez, W.A. (1979). Impact of Events Scale: A measure of subjective stress *Psychosomatic Medicine, 41*, 209-218.

Horowitz, M. J. (1997). *Stress Response Syndromes: PTSD, grief, and adjustment disorders (3rd ed.)*. Northvale, New Jersey: Jason Aronsen.

Horowitz, M. J. (1986). *Stress Response Syndrome (2nd ed.)*. New York: Jason Aronsen.

Jacobson, N.S. & Truax, P. (1991) Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 12-19.

Janoff-Bulman, R. J. (1979). Characterological versus behavioural self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 37*, 1798-1809.

Johnson, M. P., and Puddifoot, J. E. (1998). Miscarriage: Is vividness of visual imagery a factor in the grief reaction of the partner? *British Journal of Health Psychology, 3*, 137-146.

Joy, S. (1985). Abortion: An issue to grieve? *Journal of Counselling and Development, 63,* 375-376.

Kahan, M., Tanzer,J., Darvin, D., and Bover, F., (2000) Virtual reality-assisted cognitive-behavioural treatment for fear of flying: Acute treatment and follow-up *CyberPsychology and Behaviour, 3,* 387-392.

Keane, T.M. & Wolfe, J. (1990). Comorbidity in post-traumatic stress disorder: An analysis of community and clinical studies. *Journal of Applied Social Psychology, 20,* 1776-1788.

Kessler, R.C., Foster, C.L., Saunders, W.B., & Stang, P.E. (1995). Social Consequences of Psychiatric Disorders, I: Educational Attainment. *American Journal of Psychiatry, 152,* 1026-1032.

Kidner, D. (1993). Experimentation in hypnosis: towards an adequate methodology. In Lewith, G. T., and Aldridge, D. (Eds.), *Clinical Research Methodology for Complementary Therapies*. London: Hodderson and Stoughton, pp 350-364.

Kirsch, I. (1985). Response expectancy as a determinant of experience and behaviour. *American Psychologist. 40,* 1189-1202.

Kirsch, I., Montgomery, G., and Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 63,* 214-220.

Kirsch, I, (1991). The social learning or hypnosis: What do our scales really measure? *International Journal of Clinical and Experimental Hypnosis, 45*, 212-225.

Kirsch, I. & Council, J. (1992) Situational and personality correlates of hypnotic responsiveness. In Fromm, E. & Nash, M. (Eds.) *Contemporary Hypnosis Research* New York: The Guildford Press

Kobasa, S. (1979). Stressful Life Events, Personality, Health: An Enquiry into Hardiness *Journal of Personality and Social Psychology, 37*,1-11.

Koopman, C., Classen, C. & Spiegel, D. (1994). Predictors of posttraumatic stress symptoms among survivors of the Oakland / Berkeley, California, firestorm. *American Journal of Psychiatry, 151,* 888-894.

Kosslyn, S.M., Thompson, W.L., Costanti-Ferrando, M.F., Alpert, N.M. & Spiegel, D. (2000). Hypnotic visual illusion alters color processing in the brain, *American Journal of Psychiatry, 157*, 1279-84.

Kubany, E. S., Abueg, F. R., Brennan, J. M., Haynes, S. N., Manke, F. P., and Stahura, C. (1996). Development and validation of the trauma-related guilt inventory (TRGI). *Psychological Assessment, 8,* 428-444.

Lacey, H. (1997, 3rd August). *Does abortion really ruin your life?* Independent on Sunday.

Lane, J.D. & Wegner, D.M. (1995). The cognitive consequences of secrecy. *Journal of Personality and Social Psychology, 69*, 237-253.

Lask, B. (1975). Short-term psychiatric sequelae to therapeutic termination of pregnancy. *British Journal of Psychiatry, 126,* 173-177.

Lazarus, R., and Folkman, S. (1984). *Stress, Appraisal, and Coping.* New York: Springer Publishing.

Lee, E., and Gilchrist, A. (1997). Abortion psychological sequelae: The debate and the research. In Lee, H., and Lattimer, M. (Ed.), *Issues in Pregnancy Counselling: What Do Women Need and Want?* Pro-Choice Forum, pp 37-46.

Legg, C. (1998). *Psychology and the Reflective Counsellor*. Reading: BPS Books.

Lemkau, J. P. (1988). Emotional sequelae of abortion: Implications for clinical practice. *Psychology of Women Quarterly, 12,* 461-472.

Levenson, H. (1981). Differentiating among internality, powerful others and chance. In Lefcourt, H. M. (Ed.), *Research with the Locus of Control Construct, 1*, New York: Academic Press, pp15-63.

Llewellyn, S. P., and Pytches, R. (1988). An investigation of anxiety following termination of pregnancy. *Journal of Advanced Nursing, 13*, 468-471.

Lydon, J., Dunkel - Schetter, C., Cohan, C.L. and Pierce, T. (1996). Pregnancy decision making as a significant life event: a commitment approach. *Journal of Personality and Social Psychology, 71,* 141-151.

Lynn, S. J. Meyer, E. & Shindler, K. (2004) Clinical correlates of high hypnotisablity In M. Heap, R.J. Brown and D. A.Oakley (Eds.) *The highly hypnotisable person* East Sussex: Brunner-

Lynn, S.J., Kirsch, I., Barabasz,A., Cardena, E. & Patterson, D. (2000). Hypnosis as an empirically supported intervention: The state of the evidence and a look to the future. *The International Journal of Clinical and Experimental Hypnosis, 48,* 239-259.

Major, B., and Cozzarelli, C. (1992). Psychosocial predictors of adjustment to abortion. *Journal of Social Issues, American Journal of Psychiatry, 48,* 121-142.

Major, B., Cozzarelli, C., Sciacchitano A., Cooper, M., Testa, T., and Mueller, M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 59,* 452-463.

Major, B., Mueller, P. & Hildebrandt, K. (1985). Attributions, expectations, and coping with abortion. *Journal of Personality and Social Psychology, 48,* 585-599.

Major, B. & Mueller, P. (1989).Self-blame, self-efficacy and adjustment to abortion. *Journal of Personality and Social Psychology, 57,* 1059-1068.

Major, B. & Gramzow, R.H. (1999). Abortion as stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology, 77,* 735-745.

Major, B., Cozzarelli, C., Cooper, M.L., Zubeck, J., Richards, C., Wilhite, M. and Gramzow, R. (2000). Psychological responses of women after first-trimester abortion, *Archives of General Psychiatry, 57,* 777-786.

Marks, D. F. (1973). Visual imagery differences in the recall of pictures. *British Journal of Psychology, 64,* 17-24.

Marmar, C. (1997). Trauma and dissociation *The National Center for Post-traumatic Stress Disorder: PTSD research quarterly 8.*

Mawson, D., Marks, I.M., Ramm, L. & Strern, R.S. (1981). Guided mourning for morbid grief: A controlled study. *British Journal of Psychiatry, 138,* 185-193.

Mcleod, J. (1994). *Doing Counselling Research.* London: Sage Publications.

McConkey, K., Sheehan, P., Law, H. & White, D. (1977). Structural analysis of the Creative Imagination Scale. St Lucia, Queensland, Australia: Department of Psychology, University of Queensland.

Meuller, P., & Major, B., (1989) Self Blame, Self- Efficacy, and Adjustment to Abortion *Journal of Personality and Social Psychology, 57,* 1059-1068.

Montgomery, G.H., Duhamel, K.N. & Redd, W.H. (2000). A meta-analysis of hypnotically induced analgesia: How effective is hypnosis? *International Journal of Clinical and Experimental Hypnosis. 48*,138-152.

Morgan, A. H. and Hilgard, J.R. (1975) Stanford Hypnotic Clinical Scale (SHCS). In E. R. Hilgard and J. R. Hilgard, *Hypnosis in the relief of pain* (209-221). Los Altos, CA: William Kaufman.

Mulhall, D. J. (1976). Systematic self-assessment by P.Q.R.S.T. (Personal Questionnaire Rapid Scaling Technique). *Psychological Medicine, 6,* 591-597.

Muse, M. (1986). Stress-related, posttraumatic chronic pain syndrome: Behavioural treatment treatment approach. *Pain, 25,* 389-394.

Neustatter, A. (1986). *Mixed Feelings: the experience of abortion* London: Pluto Press.

Oakley, D. A., and Frasquilho, F. (1998). Hypnotic susceptibility, or F-bias: Its relevance to eating disorders. *Contemporary Hypnosis, 15,* 40-51.

Oakley, D. A. (1999). Hypnosis and conversion hysteria: A unifying model. *Cognitive Neuropsychiatry, 4,* 243-265.

Oakley, D.A., Alden, P. and Degun Mather, M. (1996) The use of hypnosis in therapy with adults *The Psychologist, 9 (11),* 502-505.

Osofsky, J. D., & Osofsky, H. J. (1972). The psychological reaction of patients to legalised abortion. *American Journal of Orthopsychiatry, 42,* 48-60.

Paintin, D. (1997). *Twenty Questions About Abortion*, London: Birth Control Trust.

Pare, C. M. B., and Raven, H. (1970). Follow up of patients referred for the termination of pregnancy. *The Lancet, 28*, 635-638.

Palmer, S. and Dryden, W. (1995) *Counselling for Stress Problems*, London: Sage.

Parry, G., Shapiro, D. A., and Firth, J. (1986). The case of the anxious executive: A study from the research clinic. *British Journal of Medical Psychology*, *59*, 221-233.

Payne, E. C., Kravitz, A. R., Notman, M. T., and Anderson, J. V. (1976). Outcome following therapeutic abortion. *Archives of General Psychiatry*, *33,* 725-732.

Pennebaker, J. W. (1993). Social mechanisms of constraint. In D.M. Wegner & J.W. Pennebaker (Eds.), *Handbook of Mental Control,* Englewood Cliffs, NJ: Prentice Hall, pp 200-219.

Potvin, L., Lasker, J., and Toedter, L. (1989) Measuring grief: A short version of the perinatel grief scale. *Journal of Psychotherapy and Behavioral Assessment*, *11,* 29-45.

Prigerson, H.G., Shear, M.K., Jacobs, S.C., Reynolds, C.F., Maciejewski, P.K., Davidson, J.R., Rosen-Heck, R., Pilkonis, P.A., Wortman, C.B., Williams, J.B., Widiger, T. A., Frank, E., Kupfer, D. & Zisook, S. (1999). Consensus for traumatic grief: A preliminary empirical test. *The British Journal of Psychiatry*, *174*, 67-73.

Rando, T. (1991, June) Complicated bereavement. Paper presented at the Eastern Regional Conference on Abuse and Multiple Personality Disorder. Dominion Hospital.

Reardon, D. (1987). *Aborted Women: Silent No More.* Chicago: Loyola University Press.

Revill, J. (2000, June 14th). *Horror stories of women at Marie Stopes abortion clinics,* The Evening Standard.

Rhue, J. and Lynn, S. (1989). Fantasy-proneness, hypnotisability and absorption: A re-examination. *International Journal of Clinical and Experimental Hypnosis. 37,* 100-137.

Robinson, J., Shaver, P. & Wrightsman, L. (1991). *Measures of personality and social psychological attitudes.* San Diego: Academic Press.

Robson, C. (1995) *Real World Research: A Resource for Social Scientists and Practitioner- Researchers* Oxford: Blackwell.

Rosenberg, M. (1989) *Society and the Adolescent Self-Image*. Revised Edition. Middletown, CT Wesleyan University Press.

Roth, A. and Fonargy, P. (1996). *What Works for Whom? A Critical Review of Psychotherapy Research.* London: The Guildford Press.

Rothbaum, O.S., Hodges, L., Smith, S., Lee, J.H. & Price, L. (2000). A controlled study of virtual reality exposure therapy for the fear of flying. *Journal of Consulting and Clinical Psychology, 68,* 1020-1026.

Rothbaum, B., Foa, E., Riggs, D., Murdock. T. & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5,* 455-475.

Rothschild,B. (2005). Applying the breaks. *Counselling and Psycotherapy Journal. 16,* 12-16.

Royal College of Obstetricians and Gynaecologists (2004). *The Care of Women Requesting Abortion: National Evidence - Based Guidelines.* London: RCOG Publications.

Rummelhart, D., McClelland, J. and the PDP Research Group (1986). *Parallel Distributed Processing. Explorations in the Microstructure of Cognition. Volume 1: Foundations,* Cambridge, MA: MIT Press.

Russo, N. (1997). Does abortion really ruin your life? *Independent on Sunday,* 3 August 1997.

Russo, N. F., Horn, J. D., and Schwartz, R. (1992). US abortion in context: Selected characteristics and motivations of women seeking abortions. *Journal of Social Issues, 48,* 183-202.

Russo, N. & Dabul, A. (1997). The relationship of abortion to well-being: Do race and religion make a difference? *Professional Psychology Research and Practice, 23,* 269-280.

Salvoskis, P. (1988). Phenomenology, assessment and the cognitive model of panic. In S.J. Rachman & J.Maser (Eds.), *Panic: Psychological perspectives.* Hillsdale, NJ: Erlaum.

Scott, M. (2000). *Assessment and conceptualisation.* In M. Scott & S. Palmer (2000) Trauma and Post- traumatic Stress disorder. London: Cassell.

Scurfield, R. M. (1993). Treatment of posttraumatic stress disorder among Vietnam veterans. In J. P. Wilson & B. Raphael, (Eds.). *International handbook of traumatic stress syndromes,* New York: Plenum Press, pp 879-888.

Shapiro, F. (1995) *Eye Movement Desensitisation and Reprocessing: Basic Principles, Protocols, and Procedures.* New York: Guidford Press.

Shusterman, L.R. (1979). Predicting the psychological consequences of abortion *Social Science and Medicine, 13A,* 683-689.

Shear, M.K., Smith-Caroff, K. (2002) Traumatic loss and the syndrome of complicated grief . *The National Center for Post Traumatic Stress Disorder: PTSD Research Quarterly, 13.*

Shor, R. & Orne, E. (1962). *Harvard Group Scale of Hypnotic Susceptibility, Form A* Palo Alto, CA: Consulting Psychologists Press.

Silverstone, P.H. & Salsi, M. (2003) Low self-esteem and psychiatric patients: Part I – The relationship between low self-esteem and psychiatric diagnosis. *Annals of General Psychiatry, 2.* 1186-1475.

Simon, N. & Senturia A. (1966). Psychiatric sequelae of abortion: Review of the literature, 1935-1964, *Archives of General Psychiatry, 15,* 378-389.

Singer, T., Seymour, B., O'Doherty, J., Kaube, H., Dolan, R. & Frith, C. D. (2004). Empathy for pain involves the affective but not sensory components of pain. *Science, 303,* 1157-1162.

Solomon, S. D., Gerrity, E. T., and Muff, A. M. (1992). Efficacy of treatments for post-traumatic stress disorder: An empirical review. *Journal of the American Medical Association, 268,* 633-638.

Spanos, N. P. (1986). Hypnosis and the modification of hypnotic susceptibility: A social psychological perspective. In Naish P. L. N. (Ed.), *What is hypnosis? Current Theories and Research.* Philadelphia: Open University Press. pp 85-120

Spanos, N. P., Gabora, N. J., Jarrett, L. E., and Gwynn, M. I. (1989). Contextual determinants of hypnotizability and of relationships between hypnotizability scales. *Journal of Personality and Social Psychology, 57,* 271-278.

Spekard, A. C. (1987) *Psychosocial Stress Following Abortion.* Kansas City. MO: Sheed and Ward.

Speckard, A. C., & Rue, V. M. (1992). Postabortion syndrome: An emerging public health concern. *Journal of Social Issues, 48,* 95-119.

Spiegel, D. & Cardena, E. (1991). Disintegrated experience: The dissociated disorders revisited. *Journal of Abnormal Psychology, 100,* 366-378.

Spiegel, D., Hunt, T. & Dondershire, H. E. (1988). Dissociation and hypnotisability in posttraumatic stress disorder. *American Journal of Psychiatry, 145,* 301-305.

Spiegel, D. (1997). Hypnosis in the treatment of post traumatic disorders. In Rhue, J., Lynn, S., and Kirsch, I. (Eds.), *Handbook of Clinical Hypnosis.* Washington, DC: American Psychological Association, pp 493-509.

Stice, E. (1994). Review of the evidence for a sociocultural model of bulimia nervosa and an exploration of the mechanism of action. *Clinical Psychology Review, 14,* 633-661.

Stutman, R.K. & Bliss, E. L. (1985). Posttraumatic stress disorder, hypnotisability, and imagery. *American Journal of Psychiatry, 142,* 741-743.

Szechtman, H., Woody, E., Bowers, K. S., and Namias, C. (1998). Where the imaginal appears real: A positron emission topography study of auditory hallucinations. *Proceedings of the National Academy of Science, 95,* 1956-1960.

Tiba, J. (1990). Clinical, research and organizational aspects of preparation for childbirth and the psychological diminution of pain during labour and delivery. *British Journal of Experimental and Clinical Hypnosis, 7,* 61-64.

Toedter, L., Lasker, J. & Alhadeff, J. (1988) The Perinatal Grief Scale: Development and initial validation. *American Journal of Orthopsychiatry 58,* 435-449.

Turner, L. (2004, May 4th) *Who has more rights, the mother or the foetus? As the issue of abortion once again raises its head in the media, Lyndsey Turner says it is an important lesson on human rights.* Education Guardian

van der Hart, O. (1988). An imaginary leave-taking ritual in mourning therapy. *The International Journal of Clinical and Experimental Hypnosis, 2,* 63-68.

van der Hart, O., Steele, K., Boon, S., & Brown, P. (1993). The treatment of traumatic memories: Synthesis, realization, and integration. *Dissociation, 6,* 162-80.

van der Kolk, B. and McFarlane, A. (1996), The Black Hole of Trauma. In Van der Kolk, B., McFarlane A. and Weisaeth, L. (Eds.) *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society.* New York: The Guildford Press, pp 3-24.

Van der Kolk, B., McFarlane, A and van der Hart, O. (1996). A general approach to treatment of posttraumatic stress disorder. In B. Van der Kolk, B., A. McFarlane and L. Weisaeth, (Eds.), *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body and Society.* New York: The Guildford Press, pp 417-441.

Wadsworth, R. (1996). Hypnotic intervention in unresolved grief. *Australian Journal of Clinical and Experimental Hypnosis, 18,* 45-56.

Wagstaff, G. F. (1991). Compliance, belief and semantics in hypnosis: A non-state, sociocognitive perspective. In S.J. Lynne and J.W. Rhue (Eds.) *Theories of Hypnosis: Current Models and Perspectives*, New York: Guilford Press, pp 362-396.

Walters, V.J. & Oakley, D.A. (2000). Hypnosis in post-abortion distress: An experimental case study *Contemporary Hypnosis, 19,* 85-99.

Walters, V. J., & Oakley, D. A., (2003) Hypnosis as a possible virtual reality context for the treatment of an environmental phobia. *Clinical Case Studies, 2*, 295-305.

Watkins, J. G., and Watkins H. H. (1997). *Ego States: Theory and Therapy*. New York: Norton.

Whalley, M. and Oakley, D. (2003) Psychogenic pain: A study using multidimensional scaling. *Contemporary Hypnosis, 20*, 16-24.

Wickramasekera, I. (1984) *A model of people at risk to develop chronic stress-related symptoms.* In F.J. McGuigan, W.Smye, & J. M. Wallaced (eds.), *Stress and Tension Control*, New York: Plenum Press.

Wickramasekera, I. (1991) The unconscious, somatization, psychophysiological psychotherapy and threat perception: Footnotes to a cartography of the unconscious mind. *Biofeedback, 19*, 18-23.

Wickramasekera, I. & Szlyk, J.P. (2003). Could empathy be a predictor of hypnotic ability? *The International Journal of Clinical and Experimental Hypnosis, 51,* 390-399.

Wiederhold, B. K., & Wiederhold, M. D., (2000). Lessons learned from 600 virtual reality sessions *CyberPsychology and Behaviour, 3,* 393-400.

Wilmoth, G. H. (1992). Abortion, public health policy, and informed consent legislation. *Journal of Social Issues, 48,* 1-17.

Wilmoth, G. H., de Alteris, M., and Bussell, D. (1992). Prevalence of psychological risks following legal abortion in the us: Limits of the evidence. *Journal of Social Issues, 48,* 37-66.

Wilson, S. C. (1976) *An experimental investigation evaluating a Creative Imagination Scale and its relationship to "hypnotic-like" experiences.* Doctoral dissertation. Heed University, Hollywood, Florida.

Woody and Bowers, (1994). A frontal assault on dissociated control In S.J. Lynn and J.W. Rhue (Eds.) *Dissociation: Clinical and Theoretical Perspectives*, New York: Guildford Press, pp 55-9.

Yapko, M. D. (1995) *Essentials of Hypnosis.* New York: Brunner/Mazel.

Yehuda, R., Resnick, H., Kahana, B., & Giller, E. L. (1993a). Long-lasting hormonal alterations to extreme stress in humans: Normative or maladaptive? *Psychosomatic Medicine, 55,* 287-297.

Young, J.E., Klosko, J.S., & Weishaar, M. (2003). *Schema Therapy: A Practitioner's Guide*. Guilford Publications: New York.

Zigmund and Snaith (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica, 67,* 361-70.

Zolese, G., and Blacker, C. (1992). The psychological complications of therapeutic abortion. *British Journal of Psychiatry, 160,* 742-749.

SECTION C: CLIENT WORK.

C.1: HYPNOSIS IN POST-ABORTION DISTRESS: AN EXPERIMENTAL CLIENT STUDY

C.2: DOES HYPNOSIS MAKE *IN VITRO, IN VIVO*? HYPNOSIS AS A POSSIBLE 'VIRTUAL REALITY' CONTEXT IN COGNITIVE BEHAVIOURAL THERAPY FOR AN ENVIRONMENTAL PHOBIA.

HYPNOSIS IN POST-ABORTION DISTRESS: AN EXPERIMENTAL CASE STUDY

(See Appendix XIX for published copy)

1. ABSTRACT

This client 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 PTSD. Symptom changes were monitored throughout the course of therapy in a multiple-baseline design. The client 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 the client's 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.

2. INTRODUCTION

There is some evidence that severe distress following termination of pregnancy can lead to Post-Traumatic Stress Disorder (PTSD: see Spekhard & Rue, 1992) and there is general agreement amongst 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 unrecognised by

health professionals. If problems are not accurately diagnosed this is likely to prevent women from receiving appropriate psychological treatment.

From my own experience of working with clients suffering from post-abortion distress three particular themes can be identified across symptoms that indicate that hypnosis may be a useful adjunct to therapy for this problem. Firstly, clients in this group display a tendency to dissociation/depersonalisation, for example 'switching off' when being around babies and young children. Secondly, they commonly show high levels of absorption in fantasising 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. Thirdly, they appear to be disposed towards increased suggestibility - 'a heightened responsiveness to social cues' (Spiegel, 1997) - these clients respond with intense emotions, particularly 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 (i.e. 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" (NSH). NSH may be evident in the distorted and self-damning cognitions that result in the negative affects such as guilt, shame and regret. Araoz (1981) believes that the post-hypnotic suggestion element of NSH leads to powerful negative self-statements that are resistant to change.

The therapeutic framework investigated in this paper 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 therapeutic techniques for resolving sexual abuse (Dolan, 1991). Whilst there are numerous clinical reports citing the efficacy of using 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. This paper begins to address this need.

3. THE THERAPEUTIC FRAMEWORK

The therapeutic framework comprised of three phases, as proposed by Brown (1995) to treat PTSD. The first phase concentrates on building resources (Brende & Benedict, 1980). The second phase confronts unresolved issues in order to facilitate emotional processing (Foa and Kozak, 1986) and the third phase focuses on personal growth and the future (Dolan, 1991).(See Appendix 1 for a more detailed account of the three phases of treatment as they apply to the present client study.)

4. DESIGN

A multiple baseline design was used. Psychometric tests were used pre- and post - therapy in order to measure overall change. Specific target symptoms were identified and were measured weekly. Anxiety, anger-hostility, somatisation 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 3 times post-therapy at one week, three months and twelve months.

5. MATERIALS

A Pre-Therapy Questionnaire (PTQ) was designed for this study, based on clinical experience, and informed by the literature on abortion (Meuller and Major, 1989; Major et al, 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 (Jonhnson & Puddifoot, 1998; Marks, 1973) were administered pre-therapy to evaluate imaginative suggestibility (Braffman & Kirsch, 1999) and strength of visual imagery.

The following measures were administered pre and post-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); and the Self Esteem Scale (Rosenberg, 1965). The wording on three additional measures, also administered pre and post-therapy, was adapted to make them appropriate for the experience of a termination. These were the Posttraumatic Stress Diagnostic Scale (PDS: Foa, 1995); the Perinatal Grief Scale (PGS: Potvin, 1988) and the Trauma Related Guilt Inventory (TRGI: Kubany, 1996).

Prior to 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 (1989) suggests provide a "holistic understanding of the person" (Lazarus1989,

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) e.g. "[I] don't read articles or like to see pictures of babies."

Affect (7) e.g. "[I feel] fearful about the future.:

Sensation (7) e.g. "[I have] chest pains."

Imagery (4) e.g. "[I have] images of [the] surgical procedure."

Cognition (7) e.g. [I find myself] wanting to 'disappear' to 'start again' somewhere."

Interpersonal relationships (7) e.g. [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 0-10 'to show where you are at present' in order to monitor change. Sophie rated how comfortable she felt about her decision to have the termination at weekly intervals on a scale between 1-7. The Hopkin's Symptom Checklist (HSCL), with sub-scales measuring 'anger / hostility', 'anxiety', 'depression' and 'somatisation' was also completed weekly. For three nights of each week (Tuesday, Thursday and Saturday) Sophie 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 et al, 1986) was completed. The Usefulness of Hypnosis (UOH) form (Walters, 1999 - see appendix 2) 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.

6. BACKGROUND TO THE STUDY

Sophie 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 6 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 following the termination, but instead, she experienced 'unreal feelings and severe distress'. Additionally, Sophie had developed strong maternal feelings towards the aborted foetus 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 / radio programmes about abortion. These symptoms affected all areas of her life. Sophie 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 socialise 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.

7. RESULTS FROM THE PRE-THERAPY QUESTIONNAIRE (PTQ) AND OTHER MEASURES

Sophie'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:

Fantasising / imagery:

Recurrent thoughts of what the baby would have looked like

Imagining baby continuing to grow

Thinking of the loss in terms of a baby rather than a foetus

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

Suggestibilty

Heightened sensitivity to suggestion (both from others and the environment) e.g. 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

Sophie 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 PDS (Foa, 1995) showed that Sophie'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/cut-off from people around her, and was emotionally numb. On the TRGI she scored above the norm on 5 of the 6 trauma related guilt factors identified by Kubany (1996) and well above the norm associated with responses to foetal death on the PGS (Potvin, 1988) – see Table 1 for both of these sets of scores. Most frequent coping styles scored on the Ways of Coping Questionnaire (Folkman & Lazarus, 1988 – see Table 1) were 'escape-avoidance' (reflecting her ability to fantasise and dissociate), 'accepting responsibility' (indicative of her efforts to intellectually accept the abortion decision) and 'confrontive coping' (illustrative of the tension with her partner following the termination). Her levels of both depression and anxiety on the HADS were in the clinically significant range (See Table 1). Sophie scored 19 on the Rosenberg Self-Esteem Scale which has a range from 10-40. The nightmare checklist showed that Sophie 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 (See Figure 1).

8. THE THERAPY

There were a total of 13 sessions spanning 17 weeks, seven of these sessions included hypnotic interventions (See Appendix 1 and Figure 1).

During the first phase of treatment Sophie 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 & Watkins, 1997). In session 7 she focused on anger she felt towards her partner and this was followed, in session 8, by exploring her identification with the foetus and the grief she felt. A hypnotic mourning ritual (session 9), in which she 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, Sophie reported experiencing particularly disturbing and vivid nightmares (for example, a 'replay of the abortion', 'being forced to look in a coffin', 'being in a plastic bag trying to breathe'). She attributed these to the impending anniversary in one month's time of what would have been the date of the birth. One particular nightmare, which she felt captured the essence of their frightening nature, was 're-scripted' (Rusch, Grunert, Mendelsohn & Smucker, 2000) in hypnosis (session 12, week 15). This involved Sophie 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 she left the bad feelings she had been experiencing in a room symbolising the past and then moved on to the future which was symbolised as another room full of good feelings now that she had psychologically resolved her termination.

9. RESULTS OF MEASURES TAKEN THROUGHOUT THERAPY AND POST-THERAPY

Sophie's SCL-90 scores indicated that phase one of therapy had achieved a progressive reduction of anxiety, depression, anger / hostility and somatisation. As soon as the second phase commenced (session 4, week 5), an increase was noted in all her SCL-90 scores though these were remained lower than her base-line scores (see Figure 1).

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 3 weeks on which measures were taken post-therapy (see Figure 1).

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

By the end of therapy Sophie's average target symptom rating was 1.1 and at the end of 3 weeks of post treatment monitoring the mean score was 0.4. In contrast to the SCL-90 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 (see Figure 2).

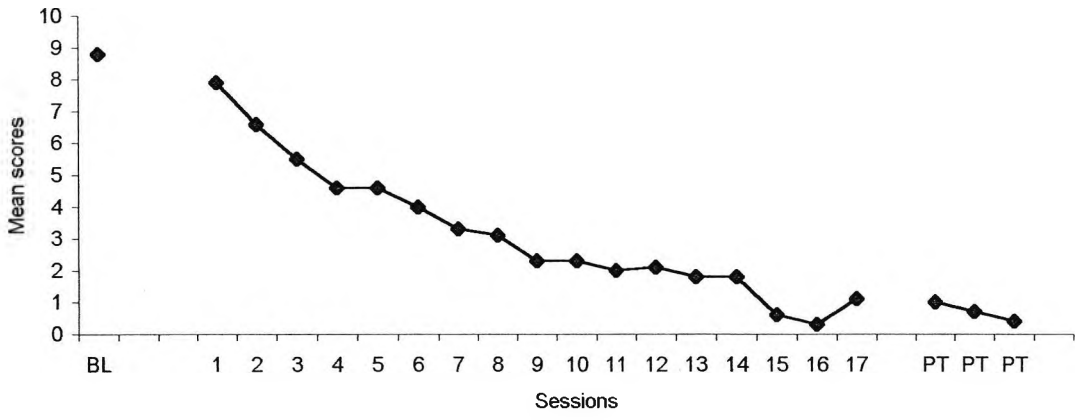


Figure 2. Mean scores of target symptoms

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

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

Table 1. Pre- and post-therapy scores.

	Pre-therapy	**Post-therapy**	**Follow-up 1 (3 months)**	**Follow-up (2 months)**
PSD Scale	Severe	criteria not met	criteria not met	criteria not met
HAD: anxiety	16	7	6	5
HAD: depression	12	2	1	1
Internality	14	29	31	38
Powerful Others	39	15	13	11
PGS: active grief	49	22	15	12
PGS: difficulty in coping	49	22	15	11
PGS: despair	47	15	16	11
Self-esteem	19	30	32	36
Ways of Coping*:	CC	SS	SS	-
(most used coping	AR	SC	D	
styles)	EA	PR	PR	
TRGI: Global Guilt	3	1	.75	0
TRGI: Guilt Cognitions	2.8	.86	.42	.8
TRGI: Distress	3.5	.88	.83	.5
TRGI: Hindsight Bias	3	.87	.57	.85
TRGI: Wrongdoing	2	.67	.2	.2
Lack of Justification	2	1.5	.6	1

**D=Distancing* *SC=Self-Control* *SSS=Seeking Social Support*
EA=Escape–Avoidance *PPS=Planful Problem Solving* *PR=Positive Reappraisal*
AR=Accepting Responsibility *CC=Confrontive Coping*

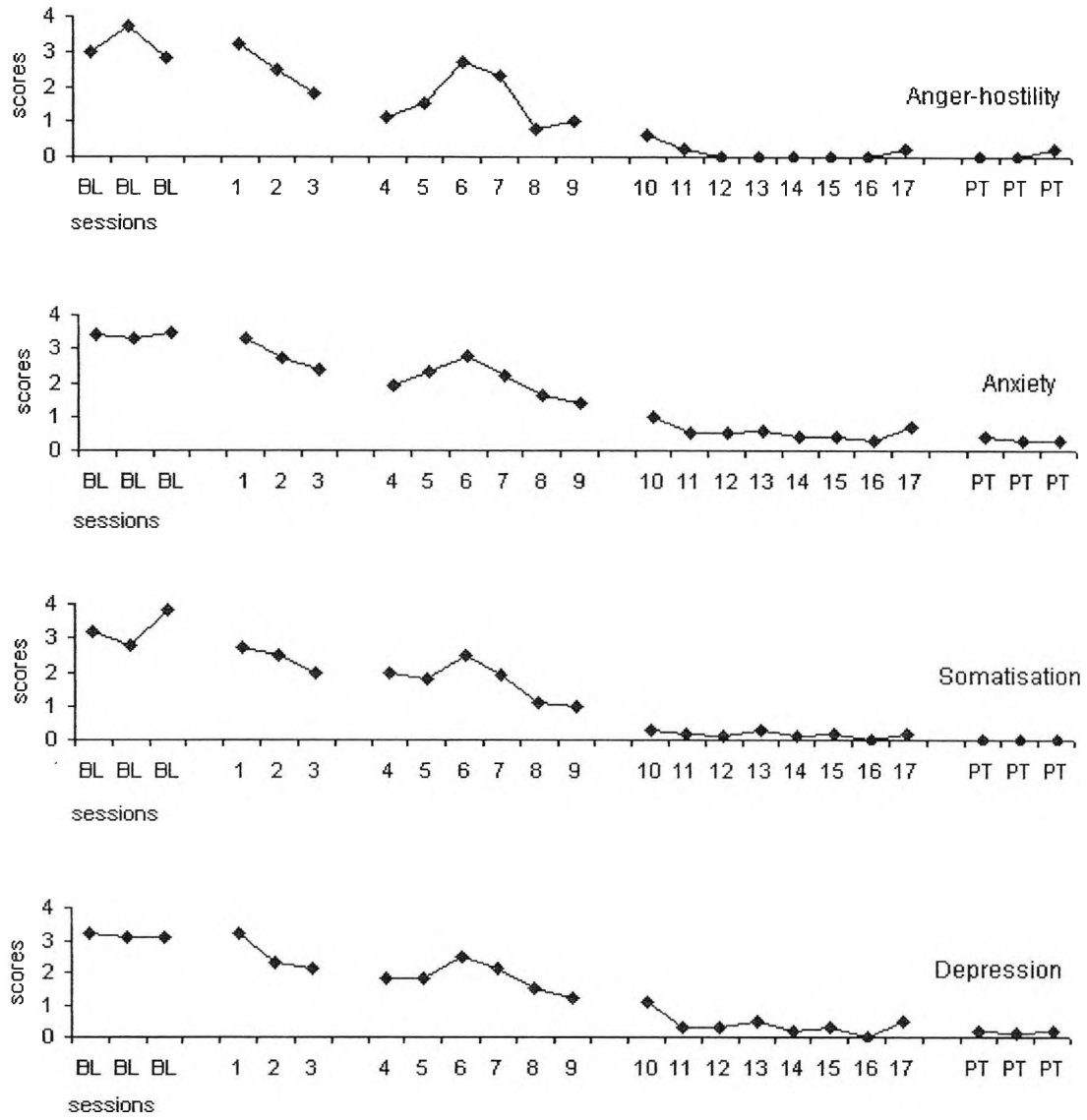


Figure 1. SCL-90 scores

Figure 1 illustrates Sophie's anger-hostility, anxiety, somatisation, and depression scores on the SCL-90 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. Sessions 1, 3, 5, 6, 9, 12 and 13 included an hypnotic intervention. The SCL-90 scores recorded Sophie's feelings in the week(s) before 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.

10. DISCUSSION

Post treatment scores suggest that the therapeutic package investigated in this study was accompanied by Sophie'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 2).

Sophie's anger-hostility scores (see fig 1.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 practice to restore calm to myself and my body'. This success may have increased Sophie's expectations that hypnosis would work for her. Sophie 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 fig. 1.b.) during this phase.

A particularly marked lowering of the HSCL depression scores (figure 1.b) followed the disclosure of the PTSD diagnosis (session 2), reflecting Sophie's MHAT comment that the diagnosis had 'given me hope about my feelings' and that 'knowing there is a recognised 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 recognise PTSD symptoms in clients presenting with severe post abortion distress, not only in order to treat the problem appropriately, but because informing the client of the diagnosis may, in itself, be an effective intervention.

The beginning of phase two of therapy was marked by a peak in all SCL-90 scores (figure 1 a-d) following the uncovering age regression (session 5) in which painful emotions surfaced about being bullied as a child (see UOH comments, appendix 2). Sophie 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 Sophie's increased 'internality' and decreased 'powerful other' scores by the end of therapy (see Table 1). Sophie 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.

Sophie's target symptom scores showed a steady decrease during the course of therapy. It is interesting that these scores, in contrast to the SCL-90 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 SCL-90. For instance Sophie'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.

Sophie commented on the UOH form (Appendix 2) that an age regression back to the experience of the termination (session 6) 'felt very vivid and real' and helped her to

realise 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, 2003). This intervention marked the beginning of a steady decrease of all her SCL-90 scores which can be seen in phase two (fig 1 a-d), suggesting that Sophie 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 she had completed resolution (see comments on UOH, appendix 2). Sophie's ability as a 'vivid imager' alongside her fantasy proneness may have contributed towards the success of this intervention. The fantasy Sophie had of her baby at the 'age it would have been' was utilised in the mourning ritual in which she was encouraged 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 pre and post-therapy (Table 1) reflects results of the meta-analysis carried out by Kirsch et al (1995). In this study it was shown that hypnosis as an adjunct to CBT 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 CBT 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 Sophie's SCL-90 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 Sophie had become desensitised 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 Sophie to very vividly experience resolution of her grief and she commented in session 10 that she had felt less guilty and self-punishing since session 9. On the UOH form Sophie had commented that this intervention had given her the opportunity to 'say goodbye'. Arguably hypnosis had provided this opportunity, since the nature of abortion (i.e. the foetus is left in the clinic), had made saying 'goodbye' difficult to do. The vividness of the hypnotic experience might also explain why Sophie had felt the mourning ritual to be particularly profound.

By the end of therapy Sophie 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 (i.e. feeling 'completely comfortable'), did not indicate that she felt some residual guilt, but was an acknowledgement of how special her foetus

was to her. Her comment was also borne out by her reduced scores on the 6 TGRI subscales at the end of therapy (see Table 1).

Sophie'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'. Likewise 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, Sophie's

own comments on the progress of therapy are consistent with there being a direct relationship between particular interventions and subsequent changes.

The questionnaire used at the outset the study to identify Sophie's cognitions, behaviours and beliefs relating to the pregnancy termination, were sensitive (e.g. ' do you have any thoughts where the foetus is now?') yet Sophie 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 my 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 foetus might be now.

The MHAT forms, completed after each therapy session, illustrated the process of Sophie's recovery. These comments, taken together 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 recognised 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 foetus 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 conceptualised the abortion as having facilitated personal growth. She was now enjoying life and looking forward to the future with

optimism. Sophie reported that she felt that the hypnotic interventions had played a vital part in her recovery.

11. 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.

REFERENCES:

Araoz, D. L. (1981). Negative self-hypnosis. *Journal of Contemporary Psychotherapy 12,* 45-52.

Ashton, J. R. (1980). The psychological outcome of induced abortion. *British Journal of Obstetrics and Gynaecology, 82,* 1115-1122.

Barber, T. X., and Wilson, S. C. (1978). The Barber Suggestibility Scale and the Creative Imagination Scale: Experimental and clinical applications. *American Journal of Clinical Hypnosis, 21,* 84-108.

Braffman, W., & Kirsch, I. (1999). Imaginative suggestibility and hypnotisability; an empirical analysis *Journal of Personality and Social Psychology, 77,* 578-587.

Brende, J.O. & Benedict, B.D. (1980). The Vietnam Combat Delayed Stress Syndrome: Hypnotherapy of 'dissociative symptoms'. *American Journal of Clinical Hypnosis, 23,* 34-40.

Brien, J., and Fairbairn, I. (1996). *Pregnancy and Abortion Counselling*, London: Routledge.

Brown, D. (1995). Pseudomemories: The standard of science and the standard of care in trauma treatment. *American Journal of Clinical Hypnosis, 37,* 1-2.

Cardena, E. (2000). Hypnosis in the treatment of trauma: A promising, but not fully supported, efficacious intervention. *The International Journal of Clinical and Experimental Hypnosis, 48,* 225-238.

Derogatis, L.R., Lipman, R. S. & Covi, L. (1973). SCL-90, an outpatient psychiatric rating scale-preliminary report. *Psychopharmacology Bulletin, 9,* 13-28.

Dolan, Y. (1991). *Resolving Sexual Abuse*. New York: Norton.

Foa, E. B., and Kozak, J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 1,* 20-35.

Foa, E. (1995). Post Traumatic Stress Diagnostic Scale. USA: *National Computer Systems, Inc.*

Folkman, S., and Lazarus, R. S. (1988). *Manual for the Ways of Coping Questionnaire*. Palo Alto, California: Consulting Psychologists Press.

Johnson, M.P. & Puddifoot, J.E. (1998). Miscarriage: Is vividness of visual imagery a factor in the grief reaction of the partner? *British Journal of Health Psychology, 3*, 137-146.

Kirsch, I., Montgomery, G., and Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive- behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 63*, 214-220.

Kubany, E. S., Abueg, F. R., Brennan, J. M., Haynes, S. N., Manke, F. P., and Stahura, C. (1996). Development and validation of the trauma-related guilt inventory (TRGI). *Psychological Assessment, 8*, 428-444.

Lazarus, A. (1981). *The Practice of Multimodal Therapy*. Baltimore:The John Hopkins University Press.

Levenson, H. (1981). Differentiating among internality, powerful others and chance. In Lefcourt, H. M. (Ed.), *Research with the locus of control construct, 1*, pp15-63. New York: Academic Press.

Major, B. Cozzarelli, C., Cooper, Lynne, M., Zubeck, J. Richards, C. Wilhite, M. Gramzow, R.H. (2000). Psychological responses of women after first-trimester abortion *Archives of General Psychiatry, 57*, 777-784.

Major, B., and Cozzarelli, C. (1992). Psychosocial predictors of adjustment to abortion. *Journal of Social Issues, American Journal of Psychiatry, 48*, 121-142.

Major, B., Cozzarelli, C., Sciacchitano A., Cooper, M., Testa, T., and Mueller, M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 59*, 452-463.

Marks, D. F. (1973). Visual imagery differences in the recall of pictures. *British Journal of Psychology, 64*, 17-24.

Meuller, P., and Major, B. (1989). Self-blame, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 57,* 1059-1068.

Paintin, D. (1997). *Twenty Questions About Abortion*, London: Birth Control Trust.

Parry, G., Shapiro, D. A., and Firth, J. (1986). The case of the anxious executive: A study from the research clinic. *British Journal of Medical Psychology, 59*, 221-233.

Potvin, L., Lasker, J., and Toedter, L. (1989). Measuring grief: A short version of the perinatel grief scale. *Journal of Psychotherapy and Behavioral Assessment, 11*, 1.

Rosenberg, M. (1965). *Society and the Adolescent Self-Image*. Princeton, NJ: Princeton University Press.

Rusch, M.D., Grunert,B.D., Mendelsohn, R.A., Smucker, M.R. (2000). Imagery rescripting for recurrent, distressing images. *Cognitive and Behavioural Practice, 7,* 173-182.

Speckard, A. C., and Rue, V. M. (1992). Post-abortion syndrome: An emerging public health concern. *Journal of Social Issues, 48,* 95-119.

Spiegel, D. (1997). Hypnosis in the treatment of post traumatic disorders. In Rhue, J., Lynn, S., and Kirsch, I. (eds), *Handbook of Clinical Hypnosis.* Washington, DC: American Psychological Association.

Van der Hart. O. (1988). An imaginary leave-taking ritual in mourning therapy: A brief communication. *International Journal of Clinical and Experimental Hypnosis, 36,* 63-69.

Walters, V.J. (1999). The Usefulness Of Hypnosis Questionnaire *An investigation of the Effectiveness of Hypnosis as an Adjunct to Therapy for Post-Abortion Distress* Unpublished MSc Dissertation.

Walters, V. J. and Oakley. D.A. (2003). Hypnosis as a possible 'virtual reality' context in cognitive behavioural therapy for an environmental phobia. *Clinical Case Studies, 2,* 295-305.

Watkins, J. G., and Watkins H. H. (1997) *Ego States: Theory and Therapy.* New York: Norton.

Zigmund and Snaith (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica, 67,* 361-370.

APPENDIX 1

Overview of the 3 phases of therapy.

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

Week	Session	Intervention
Phase 1: Stabilisation		
1	**1***	**Self-hypnosis taught for anxiety control**
2	**2**	**Client informed of PTSD diagnosis**
3		
4	**3***	**Reliving a happy childhood experience**
Phase 2: Systematic uncovering		
5	4	Explored feelings associated with abortion
6	**5***	**Exploratory reliving**
7	**6***	**Reliving the experience of her abortion**
8	7	Explored anger relating to her partner
9	8	Explored identification with the foetus and grief for foetus.
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 2

This questionnaire was administered at the end of treatment and each row of 3 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 author, the second and third boxes were completed by Sophie.

Usefulness Of Hypnosis Questionnaire (UOH)

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?
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'	*I felt relaxed for the first time in months. It felt like a release of the tension that had built up me as a result of the pain I felt.*	*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.* 4

What we did in hypnosis	What did this feel like?	How might this have helped?
Week 4/ Session 3. You watched a TV screen and watched yourself in the past having fun at your birthday party when you were 6 or 7.	*Felt very vivid to see myself and remember the experience of my birthday. It made me happy to remember feeling carefree and happy.*	*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.* 4

What we did in hypnosis	What did this feel like?	How might this have helped?
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.	*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'd never previously 'won' against my bullies and this felt empowering. I never thought that I'd be able to do this.* 4

What we did in hypnosis	What did this feel like?	How might this have helped?
Week 7 / Session 6. You went back to the experience of your termination. Your older self comforted you.	*Again this was terrifying. It was very vivid and 'real'. My older self was able to help and provide comfort.*	*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.* 5

What we did in hypnosis	What did this feel like?	How might this have helped?
Week 10 / Session 9. You hugged your baby on your hill in Shropshire. You wrapped the baby in blankets and put it in a basket and found a way to say goodbye.	*Challenging. I felt a mixture of emotions: sad, attachment, lonely, grief, relief and peace.*	*I had not given myself the opportunity to say 'goodbye' and had not felt I was able to until this point.* 5

What we did in hypnosis	What did this feel like?	How might this have helped?
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.	*Felt frightened at first as it seemed very clear and vivid but I was able to cope with it.*	*Helped conquer a 'demon' that had caused prolonged disturbed sleep and left me feeling shaky and upset on waking.* 4

What we did in hypnosis	What did this feel like?	How might this have helped?
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.	*I felt strong enough to re - face or face bad feelings I had experienced and I felt better; a sense of relief.*	*Felt able to 'divorce' myself from these feelings and felt released from them.* 5

DOES HYPNOSIS MAKE *IN VITRO, IN VIVO*?
HYPNOSIS AS A POSSIBLE 'VIRTUAL REALITY' CONTEXT IN COGNITIVE BEHAVIOURAL THERAPY FOR AN ENVIRONMENTAL PHOBIA.

(See Appendix XIX for published copy)

1. ABSTRACT

This client study illustrates the use of hypnosis as an adjunct to therapy in phobia treatment. Interventions conducted in an hypnotic context included cue-controlled relaxation and covert desensitisation, in which the client re-framed her fears and transformed fear-related images into benign stimuli. These interventions were experienced by her as having an 'as real' quality and were successful in reducing her long-standing fear of the wind to a normal level within 3 sessions. This improvement was maintained at 18 months follow-up. This outcome is discussed in relation to 'virtual reality' approaches to phobia treatments and ways in which hypnosis may facilitate cognitive behavioural techniques.

2. INTRODUCTION

Whilst Cognitive Behavioural Therapy (CBT) is the treatment of choice for phobic disorders, a meta-analysis by Kirsch, Montgomery and Saperstein (1995) indicates that the addition of a hypnotic context to CBT leads to greater effectiveness of therapy for a range of disorders. Included in the studies examined in the meta-analysis was the treatment of phobia. The present client study illustrates the possible advantages of the hypnotic context when using hypnosis as an adjunct to treating an environmental phobia.

Nearly twenty years ago Weitzenhoffer (1972) asserted that hypnosis was useful in behaviour therapy because it facilitated relaxation, increased suggestibility and

heightened vividness of imagery (see also Spinhoven, 1987). Importantly, suggested experiences in hypnosis have a more 'as real' quality to them than when the same events are simply imagined. A recent brain imaging study (Szechtman et al, 1998), has shown that sounds suggested to high hypnotisables in hypnosis produce similar brain activation to that present when the same sounds are actually heard. This effect was not present when the same participants were asked to imagine the sound as vividly as possible. The capacity to experience suggested situations in hypnosis as 'real' events may be a key factor when considering hypnosis as a useful adjunct to the treatment of phobias.

The potential benefit of providing phobic clients with 'as real' experiences in therapy is reflected in a number of studies in which technological advances have facilitated the creation of virtual environments to explore (Pertaub, Slater & Barker, 2002) and to treat a variety of phobias (e.g. Kahan, Tanzer, Darvin and Borer, 2000; Huang, Himle and Alessi, 2000; Wiederhold and Wiederhold, 2000; Anderson, Rothbaum, and Hodges, 2000, Rothbaum, Hodges, Smith., Lee & Price, 2000).

3. BACKGROUND

Sarah was 38 years old when she self-referred for therapy to the Hypnosis Unit to overcome an extreme fear of the wind which she had experienced for the previous two years. She could identify no particular cause for her fear but remembers its onset coinciding with a stressful Christmas period when the weather had been very windy. Sarah was completely preoccupied with the weather and when it was windy she felt unable to carry out normal everyday tasks such as cooking, washing up or taking a shower.

Sarah had lived on a narrow boat, moored close to a 60-foot alder tree, for over twenty years. Initially she lived on a different mooring with her previous partner, Tim, who died suddenly six years ago on the night of the move to her present mooring nearby. Additionally, around the time of her partner's death there were four other family deaths. Her phobia developed four years later. Since Tim's death Sarah had met a new partner with whom she had a good relationship.

Sarah met the DSMIV diagnostic criteria for a Specific Phobia. Self-reported scaling was used to measure the following associated physiological, behavioural and subjective symptoms (Lang. 1968):

> *Physiological:* when the weather was windy she felt physically shaken, sick and muscles in her back and neck seized up.
>
> *Behavioural:* she avoided situations in which she would be outside on windy days, but was preoccupied with listening out for the sound of the wind and felt compelled to watch the tree swaying and the clouds moving.
>
> *Subjective:* Anticipation of adverse consequences of the wind – recurrent thoughts such as: 'the branches will fall off and damage the boat', caused her intense anxiety.

Lynn, Kirsch, Barabasz, Cardena and Patterson (2000) suggest that in order to further our understanding of the efficacy of hypnosis, assessment should address such matters as hypnotic suggestibility, expectancies and motivation. Sarah's hypnotic ability was not formally measured but her ability to become thoroughly absorbed in books and

films, excellent motivation, a positive view about hypnosis and self referral for hypnosis as an adjunct to treatment, were factors indicating that hypnosis was likely to be an appropriate context for therapy. Sarah had once seen a demonstration of hypnosis used for pain management but had not previously experienced hypnosis herself.

Natural environmental phobias generally have a childhood onset (DSM IV) but a traumatic event at any age may be a predisposing factor. One hypothesis was that the weather might have been windy when her partner had died (though she had no recollection of this) and that windy weather, coinciding with Sarah's stressful Christmas some years later, had triggered fearful feelings associated with the boat and her partner's sudden death.

Sarah was mildly curious about why her fear had developed but identifying the cause was not a goal of therapy for her. However, if her symptoms were resistant to change it was agreed that hypnosis would be used as an adjunct to a psychodynamic approach, in which we would work towards identifying and resolving any underlying issues which might have caused the fear (e.g. Watkins and Watkins, 1971).

Sarah enjoyed good health and whilst she described herself as generally "quite anxious", she did not experience any other psychological problems.

4. THE THERAPY

4.1 Session I

After history taking Sarah was asked to identify her fears and listed them in the following hierarchical order, the first being the worst:

- The noise of the wind.
- The movement of the tree and a fear of the branches breaking off and hitting the boat.
- Hearing the weather forecast.
- The movement of the boat.

Sarah described how she would constantly listen out for sounds of the wind and as soon as she believed she could hear it she would feel compelled to watch the movements of the alder tree whilst crouching on the kitchen floor of the boat. Any news reports of trees falling down terrified her. She would also feel driven to listen to distant sounds of trains or aeroplanes until she was certain that these sounds were not sounds of the wind. Another aspect of the fear was her need to wear a hat tied down by a scarf when outside when windy. Furthermore, if it became windy when she out she would have to rush back indoors and on occasions this resulted in her missing important meetings.

Sarah identified coping strategies that she was already using such as telling herself that it will stop being windy and reminding herself that trees are flexible and that the roots are deep. Thoughts of the tree growing made her fear worse (because she felt it might break more easily with age), as did thoughts of the clouds moving speedily across the sky.

The rationale for using hypnosis was given, i.e. that her fear had been learnt (Wolpe, 1958, 1961) and that hypnosis would provide her with vivid experiences in which she could un-learn this habit. It was also explained that since she had become stuck in a particular way of thinking (Salkovskis, 1996), hypnosis would assist in overcoming her problem by giving her an opportunity to understand it in a different way.

4.2 Session 2

Sarah was introduced to hypnosis. In preparation for this she was asked to describe a place in which she could feel relaxed and safe. Sarah gave a vivid description of a Stately Home garden, including a wonderful 'Botticelli's Venus' fountain with water trickling from a clamshell. She described sounds of water trickling- 'a sort of musical sound', birds singing and the distant sounds of the occasional car. She was also able to describe a smell of dampness, moss and privet. She wanted to use this setting as her 'special place' where she could sit on the damp grass quite happily by herself.

Hypnotic procedure No.1: Introduction to hypnosis

Hypnotic induction included breathing techniques (including 'breathing out' a colour of tension), muscle relaxation using imagery of the warmth and comfort from a gentle sun, and being counted down a flight of 10 steps to her 'special place'. Each count was timed to coincide with her out-breath. The hypnosis lasted 25 minutes but was experienced by her as approximately 10 minutes, which indicated absorption in the hypnotic experience. She reported feeling heavy and also that she had "felt the warmth from the sunshine travelling to each part of my body". She felt as if she was 'really there' in the garden. In this context it is interesting to note that whilst the therapist had suggested that the steps were warm (making the assumption that they had be warmed by the sun) Sarah had reported that the steps had actually been experienced by her in hypnosis as feeling very cold. Sarah was encouraged by this experience and was happy to proceed to another hypnotic procedure that would address the fear listed lowest on her list.

Hypnotic procedure No. 2: Desensitisation

The same hypnosis induction procedure was repeated and Sarah was encouraged to talk during it. After reaching her special place in hypnosis Sarah was asked to find herself

transported to her boat and to have the experience of 'being there'. She described in detail the interior of the sitting room and she said that she was sitting on the floor. It was suggested that the boat was beginning to move with the wind. She was then asked to rate her fear on a scale of 0-10 (10 being the worst) and she reported it was at 5. She felt a great need to tie the boat tighter to the mooring to stop the movement but she was asked to think of her 'special place' and relax. It was suggested that the more she relaxed the more she could resist tying the boat tighter. She was then asked to let the 'back part of her mind' come up with a statement which would be helpful for her to hear. She said 'I don't need to look out of the window' had come to mind. She was asked where her fear was on the scale and she reported that it was now at 1, which she said felt fine.

In view of her success in dealing with this first item on her hierarchy Sarah was asked if she was ready to tackle the next fear on her list. She agreed to this. It was suggested that she was still on her boat and about to hear the weather forecast. She was asked to describe how she was feeling and she reported tension in her stomach, neck and face muscles. It was suggested that the forecast was predicting strong winds and she was asked to rate her fear. She reported this to be 7 or 8 on the scale of 0-10. It was suggested that she brought back all the calm, safe and relaxed feelings of her 'special place' whilst the 'back part of her mind' would, without her trying, tell her something that she needed to hear. She heard the statement ' It doesn't matter if it's windy'. Following this she rated her fear on the scale on the scale as between 2 to 3. Further suggestions were given to evoke feelings of relaxation associated with her 'special place', physical relaxation, as well as repetition of her self-statement. Following this she rated her fear at 0. Sarah was then alerted. She described the hypnotic experience and

her sense of being there inside the boat, feeling the texture of the wood and rough carpet.

At the end of this session Sarah was feeling very confident that hypnosis would work for her. She was instructed in the safe use of the induction, relaxation and 'special place' routine as her own self-hypnosis procedure and was encouraged to practise this regularly at home.

4.3 Session 3 (2 weeks later)

Sarah reported that she was less aware of the wind. On the occasions that she had noticed it she had thought, 'It's windy, so what!' She described the shift in her feelings as being as if someone had 'switched off a switch'. She was doing regular self-hypnosis but had been distracted by the noises of birds, swans and neighbours - everyday sounds that she normally enjoyed. It was suggested that she utilise these sounds to bring feelings of familiarity, comfort and safety and to focus on them rather than try to block them out. She had not been able to test out her greatest fear of very strong wind as the weather had been fairly good since the last session. She had become aware, however, that now when she heard the sound of an aeroplane she heard it only as an aeroplane rather than the rumbling of a gust of wind. She had not felt the need to look out of the window at the alder tree and when she spotted the same tree from a train window on her way home from work she had noticed that she had not felt at all concerned. She also noticed that on occasions when the weather had been breezy she had been able to go out without feeling anxious, something she could not have done prior to therapy. However, she felt that she still needed to convince herself that the tree could move a lot more without breaking. It was decided to progress to the two items she had identified as being the highest on her fear hierarchy.

Hypnotic procedure No.3: Further desensitisation.

After the induction and 'special place' procedures it was suggested that Sarah feel herself to be on her boat and that the wind was blowing strongly. She said she was aware of things moving, cutlery clanking together and noises in the chimney. She then became aware of sounds outside the boat. She described the sound of the wind building up and gradually getting closer. She began to feel tension in the muscles of her back and stomach and on her fear scale she was at 6 or 7. It was suggested that she look at the tree and see that it could twist and bend without breaking. This was followed by her fear reducing to 4 to 5 on the scale. It was then suggested that she listened to the trickling fountain that she so much enjoyed in her 'special place' and that this would bring feelings of calm and relaxation. This was followed by a reduction on her fear scale to 2 or 3. Finally, it was suggested that the tree was dancing to the trickling sound. She then reported that her fear had dropped to 1.

After alerting Sarah, she commented that she was struck by how much the sound of the trickle of the fountain had helped. She also reported that she had also found the concept of the tree 'dancing' a very gentle, relaxing thought. It was particularly interesting that during the procedure the gentle sound of the fountain had been transformed, without suggestion, into a roaring waterfall 'like standing under Niagara Falls'. She appeared very surprised, not only that this had sprung to mind, but also because it had felt as if she was really hearing the sound of the waterfall. She then commented that this was a wonderful sound which very much reflected her love of nature and the outdoors. She said that this sound was all she needed to imagine in order to overcome her anxiety.

Sarah felt very hopeful at the end of the session. She was looking forward to the difference that overcoming her fear would make to her life. She commented that since

the first session on which hypnosis had been used (Session 2) she had been able to do things that she had not done for two years in windy weather, for instance washing up, having a shower and having the concentration to play trivial pursuit with her partner. It felt as if she could carry on as normal. Once again she described this as a feeling that someone had 'flicked a switch'.

She was pleased that that people at work had noticed a change in her especially as she would now go out at lunch time when it was windy, something that she could not do for the last two years even in a slight breeze. She was also delighted that she no longer needed to wear the hat and scarf when out and about.

It was decided in this session that Sarah would report back in two or three weeks after testing her recovery in windy weather. This she did and, since her improvement had been maintained, it was decided that she did not need further sessions.

4.4 Follow-up

One year later Sarah was delighted to report that her progress had been maintained and remarked that her concentration had also improved now that she was no longer distracted by a preoccupation with the weather. All of her symptoms, such as feeling compelled to crouch inside the boat watching the speed of the clouds during the night; feeling shaken, sick and experiencing muscle tension; avoiding going out in the wind, had gone. She said she now felt the sound of the wind was an 'annoyance' but did not cause her any fear. She felt her anxiety about branches falling off the tree was now at an entirely normal level and remarked that NOT being concerned about a very old tree dropping it's branches on one's boat would be rather foolhardy!

Sarah commented that one of the techniques she had learned in therapy, that of visualizing things which frightened her as something that she could draw comfort from (like changing the wind sounds into waterfall sounds) had also been useful since. It had not only helped her overcome her fear of the wind, but she had also used it to stop feeling panicky when driving on the motorway by changing the sound of the car engine into comforting sounds of a waterfall and water.

18 months after treatment Sarah wrote 'I still use the techniques you taught me, although not for the original reason [the wind phobia] – that is now totally under control'.

5. DISCUSSION

5.1 The hypnotic context and the process of change

Studies frequently cite the positive role of expectancy in therapeutic outcome. (Kirsch, 1990, 1997; Schoemberger, 1999). Labelling a therapy as 'hypnotic' can raise clients expectation of its efficacy (Wagstaff and Royce, 1994) and Sarah had come to therapy with the expectation that hypnosis would be helpful to her. Vividness of imagery has sometimes been referred to as somewhat secondary to expectations (Lynn, Kirsch, Barabasz, Cardena and Patterson, 2000). However, in the light of recent neurological studies such as Szechtman et al (1998), referred to above, we need to consider the extent to which the level of subjective 'realness' of the hypnotic experience may contribute to therapeutic change. Sarah reported her experience in hypnosis, of being on the boat etc., as one of 'being there' and of being directly engaged with the fearful situations as they unfolded and developed. She also had the experience of using her coping strategies *'in vivo'* and demonstrating their effectiveness in 'real' situations to herself. This felt 'realness' or 'virtual reality' of the hypnotic experience may be crucial in

facilitating a positive experience of mastery, accompanied by all the relevant mental processing. This is arguably more effective than using simply imagined situations, which, as indicated by the data of Szechtman et al (1998), are not experienced subjectively or neuropsychologically as real and so arguably do not provide the equivalent rehearsal experience.

Schoenberger (1999), in discussing expectancy and fear, comments that once expectancy of anxiety is reduced clients are more prepared to progress to *in vivo* exposure in which they learn to build on skills developed by the use of imagery techniques. The vividness of a suggested hypnotic experience may accelerate this process by giving the *in vitro*, imagined situations set up by the therapist an *in vivo* quality. This in turn would be expected to facilitate the transfer of coping skills to actual everyday situations. The degree of felt realness may thus be a contributing factor in moderating the speed at which clients are able to achieve mastery over a phobia.

It was also notable that Sarah's self-statements developed in hypnosis had such a profound effect, especially since they were of a very ordinary nature. Indeed, Sarah had used self statements prior to her therapy, such as telling herself that it will stop being windy, and reminding herself that trees are flexible and that the roots are deep, but whilst these had been useful coping strategies she continued to experience the fear. The self-statements elicited in hypnosis, 'I don't need to look out of the window' and 'It doesn't matter if it's windy' were on the face of it no more profound or insightful but, in contrast to the ones she had used previously, had tremendous effect. It may be that the context of hypnosis increased the significance of these self-statements and consequently their effectiveness.

Another observation was the ease with which Sarah was able to transform a frightening sound into a comforting one. Notably, she had arrived at the idea of transforming the sound of the wind to the sound of a waterfall herself after the therapist's reference to the tree 'dancing in the wind'. It is possible that this was the result of a series of associations that began when it was suggested that the wind was blowing and that she look at the tree moving. It may be further speculated that this frightening image triggered a physiological response. The therapist then reframed the feared image to a pleasant image of the tree 'dancing in the wind' building on the client's imagery of the 'musical sound' of the fountain. This suggestion successfully reduced her level of arousal. The resulting feeling of comfort may have encouraged Sarah to become more intensely focused on sounds whilst at the same time experiencing an increasing sense of mastery. It is possible that this sense of mastery enabled her to then focus on the reality of the sound of the strong wind leading her to associate this with a more congruent sound of a roaring waterfall.

5.2 Implications for the use of language in therapy

The style of language used in the present study encouraged Sarah in hypnosis to experience situations rather than simply to imagine them. This distinction is an important one and in general terms it seems worth considering the detail of language used in interventions more carefully in accounts of clinical cases. The distinction between imagining and experiencing is also a consideration when pacing therapy. It may, for example, be appropriate in some cases of severe trauma, especially when the client is highly hypnotisable, to use hypnotic interventions that suggest a client 'imagine' before progressing to suggestions of 'experiencing' to avoid the risk of overwhelming them with negative feelings.

5.3 Hypnosis as a 'virtual reality therapy'.

It has been generally recognised that the use of *in vivo* procedures (including virtual reality procedures), whenever possible, is likely to be more effective therapeutically than employing *in vitro*, imaginal procedures. It can similarly be claimed that there are advantages in using computerised virtual reality over real situations in the treatment of phobia (see Pertaub, Slater & Barker 2001a,b). For instance, endless types of useful situations can be set up in which the client can rehearse unlearning their fear. This advantage is also one that can be claimed for hypnotic approaches. Furthermore, it is noteworthy that participant comments describing the 'virtual experience' quoted by Pertaub, Slater and Barker (2002) are very similar to those of clients describing the 'realness' of a hypnotic experience. Studies using virtual reality in the treatment of phobia are exciting, but we should be mindful that hypnosis would appear to offer the additional advantage of providing "virtual reality" without the need for technology and expensive programming.

6. CONCLUSIONS

Not all clients receiving hypnosis as an adjunct to therapy for phobias make progress as rapidly as described here. Indeed, we go to great lengths to inform clients that hypnosis is not a magic pill. However, some clients do experience recovery as if they have 'flicked a switch'. It is suggested in this paper that one factor which may contribute to such rapid change is the *'in vivo'* quality conferred on *'in vitro'* procedures by conducting a standard form of treatment in a hypnotic context.

REFERENCES:

Anderson, P. L., Rothbaum, B. O., and Hodges, L., (2000). Virtual reality: using the virtual world to improve quality of life in the real world. *Bulletin of the Meninger Clinic, 65*, 78-91.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th Edition)*. Washington, DC: American Psychiatric Association.

Kahan, M., Tanzer,J., Darvin, D., and Bover, F., (2000). Virtual reality-assisted cognitive-behavioural treatment for fear of flying: Acute treatment and follow-up. *CyberPsychology and Behaviour, 3,* 387-392.

Kirsch, I. (1985). Response expectancy as a determinant of experience and behaviour. *American Psychologist, 40,* 1189-1202.

Kirsch, I. (1990). *Changing expectations: A key to effective psychotherapy*. Belmont, CA: Brooks / Cole.

Kirsch, I. (1997). Response expectancy theory and application: A decennial review. *Applied and Preventive Psychology, 6*, 69-79.

Lang, P.J. (1968). Fear reduction and fear behaviour: problems in treating a construct. In Research in psychotherapy, 111 (ed. J. M. Schien), pp. 90-103. American Psychological Association, Washington CD.

Lynn, S.J., Kirsch, I., Brabasz, A., Cardena, E.,and Patterson,D., (2000). Hypnosis as an empirically supported clinical intervention: The state of the evidence and a look to the future *The International Journal of Clinical and Experimental Hypnosis, 48,* 239-259.

Schoemberger, N, (1999). Expectancy and fear. In Kirsch, I. (ed) *How expectancies shape experience* Washington, DC: American Psychological Association.

Pertaub, D-P., Slater, M. and Barker, C. (2002). An experiment on public speaking anxiety in response to three different types of virtual audience. *Presence: Teleoperators and Virtual Environments*, 11, 68-78.

Rothbaum, O.S., Hodges, L., Smith, S., Lee, J.H. & Price, L. (2000). A controlled study of virtual reality exposure therapy for the fear of flying *Journal of Consulting and Clinical Psychology, 68,* 1020-1026.

Salkovskis, P., (1996). The cognitive approach to anxiety: Threat beliefs, safety-seeking behavior, and the special case of health anxiety and obsessions. In: P. Salkovskis (Ed.) *Frontiers of Cognitive Therapy*, New York: The Guilford Press.

Slater, M., Pertaub, D-P. & Steed, A. (1999). Public speaking in virtual reality: Facing an audience of avatars. *IEEE Computer Graphics and Applications, 19,* 2-5.

Szechtman, H., Woody, E., Bowers, K. S., and Namias, C. (1998). Where the imaginal appears real: A positron emission topography study of auditory hallucinations. *Proceedings of the National Academy of Science, 95,* 1956-1960.

Spinhoven, P. (1987) Hypnosis and behaviour therapy: a review *The International Journal of Clinical and Experimental Hypnosis, XXXV*, 8-31.

Wagstaff, G.F. & Royce, C. (1994). Hypnosis and the treatment of nail biting: A preliminary trial. *Contemporary Hypnosis, 11,* 9-13.

Watkins, J. G. (1971). The affect bridge: A hypnoanalytic technique. *International American Psychologist, 40,* 1189-1202.

Weitzenhoffer, A. M., (1972). Behaviour therapeutic techniques and hypnotherapeutic methods. *American Journal of Clinical Hypnosis, 15,* 71-82.

Wiederhold, B. K., & Wiederhold, M. D., (2000). Lessons learned from 600 virtual reality sessions *CyberPsychology and Behaviour, 3,* 393-400.

Wolpe, J., (1958). *Psychotherapy by reciprocal inhibition.* Stanford University Press: California.

Wolpe, J., (1961) The systematic desensitisation treatment of neurosis, *Journal of Nervous and Mental Diseases, 132,* 189-203.

SECTION D: THE LITERATURE REVIEW

WHAT EXACTLY DO YOU THINK YOU ARE DOING? A REVIEW OF HYPNOTIC AND NON-HYPNOTIC IMAGERY TECHNIQUES USED IN THE TREATMENT OF PTSD

1. INTRODUCTION

Imaginal exposure is arguably one of the most researched interventions for Post Traumatic Stress Disorder (PTSD) (Foa and Meadows, 1997). Grounded in theories postulating that prolonged exposure to fear-provoking stimuli leads both to a reduction of anxiety (e.g. Wolpe, 1958, 1961) and emotional processing (e.g. Foa and Kozak, 1986; Rachman, 1995), exposure techniques require the client to 'relive' the trauma memory in their imagination (imaginal or *in vitro* exposure) in order to activate feelings that were experienced at the time of the event (Foa, Rothbaum, Riggs and Murdock, 1991). Exposure techniques are central to cognitive-behavioural therapy for PTSD and are generally regarded to be both safe and effective (Harvey, Bryant and Tarrier, 2003).

Whilst anxiety management techniques such as stress inoculation training are included in CBT trauma treatment protocols (Meichenbaum, 1975), prolonged exposure necessitates emotional engagement with the trauma memory in the absence of anxiety management during the exposure period (Craighead, Craighead, Kazdin and Mahoney, 1994). The protocol also places importance on the additional use of *in vivo* exposure to address current avoidances, which may have developed subsequent to the trauma (e.g. Foa and Rothbaum, 1998). Critically, the reliving must introduce new information not compatible with the trauma memory (Foa, Steketee and Rothbaum, 1989) and be conducted within a safe, supportive, therapeutic relationship (van der Hart and Spiegel, 1993).

In general psychological practice *in vivo* experience, where this is possible, is considered to be more effective than *in vitro* or imaginal procedures. More recently, virtual reality technology (VR) has attempted to bridge the gap between *in vivo* exposure and imagined exposure by providing 'as real' environments to augment CBT treatments. Interestingly, subjective reports of virtual environment experiences (Pertaub, Slater and Barker, 2001b) are strikingly similar to subjective reports of hypnotically suggested scenarios, which are often described by clients as feeling 'real' (Walters and Oakley, 2003). Clearly for PTSD, *in vivo* exposure to the original traumatic experience is generally not either possible or desirable and so reliance is placed on exposure in imagery. It seems possible that carrying out exposure treatments in hypnosis can add a valuable virtual reality (or *in vivo*) quality to therapy.

Another related observation (clinical experience, VW) is that clients who have previously experienced CBT imagery interventions, often comment that these feel different to hypnotic interventions involving imagery. There is, it would seem, a general perception that 'hypnotic imagery' is different to imagery used in CBT techniques. However, many interventions labelled 'hypnosis' would appear almost identical to many non-hypnotic techniques. This similarity, yet difference, can lead to an unnecessary divisiveness and competition between those who use hypnosis and those who do not. For example, some therapists have asserted with considerable strength of feeling that they would never use hypnosis, whereas others have argued that hypnotic techniques are simply guided imagery and a number who use guided imagery assert that they are, in effect, using hypnosis (pers com, experience from teaching hypnosis workshops). There is clearly some confusion and ambiguity about what exactly therapists believe they are doing.

The purpose of this review is to examine the use of imagery in therapy within both hypnotic and non-hypnotic contexts and to evaluate whether or not these strategies are essentially the same or different. If they are different, what might account for these differences? It is not within the scope of this review to address all therapies for all disorders and it has been decided to focus, in particular, on imagery used in CBT for the treatment of PTSD since these techniques are frequently reported in the CBT literature (Foa and Meadows, 1997). Similarly the use of hypnotic imagery in the treatment of PTSD has received much attention in the hypnosis literature (Cardena, 2000).

Many, possibly most, psychologists will have some understanding about what cognitive –behavioural therapy is but less will be knowledgeable about hypnosis. The review therefore begins by describing the nature of hypnosis. This is followed by an examination of studies that have investigated the efficacy of imaginal exposure in the treatment of PTSD. Relevant studies from the hypnosis literature are then discussed. Typical imagery interventions used in exposure therapy in both hypnotic and non-hypnotic contexts are reviewed in context with texts and journal articles that have focussed on therapeutic techniques. This is followed by a review of case reports that illustrate the use of these techniques in the treatment of PTSD selected from peer reviewed CBT and hypnosis journals. The effect that the addition of hypnosis may contribute to exposure procedures is then considered and, finally, recommendations are made in the light of conclusions drawn from this review.

2. THE NATURE OF HYPNOSIS

There has been an ongoing debate between those who subscribe to a 'state' view of hypnosis (i.e. hypnosis is an altered state of consciousness or special 'trance') and those who hold a 'non-state', or sociocognitive, view (i.e. hypnosis is a normal, yet complex,

psychological process) (see Heap, Brown and Oakley 2004 for a review). Others have proposed a more 'naturalistic' conceptualisation of hypnosis in which hypnosis is viewed as a special type of communication (Yapko, 1995). There has, however, generally been difficulty in finding a theory that can adequately explain hypnotic phenomena and individual differences in hypnotic responsiveness.

The subjective experience of hypnosis has been examined in context with such topics as absorption and focussed attention (e.g. Crawford, 1994), regression (e.g. Fromm, 1992), dissociation (e.g. Woody and Bowers, 1994; Hilgard, 1979; Spiegel, 1997), neurophysiological markers of hypnosis (e.g. Gruzelier, 1998), vividness of imagination (e.g. Barber, Spanos and Chaves, 1974), expectation and motivation to respond to hypnotic suggestion (e.g. Kirsch, 1991) and compliance (e.g. Wagstaff, 1991).

The concept of 'trance' is frequently used to indicate the particular subjective experience characteristic of hypnosis and has been a topic extensively examined in the hypnotic literature. Yapko (1995), for example, describes the characteristics of trance such as selective attention and dissociation within the context of normal psychological processes and suggests that these processes are responsible for increased responsiveness to suggestion during hypnosis. Others have demonstrated that the context of hypnosis in itself can influence responsiveness to suggestion and subjective experience of change (Gandhi and Oakley, 2005). A further line of enquiry has been whether trance can be objectively assessed. For example Spiegel and Spiegel (1978) have suggested that observation of a subjects eye movements can convey information about depth of trance. Yapko (1995), on the other hand, argues that trance cannot be objectively measured by an observer and that it impossible to know at what point a person has moved away from normal awareness and entered a trance state.

In addressing the need to clarify the definition of trance Pekala and Kumar (2000) have attempted to operationalise the concept using a phenomenological approach to assess consciousness. The authors used a specially designed measure which included questions related to consciousness e.g. 'My state of awareness was not unusual or different from what it normally is'. This was completed retrospectively following an induction in order to map subjective experience and compared results to an 'eyes closed sitting quietly' condition. Whilst Pekala and Kumar (2000) claim to have successfully operationalised trance it would appear that the context of hypnosis and the influence that this may have had on experience was not taken into consideration when interpreting their results. An explanatory model of consciousness that integrates many of the views about hypnosis described above has been developed by Brown and Oakley (2004). These authors suggest that the subjective experience of absorption and inward focus away from extraneous distractions (i.e. 'trance'), along with beliefs and expectations about hypnosis, will increase responsiveness to suggestion.

Responsiveness to suggestion will also be determined by an individual's hypnotic suggestibility. The hypnosis literature is in general agreement that people vary in their ability to be hypnotised and that an important characteristic of hypnotic responding is that it has an automatic or involuntary quality (Heap and Aravind, 2000). Suggestions can influence subjective awareness in a variety of ways (e.g. somatically, behaviourally, cognitively and affectively). There are a number of hypnotisability scales that can measure a person's overall hypnotic susceptibility, for instance, the Stanford Hypnotic Clinical Scale (Morgan and Hilgard, 1975) and the Creative Imagination Scale (Barber and Wilson, 1978). Hypnotisability scores are generally not a reliable indicator of clinical outcome with clients who have experience hypnosis as an adjunct to therapy, in therapeutic practice hypnotisability scales are most useful to establish the type of

suggestions that the client is most responsive to. The Creative Imagination Scale (Barber and Wilson, 1978), for example, comprises of 10 scenarios which the person is asked to respond to with the 'power of their imagination'. Should a client respond well to a scenario involving an auditory suggestion, but not to one involving a visual suggestion, the therapist might decide to focus on the *sounds* of waves, rather than the *colour* of the sea when developing a hypnotic routine for a client. Of particular relevance to this review is the general consensus of opinion that the PTSD population are potentially high in hypnotisability (Evans, 2003; Spiegel, 1997; Stuttman and Bliss, 1985) a tendency which may have developed due to an ability to become involved in imagery as a distraction from on-going trauma in childhood (Oakley, Alden and Degun Mather, 1996).

3. STUDIES EXAMINING THE USE OF IMAGERY IN THE TREATMENT OF PTSD

3.1 The role of emotional engagement

A controlled study by Jaycox, Foa and Morral (1998) examined the outcome of prolonged exposure in context with emotional engagement and habituation. The participants were 37 female rape victims suffering from chronic PTSD. Participants were instructed to close their eyes and recount the assault 'as if it were happening now' and to focus on emotions as they brought details of the assault to mind for between 45-60 minutes. The participants were told to listen to an audio recording of their trauma narrative every day imagining that 'the assault is happening now'. Results indicated that participants who experienced highest levels of emotional engagement in the first session achieved greatest reduction of PTSD symptoms on completion of therapy, indicating that emotional engagement in imaginal exposure plays an important role in successful outcome. Nevertheless, 'emotional engagement' in prolonged exposure is often a

painful experience, a factor that perhaps explains why 18 of the original 55 participants dropped out of Jaycox, et al's (1998) study.

Foa et al (1991) have commented that PTSD sufferers cope well with exposure therapy. However, Jaycox et al (1998) recognising that, by definition, PTSD sufferers are reluctant to engage in remembering traumatic memories, suggest that individuals should be educated in the importance of engagement in such techniques in order to prevent them dropping out of therapy. It could be speculated that those who continue with treatment following such an exposition are likely to demonstrate greater self-efficacy (even prior to therapy) than those who feel less able to tolerate exposure to memories and thus drop out of therapy, a factor which may arguably distort evaluation of the efficacy of treatment.

Furthermore, there has been some concern expressed in the literature (e.g. Vaughan and Tarrier, 1992; Pitman, Altman, Greewald, Longpre, Macklin, Poire and Steketee, 1991; Tarrier, Pilgrim, Sommerfield, Faragher, Reynolds, Graham, and Barrowclough, 1999; Rothschild, 2005) regarding the possibility that imaginal exposure might exacerbate PTSD symptoms, a criticism that proponents of exposure therapy have attempted to address. Hembree, Foa, Dorfan, Street, Kowalski and Tu (2003), for example, reviewed 25 controlled studies of CBT treatment for PTSD and concluded that there was no difference in dropout rates among exposure therapy, cognitive therapy, stress inoculation training and EMDR treatments. This study gave further support to an earlier study (Foa, Zoellner, Feeny, Hembree, and Alvarez-Conrad, 2002) which found that only a minority of 76 participants experienced exacerbation of symptoms following prolonged exposure and that this was unrelated to clinical outcome.

Other studies, however, report findings that support a contrasting view. Tarrier et al, (1999), for example, compared a cognitive intervention with an imaginal exposure intervention and reported that symptoms 'worsened' following imaginal exposure, though Devilly and Foa (2001) criticised Tarrier et al's interpretation of results, criticising the study for using only imaginal exposure rather than imaginal and *in vivo* exposure combined.

In their review of treatments for PTSD, Solomon and Johnson (2002) observe that exposure needs to be long enough to enable the fear to subside, but that the intensity of the exposure should be controlled by the client. This may be difficult to achieve since the manner in which emotions emerge is not always predictable. Indeed, Rothschild (2005) has commented that even the most competent therapists sometimes fail to prepare clients sufficiently before exposure to trauma. A particular concern expressed by Rothschild is that therapists working within a range of therapeutic models appear to be skilled at helping clients to re experience the trauma but are less aware of methods that prevent clients from becoming emotionally overwhelmed.

3.2 Is prolonged imaginal exposure really necessary?

Some studies have questioned whether therapies that place particular focus on prolonged exposure are necessarily the most effective treatments for PTSD. For example, Grunert, Smucker, Weiss and Rusch (2004), in their cognitive-behavioural analysis of two PTSD sufferers, reported that prolonged exposure alone was insufficient to bring about sustained recovery. However, they found that the subsequent addition of imagery-based cognitive restructuring interventions facilitated speedy and lasting recovery. Whilst the small size of the study makes these findings difficult to generalise,

Grunert et al's (2004) findings raise important questions about the components of PTSD protocols.

The process of change was examined by Nishith, Resick and Griffin (2002) in a study comparing prolonged exposure with cognitive processing therapy for 108 rape victims suffering from chronic PTSD. The experimenters used a nine-session prolonged exposure protocol involving imaginal and *in vivo* exposure to evoke the participants emotional engagement in the trauma memory whilst describing it in the present tense for between 45-60 minutes and listening to an audio recording of this every day (Foa and Rothbaum, 1998). The cognitive processing therapy protocol required the participants to write in detail about their rape experience (for an unspecified length of time), describing the meaning the rape had for them and to complete homework exercises in which negative beliefs were challenged.

Results suggested that for both conditions symptoms generally worsened during the first 3 sessions before improving. However, avoidant symptoms following prolonged exposure became worse in the first few sessions of therapy during which time they declined in the cognitive processing therapy condition. The authors noted that there is most risk of clients dropping out of therapy before session four, a factor which may increase the chance of clients dropping out of therapy when PE is used alone. Nishith et al's study (2002) suggests that whilst sessions of prolonged exposure appeared to lead to eventual remission of symptoms, more research is necessary to determine what type of method is most acceptable to clients. Related to this suggestion is the need to critically evaluate the length of exposure recommended in familiar treatment protocols (e.g. as stipulated in Foa and Rothbaum's manual, 1998).

Long-term follow-ups are also essential to evaluate the effectiveness of therapeutic approaches and provide further insights about progress which may not be apparent in the shorter term. Whilst follow-ups of studies examining imaginal exposure of up to one year have been reported in the literature (e.g. Jaycox, Zoellner, and Foa, 2002), longer-term follow-ups are less common. A recent five-year follow-up comparing cognitive therapy with exposure therapy (Tarrier and Sommerfield, 2004) is therefore unusual and worthy of attention. These authors found that 12 months following therapy the two treatments resulted in similar treatments effects, whilst at 5 year follow up 29% of the exposure treatment group were diagnosed with full PTSD symptoms in contrast to the participants who received cognitive therapy, none of whom were diagnosed with full symptoms. A particular observation was that the cognitive therapy group also had lower levels of avoidance than the prolonged exposure group. The authors concluded that the cognitive therapy condition, which focussed on meaning and beliefs and did not include exposure, involved changing underlying beliefs and this may have contributed to sustained recovery. In contrast, they suggest that prolonged exposure (which does not include any therapeutic work that directly addresses meaning or beliefs) was less successful in modifying cognitions in the long-term.

4. RELEVANT STUDIES FROM THE HYPNOSIS LITERATURE

4.1 The use of hypnotic imagery in the treatment of PTSD

Cardena (2000), in reviewing the efficacy of hypnosis in the treatment of PTSD, outlines three reasons why hypnosis should be a particularly appropriate adjunct to treatment. Firstly, he notes that those suffering from PTSD have been shown to be more hypnotisable than normal controls (Cardena, 1996; Spiegel, Hunt and Dondershine, 1988; Stuttman and Bliss, 1985); secondly, that therapeutic outcome following the use of hypnosis might be related to the client's hypnotisability (Levitt,

1993; Spiegel, Frischolz, Maruffi and Spiegel 1981; Speigel, Frischholz, Fleiss and Spiegel, 1993); and thirdly, that hypnotic techniques can help to control the emotional impact of exposure treatments for PTSD (Brown and Fromm, 1986).

4.2 The nature of hypnotic imagery

Individual differences in imaginative ability has long been a focus of study in the hypnosis literature and the general finding is that whilst low imagers usually score low in hypnotizability, high imagers can be found at all levels of hypnotisability, that is, the distribution is non-linear or fan-shaped (e.g. Spanos, 1986). Hypnotic suggestion involves interaction with multiple sensory images (Heap and Aravind, 2002) rather than visual imagery alone. For example, some individuals respond particularly well to auditory imagery suggestions, whilst others show particular responsiveness to tactile imagery suggestions.

The effect of hypnosis on visual information processing has been examined in several studies and findings have shown that hypnotised highly hypnotisable individuals performed better than non-hypnotised highs in a range of visual tasks (Friedman, Taub, Sturr, and Monty, 1987; Crawford, Wallace, Normura and Salter, 1986; Atkinson, 1990; Crawford and Allen,1983). Some theorists have suggested that highly hypnotisable individuals generally have a particularly imagery biased cognitive style (Nadon, Laurence and Perry, 1987). Thus, given the high hypnotisability of PTSD sufferers it might be expected that this group will be receptive to image-based therapeutic suggestion and that hypnosis might enhance these skills.

4.3 'Hypnotherapy' or hypnosis as a therapeutic technique?

Some articles in peer-reviewed journals misrepresent hypnosis as being a therapy in itself. For example, Solomon and Johnson (2002) in their review of psychosocial treatments for posttraumatic disorder list 'hypnotherapy' as one of two 'insight-orientated' therapies, the other listed being psychodynamic therapy. Similarly, in a recent review of meta-analytic findings of CBT for anxiety disorders, Deacon and Abramowitz (2004) refer to hypnosis as 'an approach to therapy'. Neither descriptions are accurate since hypnosis is neither a therapeutic approach nor a therapy in itself, rather it is a therapeutic tool that can use hypnotic imagery adjunctively in the treatment of PTSD within any therapeutic orientation, for example psychoanalysis (Brown and Fromm, 1986), CBT (Ffrench, 1995) behavioural therapy (Willshire, 1996), strategic therapy (Kingsbury, 1993), ego-state therapy (Phillips,1993) and multi-modal therapy (MacHovec,1984). Hypnosis is no more a therapy in itself than 'imagery' is.

The use of hypnosis as a tool to examine the role that suggestion has on cognitive processes has been prolific in recent years, for example, in the study of pain (Rainville, Duncan, Price, Carrier and Bushnell, 2002; Derbyshire, Whalley, Stenger, Oakley, 2004), conversion disorder (Oakley, 1999a) as well as the use of functional brain imaging to investigate hypnotisability and brain mechanisms during traumatic recall (Vermetten and Bremner, 2004). A great deal of current hypnosis research has relevance to both the treatment and understanding of PTSD.

Although there are a number of published case studies describing hypnotic imagery to treat PTSD going back nearly 200 years (see Vijselaar and van der Hart, 1992), the systematic study of clinical hypnosis has lagged behind experimental hypnosis and there are few large controlled clinical studies comparable to those reported in the CBT literature. A notable exception is a controlled study by Brom, Kleber and Defare (1989),

involving 112 participants suffering from PTSD which investigated the use of "hypnotherapy" compared to systematic desensitisation and psychodynamic therapy. These researchers found that whilst there was overall no significant difference in outcome between the three conditions, "hypnotherapy" was the superior treatment for intrusive symptoms and psychodynamic therapy was the best treatment for avoidant symptoms. Unfortunately, in labelling hypnosis techniques 'hypnotherapy', albeit 'within a behavioural context' (p 607), and comparing 'hypnotherapy' to psychodynamic therapy, the authors perpetuate the myth that hypnosis is a therapy in itself.

In a meta-analysis of 61 controlled studies (van Etten and Taylor, 1998), of which Brom et al's (1989) study was the only one in which hypnosis was used, the authors found that overall, behavioural therapy and EMDR were the most effective psychological therapies. However, as noted by Harvey, Bryant and Tarrier (2003) a 5-year follow-up of patients treated by EMDR (Shapiro, 1995) showed that treatment gains were not maintained.

Kirsch, Montgomery & Sapirsteins' (1995) meta-analytical study is of particular value in clarifying the adjunctive role of hypnosis for a range of clinical problems. These authors analysed 18 studies in which CBT was compared to the same therapy when hypnosis was used adjunctively. Results showed better therapeutic outcome for a variety of clinical problems when hypnosis was used with CBT than when the same treatment was used without the use of hypnosis. It should be noted that none of the 18 studies included the treatment of PTSD. However, a particularly interesting finding is that the effect achieved by the addition of hypnosis was noted two years after treatment had ended. This observation, along with observations noted by Tarrier and Sommerfield

(2004) and Harvey et al. (2003), emphasise the importance of long-term follow-up in order to accurately assess treatment outcome. Indeed, in another meta-analysis of controlled clinical trials, Sherman (1998) commented, at least tentatively, that the benefits of using hypnosis for PTSD might be noted at long-term follow-up rather than at the end of therapy.

5. AN OVERVIEW OF THE TYPES OF IMAGERY ALLUDED TO IN CBT NON-HYPNOTIC CONTEXTS.

The overview of imagery techniques described below confirms that there are remarkable similarities between non-hypnotic imagery interventions and hypnotic imagery interventions (Lynn, Meyer and Schindler, 2004; Kirsch et al, 1995) and also illustrates that a number of diverse non-hypnotic imagery techniques are used by practitioners that may not be so well represented in controlled experimental studies which necessitate use of standardised protocols (e.g. Foa and Rothbaum, 1998). In reviewing a selection of texts and journal articles that describe the use of imagery in CBT for the treatment of anxiety and PTSD, a variety of terms can be identified. These can be grouped broadly under the headings, relaxation, reliving, imagery rehearsal and symptom management.

5.1 Examples of imagery in non-hypnotic contexts

Relaxation

Some relaxation techniques, e.g. progressive relaxation (Lazarus,1989; Ost,1987), described in the CBT literature include those that use limited imagery. However, Palmer and Dryden (1995) describe a 'multimodal relaxation technique' that involves imagery of a favourite relaxing place and attending to sensory modalities (sight, sound, smell and touch).

Reliving

Typically, reliving techniques involve the client describing the trauma in the present tense as if it was happening in the 'here and now' (Jaycox et al, 2002; Tarrier and Humphreys, 2000). Whilst Foa and Meadows (1997) assert that this should be done in the absence of anxiety management, Palmer and Dryden (1995) describe reliving techniques to help clients tolerate fear, such as imaging the traumatic event as if the client is 'watching a film'.

'Image restructuring' (Layden, Newman, Freeman and Byers-Morse, 1993) and 'imagery rescripting' (Smucker, Dancu, Foa and Niederee, 1995) likewise require the client to describe the trauma in the present tense along with associated affect. Unlike the Foa and Meadows protocol (1997) the therapist helps the client to re-script the scenario so that it has a successful outcome. For example, if a client describes being abused as a child the therapist might introduce the concept of being protected, possibly by a significant other or the adult self. Such imagery techniques may evoke physical feelings experienced at the time.

Teasdale (1996) describes the use of imagery within his Interacting Cognitive Subsystems framework in which imagery is used to 'replay' early experiences (for example childhood abuse) from the perspective of the powerful adult in order to promote change at a more emotional, fundamental level than when addressing cognitions alone. Similarly, McGinn and Young (1996) describe a reliving technique used in Schema Focused Therapy which is designed to facilitate schematic change. The client is asked to visualise a scene from the past and then describe it vividly including how they looked at the time, time of day etc., and then asked to access feelings

associated with their 'newer part', for example, the self who is able to confront a punitive parent.

Reliving an anxiety-provoking situation may also form part of the assessment in order to elicit automatic thoughts (Clark, 1989) and access 'repressed or elusive beliefs' (Trower, Casey and Dryden, 1996, p74).

Imaginal rehearsal

The use of 'imaginal rehearsal' or 'time projection' techniques enable clients to experience situations with adaptive thoughts and feelings in order to enhance expectations of coping and mastery (Trower, Casey and Dryden, 1996; Palmer and Dryden, 1995). Similarly 'goal rehearsal', or 'coping imagery', is presented by Lazarus (1989) as visualisation of coping in particular situations.

Symptom management

Kennerley (1996) describes the use of 're-focusing' or 'grounding' techniques in which clients focus attention away from dissociative symptoms towards an image of a safe place that can be associated with relaxation (Kennerley, 1996). Similarly, in helping clients to master physical pain associated with a trauma, 'transformation imagery' techniques are suggested by Kennerly in which the client describes the physical sensation and then transforms this in a way that facilitates its removal from the body.

'Trauma coping imagery' (Sharpe, Tarrier and Rotundo, 1994; Palmer and Dryden, 1995) has been used to manage flashbacks, for example by changing the ending of the flashback by introducing the image of being hugged by someone that the client trusted.

5.2 Examples of imagery in hypnotic contexts

Relaxation

The use of hypnotic imagery to promote relaxation frequently involves imagery suggestions of a safe, special or private place and is sometimes used to mark the beginning of the hypnotic experience (Heap and Aravind, 2002; Karle and Boys, 1987). Ego-strengthening (i.e. confidence building) suggestions are often given during hypnotic relaxation (Heap and Aravind, 2002; Edmunds and Gafner, 2003). Metaphorical imagery is frequently used in hypnotic ego strengthening – such as imagery of obstacles being knocked away that could interfere with the client's determination to achieving helpful change (Gibbons, 1973).

Associated cues are used to enable clients to access calmness (or other helpful feelings) when these might be needed. The associated cue (e.g. a word chosen by the client) is paired in hypnosis with the desired emotion. With practice the association is strengthened and the targeted feeling can be brought back automatically by bringing to mind the cue. A post-hypnotic suggestion may be given in hypnosis to evoke the desired response in the person's everyday life (see Karle and Boys, 1987; Heap and Aravind, 2002; Alman and Lambou, 1992).

Reliving

The terms used for reliving in a hypnotic context include 'age regression' (Spinhoven, 1992) or 'hypnotic reliving' (Walters and Oakley, 2002). Examples include 'safe remembering techniques' such as imagery of being inside a protective bubble (Alden, 1995) whilst revisiting the scene of a trauma. The client is able to get out of the bubble and interact with the scene when they feel ready to do so. Both techniques involve cognitive restructuring, often through ego state techniques and provide the opportunity

for clients to experience retrospective comfort, usually from their 'older wiser self' (Dolan, 1997).

'Uncovering' is a technique used to elicit insights (Karle and Boys, 1987). Whilst this term has connotations of psychoanalytic therapy it can be used within any therapeutic framework. The safe remembering techniques described above may be also used in an open-ended way to identify particular issues. For instance, following a hypnotic induction (i.e. the 'ritual' that marks the beginning of the hypnotic procedure), it might be suggested to a client that they 'go back to a time that will be helpful to re-visit'. The use of finger signals might be included (i.e. 'ideo-motor responding'). The rationale for this technique is that these signals communicate directly with the unconscious mind (Karle and Boys, 1987). Ego state techniques (Watkins and Watkins, 1997) are used to facilitate cognitive re appraisal and thus make shifts in beliefs that underpin distress.

A technique called 'The Affect Bridge' (Watkins and Watkins, 1971) involves the client focussing on his or her heightened emotions whilst imagining a current anxiety-provoking situation, representative of their distress (e. g. an aspect of the trauma). The client is then asked to imagine walking across a bridge back in time to the source of this emotion so that cognitive reappraisal and emotional resolution can take place. Ego state techniques are used within this technique to enable clients to gain insights and receive retrospective comfort (Walters and Oakley, 2002, Watkins and Watkins, 1997).

Imaginal rehearsal

This technique is frequently referred to as 'age-progression' in the hypnosis literature (Hammond, 1990) and is used to enhance expectations of coping and accomplishment of a successful outcome (Heap and Aravind, 2002). Torem (1991) describes a

procedure called 'back from the future' in which clients experience going forward in time to when they have resolved their problem and then brings the associated good feelings back from the future into the present.

Symptom management

The use of self-hypnosis in symptom management is particularly well-documented in the hypnosis literature (Karle and Boys, 1987; Heap and Aravind, 2002; etc) and a self-help manual in training individuals to use this technique has been published (Alman and Lambrou, 1992). Self-hypnosis is commonly taught routinely at the beginning of therapy for PTSD (Walters and Oakley, 1999). The use of rapid self-hypnosis (Martinez-Tendero, Capafons, Weber and Cardena, 2001), a technique involving frequent but brief self-hypnosis, is often taught to manage anxiety symptoms. Nightmares can be treated by 'imaginal rehearsal' and 'image rescripting' (Kingsbury, 1993).

6. THE REPORTING OF IMAGERY TECHNIQUES IN CASE STUDIES

In order to further explore the use of imagery in hypnotic and non-hypnotic contexts, it was decided to examine case reports in which the use of imagery in the treatment of trauma has been described (see Appendix 1 and 2).

It had originally been intended to review a number of case reports written by British counselling and clinical psychologists and to select these from the relevant British peer reviewed journals. However, in contrast to expectations, there was a dearth of published case reports illustrating treatment for PTSD in UK psychological journals Thus the eight case reports sampled for review were identified from a wider search including British, American and Australian journals.

6.1 Types of traumas treated

The case reports examined from hypnosis journals included the use of hypnosis in the treatment of PTSD following childhood abuse, violent robbery, severe electric shock, life-threatening home invasion and witnessing a fatal accident. The case reports published in non-hypnosis journals included treatment of PTSD following rape, witnessing a fatal shooting, multiple trauma and violent assault.

6.2 Rationales given for the treatment used

All case reports published in non-hypnosis journals presented the use of exposure (imaginal and *in vivo*) techniques as being empirically supported for the treatment of PTSD. For example, Sharp and Espie (2004) referred to a review by Harvey, Bryant and Tarrier (2003) which concluded that exposure therapy is effective in improving PTSD symptoms. Jaycox, Zoellner and Foa (2002) quoted an article that supported the efficacy of CBT for PTSD and asserted that it is 'the most studied treatment' for PTSD (Foa and Meadows, 1997). Tolin and Foa (1999) made reference to a number of clinical trials that proved efficacy for exposure therapy (e.g. Fairbank and Keane, 1982; Keane, Fairbank Caddell and Zimering, 1989; Foa, Rothbaum, Riggs and Murdock, 1991; McCaffrey and Fairbank,1985). Feske (2001) stated that 'exposure therapy is the most fully documented effective treatment to date' and compared this to 'other efficacious treatments such as cognitive therapy and anxiety management training'.

In contrast, many of the hypnosis case reports presented a rationale for using hypnosis that drew links between the dissociative nature of PTSD and dissociation as a characteristic of hypnosis (Ffrench, 1997, Lumsden, 1999; Degun-Mather, 1997). The high hypnotisability of PTSD sufferers that is frequently reported in the literature (e.g. by Evans, 1994; Speigel, Hunt, and Dondershire, 1988, Stutman and Bliss, 1985) was

also given as a rationale for using hypnotic techniques (Ffrench, 1997) as was the client's positive attitude towards hypnosis (Lumsden, 1999) and the value of hypnotic safe-remembering techniques to help keep the client's distress to a minimum (Degun Mather, 1997). Whilst all authors made reference to studies that supported the techniques they used, this was noticeably understated in comparison to the case reports taken from non-hypnosis journals. Readers more familiar with the style of case reports published in journals such as the Journal of Clinical Psychology and Journal of Counselling Psychology, might expect more emphasis placed on reference to empirical support for the protocol presented than was found in the case reports published in the specialist hypnosis journals.

6.3 The therapeutic protocol and imagery techniques

Whilst all psychologists will be familiar with CBT techniques, by comparison, only a small number will be conversant with hypnotic techniques. However, it was evident that the hypnosis case reports had all been written for a specialist audience and had assumed the readers' prior knowledge of hypnosis. Some terms (e.g. 'induction', 'deepening', 'direct suggestion', 'trance', 'post-hypnotic suggestion') were introduced without explanation (e.g. Lumsden, 1999; Ffrench, 1997) and were not fully operationalised (Pekala and Kumar, 2000), a factor which may perpetuate a conception of hypnosis as being rather esoteric (if not unscientific) if read by psychologists unfamiliar with these terms. Likewise, the concept of hypnotic techniques, to facilitate 'communication with the unconscious mind' through the use ideomotor finger signalling, evident in all reports, was generally rather lacking in theoretical explanation and therefore risks creating impressions of hypnosis employing rather mysterious techniques.

Three of the authors using hypnosis had formally tested hypnotic suggestibility using the Stanford Hypnotic Clinical Scale (Morgan and Hilgard, 1975), which takes 30 minutes to administer and includes items that assess imaginative involvement. All reported on the client's feelings about the use of hypnosis in their therapy. In all case reports hypnotic imagery techniques were used following a formal induction procedure, for instance an 'eye fixation' procedure frequently marked the beginning of the procedure followed by imagery of a relaxing scene with reference to involvement of sensory modalities, anxiety reducing and ego-strengthening. Metaphorical techniques were used for ego strengthening by one author (Lumsden, 1999) in which energy was symbolised by 'breathing in' energy from the sun. Post-hypnotic suggestion (Ffrench, 1997) to increase expectations that positive feelings experienced during hypnosis could be accessed out of hypnosis was commonly used to encourage a sense of mastery.

All authors writing in the hypnosis journals reported using hypnotic imagery in the initial stages of therapy to reduce anxiety before confronting the trauma in age regression techniques. Methods included cue-controlled relaxation (Willshire, 1996; Ffrench, 1997) in which the client was taught to be able to induce relaxed feelings with the aid of an associated cue which had been rehearsed in hypnosis. All of these case studies used 'safe remembering' age regression techniques (Ffrench, 1997; Lumsden, 1999; Degun-Mather,1997; and Willshire1996). Following confrontation of the trauma some case reports described age progression techniques (Willshire, 1996; Lumsden, 1999) which enabled the client to experience a situation they had previously avoided. Numbers of sessions completed ranged between 5-14. Instructing clients to practice self-hypnosis to reduce anxiety daily was apparent in all case studies.

Addressing individual differences in imagery styles would seem essential in order for the therapist to help regulate clients' emotional engagement during prolonged exposure. However, in spite of the impact that imagery has on the activation of emotions, none of the case reports from the non-hypnosis journals measured imaginative abilities, for example by using the Vividness of Visual Imagery Questionnaire (Marks, 1973). The therapeutic protocol, used in the three PE case reports, all followed treatment manuals (Foa, Hearst-Ikeda, Dancu, Hembree and Jaycox, 1997; Foa and Rothbaum,1998) or, in the case of the image habituation training, followed a protocol published in a previous study (e.g.Vaughan and Tarrier,1992). Two studies reported that they had given a rational for treatment to the client. One case study (Jaycox et al, 2002) included a verbatim introduction to the treatment adapted from the original treatment manual (Foa and Rothbaum, 1998). The same study described how she had explained to her client that she [i.e. the client] 'would be in control of the process and she would be able to choose the pace of therapy' (p899). However, consistent with prolonged exposure treatment none of the protocols included instructions for relaxation during exposure.

The prolonged exposure treatment protocols included breathing retraining, a psychoeducational component, prolonged imaginal exposure (during a period of 45-60 minutes), *in vivo* exposure (in homework) and cognitive restructuring. Treatment involves 9 sessions although Jaycox et al (2002) comment that in non-research settings it may be beneficial for clients to receive more sessions. The image habituation training protocol consisted of one therapist-led training session prior to treatment which involved audio recording the client describing the trauma in five separate sentences followed by a 30 second period of silence in which the client was asked to visualise the trauma as intensely as possible. Each audio recorded sentence was presented six times.

The client was instructed to repeat this procedure twice each day over the next five days.

6.4 Reasons stated for the therapeutic outcome

Both hypnosis and non-hypnosis case studies reported successful outcomes. Rationales given for the success of therapy in the hypnosis case studies included the effectiveness of hypnosis to facilitate state dependent memories (Degun Mather, 1997) and all reported that hypnotic interventions successfully prevented unnecessary distress. For example, the use of hypnotic techniques to facilitate temporary dissociation and thus to allow gradual and controlled exposure through the use of safe remembering techniques (Degun-Mather, 1997). Other reasons given for the success of therapy included the use of hypnotic techniques to enhance desensitisation and ego strengthening (Willshire 1996; French, 1997) and to facilitate cognitive reappraisal through hypnotic imaginal exposure (Degun Mather, 1997; Lumsden, 1999). A frequent comment was that hypnosis increased expectations of recovery and thus capitalised on high levels of motivation.

In the non-hypnosis case reports, Jaycox et al (2002) and Sharp and Espie (2004) observed that modification of dysfunctional beliefs took place without any interventions that addressed cognitions and hypothesised that focussing on the trauma narrative facilitated more realistic appraisal. Feske (2001) noted that prolonged exposure, whilst effective in reducing core PTSD symptoms did not address other problems. This author suggests that a two-stage protocol (such as that designed by Cloitre, 1998), in which affect and interpersonal regulation skills are taught prior to exposure so that PTSD-related exposure, is better tolerated. Tolin and Foa (1999) reasoned that treatment success demonstrated in their case study was partly to due to imaginal and *in vivo*

exposure techniques which enabled the client to believe that nothing terrible would happen when confronting the fear.

7. WHAT, IF ANYTHING, DOES HYPNOSIS ADD TO THE USE OF IMAGERY IN THE TREATMENT OF PTSD?

A pivotal intervention in the treatment of PTSD illustrated in this review, both in non-hypnotic and hypnotic imagery interventions, involves exposure to traumatic memories in order to invoke emotions experienced at the time of the trauma. It would seem that protocols used in non-hypnosis experimental studies often employ reliving techniques such as those described by Foa and Rothbaum (1998). However, it should be noted that, according to the broader literature it is likely that CBT therapists also use a wider range of imagery techniques (e.g. as described by Kennerley, 1996). Whilst case studies and experimental studies reviewed here demonstrate that both hypnotic and non-hypnotic imagery is evidently rooted in exposure and emotional processing theories, psychologists using hypnotic imagery techniques are also strongly influenced by theories drawn from the hypnosis literature. This influence is now examined in context with findings of this review.

7.1 The hypnotic induction

It was noted earlier that clinicians using hypnosis often include a hypnotic induction such as eye fixations or 'special place' imagery. Induction procedures are generally considered useful in formalising the beginning of the hypnotic routine and in capitalising on increasing the client's expectations associated with the hypnotic context. Indeed, it has long been known that the label of hypnosis may considerably influence the experience of suggestion. For example, some 30 years ago Lazarus (1973b) noted that labelling a procedure as relaxation resulted in less clinical improvement than when

it was called hypnosis. Similarly, Kirsch (1999) has drawn attention to the therapeutic advantage of the hypnotic context, identifying a number of studies that have shown the effect of expectancy on responsiveness to suggestion (e.g. Kirsch, Council and Mobayed, 1987; Wickless and Kirsch, 1989).

Interestingly, a recent study by Gandhi and Oakley (2005) has indicated that the induction procedures such as those illustrated in the case reports reviewed are not strictly necessary. In a controlled experiment involving 105 participants, they examined the effect that the label 'hypnosis' has on suggestibility. Using an identical procedure in two conditions, one labelled 'hypnosis' and the other 'relaxation', the authors found a significant increase in suggestibility following the hypnosis condition whereas the relaxation condition resulted in only a modest increase. These results demonstrate that it is the hypnotic context (i.e. the individual's beliefs and expectations about hypnosis) that is key to responsiveness to suggestion, rather than the procedure itself.

7.2 The experience of hypnosis

It has previously been noted that hypnotic and non-hypnotic imagery techniques are strikingly similar, for example Kennerley's (1996) use of non-hypnotic imagery to manage dissociative symptoms are very similar to hypnotic techniques described in the hypnosis literature. However, the client's experience of hypnotic imagery techniques is likely to be intrinsically different to similar non-hypnotic techniques depending on whether the label hypnosis has been used and whether the therapist has taken into consideration the client's individual style of responding to suggestion.

Psychologists using hypnosis in the case reports reviewed here were mindful of individual differences in responding to hypnotic imagery suggestions and noted that PTSD sufferers have generally been found to be high in hypnotic suggestibility (Spiegel and Spiegel, 1978; Evans, 1994; Spiegel Hunt and Dondershine, 1988). The use of hypnotisability scales, such as the Stanford Hypnotic Clinical Scale (Morgan and Hilgard, 1975) referred to in the hypnosis case reports reviewed, enables psychologists to gather rich information regarding their clients' subjective response to suggested imagery (Council, 1999) which can be used to enhance responsiveness and thus emotional engagement.

Indeed, the high hypnotisability of PTSD sufferers is a factor that may facilitate particular involvement in the highly intuitive and intensely emotional experience characteristic of hypnosis, considered by Fromm (1992) to reflect primary process thinking. Moreover, recent neuroimaging studies have shone further light on hypnotic experience. For example, the use of hypnotic suggestion with highly hypnotisable individuals can lead to profound changes of experiences in which hypnotically suggested events trigger brain mechanisms very similar to those activated when actually experiencing the event (Szechtman, Woody, Bowers and Namias, 1998). The same brain effects are not seen when the participants were asked to imagine the same events. Similarly, Derbyshire et al (2003) found considerable similarity in brain activation during hypnotically and physically induced pain, but not during imagined pain.

It has been noted that the hypnotic experience is very similar to that described by individual's who have experienced virtual reality environments (Walters and Oakley, 2003). A particular characteristic of these experiences is 'immersion' which can be compared to emotional engagement, a factor noted by Jaycox et al, (2002) to be

predictive of good therapeutic outcome. Importantly, there is also a sense that the person really knows that the VR environment or hypnotically suggested scenario is not real as if 'a part of the person' is monitoring the situation which remains not engaged (Hilgard, Morgan and Macdonald, 1975), a factor which may assist safe remembering. It has been noted that the client's beliefs and expectations of hypnosis will influence their subjective experience. Similarly, the therapist's beliefs about what hypnosis can achieve will influence their confidence in the techniques that they use (Strauss, 1997). Experiential learning is an important component in hypnosis training and psychologists using hypnosis are likely to have experienced at first hand a range of hypnotic phenomena (Wark and Kohen, 2002). Thus, the context of hypnosis will have considerable influence on the therapist's delivery of imagery interventions, for example by softening their tone of voice and facilitating heightened engagement in the procedure. This, in turn, influences the client's experience. Yapko (1989) has suggested that hypnotic communication acts as a "catalyst" for helping clients to use resources which they were previously unaware of and emphasises the importance of the therapeutic relationship in influencing subjective experience of the client. He describes a highly tuned interdependence between hypnotist and client, 'each following the other's leads whilst at the same time leading.' (Yapko, 1989, p64).

7.3 Hypnotic phenomena

Whilst imagery techniques are generally transferable across therapeutic models, techniques utilising hypnotic phenomena, such as ideomotor responses (finger signalling) illustrated in the hypnosis case reports reviewed, are unique to hypnotic procedures (Heap and Aravind, 2002). Other examples of hypnotic phenomena, such as arm levitation and post-hypnotic suggestion can also be used therapeutically. For example, imagery of a balloon tied to a wrist may result in the arm rising involuntarily,

an experience not usually possible if the person did not believe that they were 'in hypnosis' (Heap and Aravind, 2002). Response to post hypnotic suggestion can be accounted for by response expectancy (Kirsch and Council, 1992) and enables appropriate imagery to be activated automatically at times when it is needed by the client. Used therapeutically, such techniques may increase expectations that 'hypnosis is working for me'.

7.4 Using hypnosis to facilitate clients' tolerance of relieving techniques

It would seem that the successful use of hypnotic safe-remembering procedures reported in the literature challenges assertions that prolonged exposure should be carried out in the absence of techniques to reduce distress (Craighead, Craighead, Kazdin and Mahoney, 1994) or that participants need to describe their traumatic experience in great detail (Nishith, Resick and Griffin, 2002). Indeed, examples of reliving techniques drawn from the hypnosis literature frequently make reference to 'remembering only what is necessary for healing' (Degun Mather, 1997) and caution against the unnecessary eliciting of details about the trauma (Spiegel, 1997; Dolan,1991). Most importantly, since no one therapy can claim overall superiority in the treatment of PTSD (Solomon and Johnson, 2002), ethical principles should guide therapists to use therapeutic interventions that cause clients least distress.

According to results of a survey conducted in the USA less than 50% of therapists trained and experienced in the treatment of PTSD use imaginal exposure in the treatment of PTSD (Black Becker, Zayfert, and Anderson, 2004). The authors of the survey conclude that the reasons for this may include nervousness about possible contraindications (such as symptom exacerbation) and express their concern that therapists' 'erroneous beliefs' may prevent clients from receiving appropriate treatment.

Similarly, negative remarks based on erroneous beliefs about hypnosis (Deacon and Abramowitz, 2004) have hindered the opportunity for clients to receive therapy for PTSD, including hypnotic interventions that ensure safe and comfortable exposure to trauma.

8. CONCLUSION

Whilst there a number of procedural differences between hypnotic and non-hypnotic uses of imagery, this would seem largely related to the historical association of certain techniques with particular therapeutic models. However, an increasing blurring of the differences between therapeutic models (Palmer and Woolfe, 2000) has begun to challenge who owns which technique. Furthermore, therapists are sometimes unaware that the techniques they use are also used by therapists subscribing to other therapeutic models.

However, it is suggested here that even if clinicians use techniques that are similar to hypnotic techniques, it would be erroneous to suggest that they are using hypnosis unknowingly, or that clients can 'slip into' hypnosis during, for example, non-hypnotic relaxation techniques since the crucial difference between hypnotic and non-hypnotic imagery interventions is essentially facilitated by the labelling of the procedure. Thus non-hypnotic relaxation techniques, meditative techniques, even daydreaming, etc may be 'trance-like' but are not 'hypnotic'. Similarly, therapeutic suggestions may be given in a non-hypnotic context but are likely to be experienced differently if they are suggested in a hypnotic context (e.g. Lazarus, 1973b). The distinctions between trance and hypnosis, as well as suggestion and hypnosis are important.

The hypnotic context could be described as serving to fuse trance and suggestion together, a fusion that facilitates an experience transcending the non-hypnotic

experience. A particular characteristic of this experience appears to be a difficulty in finding words to describe it, though it is often reported to feel deeply involving and 'real'. Indeed, clinicians should not underestimate the profound effect that the hypnotic context may have on the intrapsychic experience such as heightened engagement, a range of hypnotic phenomena and various complex cognitive processes (Brown and Oakley, 2004). The application of imagery in the context of hypnosis to the treatment of PTSD, as well as other clinical problems, thus requires specialist knowledge in order to manage the experience that the client has entered into; to fully understand both the possibilities and limitations of the hypnotic experience; and to devise appropriate methods that fully exploit the use of hypnotic imagery.

Cardena (2000) comments that the lack of systematic research on the use of hypnosis is a cause for concern. More controlled studies using hypnotic imagery are, indeed, necessary to asses its value as an adjunctive tool in therapy and to enable therapists using hypnosis to benefit from a similar weight of empirical evidence to that which has given credibility to more widely researched interventions. Moreover, any research carried out should explicitly indicate which therapeutic model the imagery techniques were applied to in order to ensure that hypnosis is accurately represented as an adjunctive procedure to established treatments rather than a therapy in itself. It should also more adequately define the hypnotic techniques involved in context with relevant hypnosis theories.

It is suggested that the above recommendations would help to clarify exactly what we are doing.

REFERENCES:

Alden, P. (1995). Back to the past: Introducing the 'bubble'. *Contemporary Hypnosis, 12,* 59-68.

Alman, B. M. and Lambrou, P. (1992) *Self-hypnosis: The Complete Manual for Health and Self-change* (2nd Ed), New York & London: Brunner Routledge.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition.* Washington, DC, American Psychiatric Association.

Barber, T. X., Spanos N. & Chaves, J. (1974). *Hypnosis: Imagination and human potentialities,* New York: Pergamon.

Barber, T. X. & Wilson, S. C. (1978). The Barber Suggestibility Scale and the Creative Imagination Scale: Experimental and clinical applications. *American Journal of Clinical Hypnosis, 21,* 84-108.

Black Becker, C., Zayfert, C. and Anderson, E. (2004). A survey of psychologists' attitudes towards and utilisation of exposure therapy for PTSD *Behaviour Research Therapy, 42(3),* 277-292.

Brom, D. Kleber, and Defare, P. (1989). Brief psychotherapy for posttraumatic stress disorders *Journal of Consulting and Clinical Psychology, 57,* 607-612.

Brown, D.P. and Fromm, E. (1986) *Hypnotherapy and hypnoanalysis,* Hillsdale NJ: Erlbaum.

Brown, R. & Oakley, D. (2004). An integrative cognitive theory. In M. Heap, R. Brown and D. Oakley (Eds.) *The highly hypnotisable person* East Sussex: Brunner-Routledge.

Cardena, E. (1995). Dissociativity in Gulf War PTSD patients. *International Journal of Clinical and Experimental Hypnosis, 44,* 394.

Cardena, E. (2000). Hypnosis in the treatment of trauma: A promising, but not fully supported, efficacious intervention. *International Journal of Clinical and Experimental Hypnosis, 48,* 221-234.

Clark, D. M. (1989). Anxiety States: Panic and Generalised Anxiety. In K. Hawton, P. M. Salkovskis, J. Kirk, D. M. Clark (Eds.) *Cognitive behaviour therapy for psychiatric problems: A practical guide,* Oxford: Oxford University Press.

Cloitre, M.(1998). Sexual revictiminisation: Risk factors and prevention. In V.M.Follette, J.I. Ruzek and F.R. Abueg (Eds.) *Cognitive-behavioural therapies for trauma* (278-304). New York: Guildford.

Council, J. (1999). Measurement and modification of hypnotic responsiveness. In I.Kirsch, A.Capafons, E. Cardena-Buelna. And S. Amigo (Eds.) *Clinical hypnosis and self-regulation: Cognitive-behavioural perspectives* Washington: American Psychological Association.

Craighead, L., Craighead, W. E., Kazdin, A. and Mahoney, M. J. (1994). *Cognitive and behavioural interventions: An empirical approach to mental health problems* Massachusetts: Allyn and Bacon.

Crawford, H. J. and Allen, S.N. (1983). Enhanced visual memory during hypnosis as mediated by hypnotic responsiveness and cognitive strategies. *Journal of Experimental Psychology: General, 112,* 662-685.

Crawford, H.J., Wallace, B., Normura, K. and Slater, H. (1986). Eidetic-like imagery in hypnosis: Rare but there. *American Journal of Psychology, 99,* 527-546.

Crawford, H. J. (1994). Brain dynamics and hypnosis: Attentional and disattentional processes. *International Journal of Clinical and Experimental Hypnosis, 42,* 204-32.

Deacon, B.J. & Abramowitz, J.S. (2004). Cognitive and behavioural treatments for anxiety disorders: A review of meta-analytic findings. *Journal of Clinical Psychology, 60,* 429-441.

Degun-Mather, M. D. (1997). The use of hypnosis in the treatment of post-traumatic Stress disorder in a survivor of multiple childhood trauma. *Contemporary Hypnosis 14,* 100-104.

Derbyshire, S.W.G, Whalley, M.G., Stenger, V.A., Oakley, D.A. (2004). Cerebral activation during hypnotically induced and imagined pain. *NeuroImage, 23,* 392-401

Devilly, G. J. and Foa, E.B. (2001). The investigation of exposure and cognitive therapy: Comment on Tarrier et al. (1999). *Journal of Consulting and Clinical Psychology, 69,* 114-116.

Dolan, Y. (1991). *Resolving Sexual Abuse*. New York: Norton.

Edmunds, D. and Gafner, G. (2003). Touching trauma: combining hypnotic ego strengthening and zero balancing. *Contemporary Hypnosis, 20,* 215-220.

Evans, B.J. (1994). Understanding post-traumatic stress disorder: Treatment implications. In B. J. Evans (Ed.) *Hypnosis in the management of anxiety disorders* (951-76). Heidelberg: Australian Society of Hypnosis.

Evans, B.J. (2003). Hypnosis for posttraumatic stress disorders *Australian Journal of Clinical and Experimental Hypnosis, 31,* 54-73.

Fairbank, J.A. and Keane, T. M. (1982). Flooding for combat-related stress disorders: Assessment of anxiety reduction across traumatic memories. *Behaviour Therapy, 13,* 499-510.

Feske, U. (2001). Treating low-income and African- American women with posttraumatic stress disorder: A case series *Behaviour Therapy, 32,* 585-601.

French, C. (1995). The meaning of trauma: Hypnosis and PTSD, *Australian Journal of Clinical and Experimental Hypnosis, 23,* 113-123.

Ffrench, C. (1997). Hypnotherapeutic treatment of PTSD following severe electric shock *Hypnos, XXIV*, 19-24.

Foa, E. B., and Kozak, J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20-35.

Foa, E.B., Steketee, G. and Rothbaum, B.O. (1989). Behavioural / cognitive conceptualisation of post-traumatic disorder *Behaviour Therapy, 20,* 155-176.

Foa, E.B., Rothbaum, B. O., Riggs, D. S. and Murdock, T.B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioural procedures and counselling. *Journal of Consulting and Clinical Psychology, 59,*715-723.

Foa, E. (1995). Posttraumatic Stress Diagnostic Scale. USA: *National Computer Systems, Inc.*

Foa, E. B. & Rothbaum, B. O. (1997). *Treating the Trauma of Rape*. New York: Guilford Publications, Inc.

Foa, E. B. and Meadows, E.A. (1997). Psychosocial treatments for posttraumatic stress disorder. A critical review. *Annual Review of Psychology, 48*, 449-480.

Foa, E. B., Hearst-Ikeda, D.E., Dancu, C. V., Hembree, E. A., and Jaycox, L. H. (1997). *Prolonged exposure (PE) manual.* Unpublished document, Eastern Pennsylvania Psychiatric Institute, Allegheny University of the Health Sciences.

Foa, E.B. and Rothbaum, B.O. (1998). *Treating the trauma of rape: A cognitive-behavioural therapy for PTSD* New York: Guildford.

Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms? *Journal of Consulting and Clinical Psychology, 70,* 1022-1028.

Friedman, H., Taub, H.A., Sturr, J.F., and Monty, R. A. (1987). Visual information processing speed in hypnotised and nonhypnotised subjects *Journal of General Psychology, 114,* 363-372.

Fromm, E. (1992) An ego-psychological theory of hypnosis. In Fromm, E. & Nash, M. (Eds.) *Contemporary Hypnosis Research* New York: The Guildford Press.

Gandhi, B. and Oakley, D. (In press). Does 'hypnosis' by any other name smell as sweet? The efficacy of 'hypnotic' induction depends on the label 'hypnosis'. *Consciousness and Cognition.*

Gibbons, D. (1973) *Beyond Hypnosis: Explorations in hyperempiria.* NJ: Power Publishing Co.

Grunert, B.K., Smucker, M.R., Weis, J.M. and Rusch, M.D. (2003). When prolonged exposure fails: adding an imagery-based cognitive restructuring component in the treatment of industrial accident victims suffering from PTSD. *Cognitive Behaviour and Practice, 10,* 333-346

Gruzelier, J. (1998), A working model of the neuropsychophysiology of hypnosis: A review of evidence. *Contemporary Hypnosis, 15,* 5-23.

Hammond D. C. (1990). Handbook of hypnotic suggestions and metaphors New York: Norton.

Harvey, A.G., Bryant, R.A. & Tarrier, N. (2003) Cognitive behaviour therapy for posttraumatic stress disorder *Clinical Psychology Review, 23,* 377-407.

Heap, M., Brown, R. J. & Oakley, D. A. (2004). High hypnotisability: Key issues. In M. Heap, R. Brown and D. Oakley (Eds.) *The Highly Hypnotisable Person* East Sussex: Brunner-Routledge, pp3-29.

Heap, M. & Aravind, K. (2002). *Hartland's Medical and Dental Hypnosis,* Fourth Edition Edinburgh: Churchill Livingstone.

Heap, M. (1996)

Hembree, E. A., Foa, E. B., Dorfan, N.M., Street, G. P., Kowalski, J. and Tu, X. (2003) Do Patients Drop Out Prematurely from Exposure Therapy for PTSD? *Journal of Traumatic Stress, 16,* 555-562.

Hilgard, E.R. (1979). Divided consciousness in hypnosis: The implications of the hidden observer, In Fromm and R.E. Shor (Eds.) *Hypnosis Developments in Research and New Perspectives,* 2nd edition, 45-79, New York: Aldine.

Hilgard, E.R., Morgan, A.H. and Macdonald, H. (1975). Pain and dissociation in the cold pressor test: A study of hypnotic analgesia with "hidden reports" through automatic key pressing and automatic talking. *Journal of Abnormal Psychology, 84,* 280-289.

Holroyd, J. (1992). Hypnosis as a methodology in psychological research. In E. Fromm and M. Nash (Eds.) *Contemporary hypnosis research* New York: The Guildford Press.

Horowitz, M. J., Wilner, N. & Alvarez, W.A. (1979). Impact of Events Scale: A measure of subjective stress *Psychosomatic Medicine, 41,* 209-218.

Jaycox, L. H., Zoellner, L. A., & Foa, E. B. (2002). Current Perspectives: Cognitive behavior therapy for PTSD in rape survivors *Journal of Clinical Psychology, 58,* 891-906.

Jaycox, L.H., Foa, E.B. and Morral, A.R. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of Consulting and Clinical Psychology, 66,* 185-192.

Karle, H. & Boys, J. (1987). *Hypnotherapy: A practical handbook.* London: Free Association Books.

Keane, T. M., Fairbank, J.A., Caddell, J.M., and Zimering, R.T. (1989) Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans *Behaviour Therapy, 20,* 245-260.

Kennerley, H. (1996). Cognitive therapy of dissociative symptoms associated with trauma *British Journal of Clinical Psychology, 35,* 325-340.

Kingsbury, S. J. (1993). Brief hypnotic treatment of repetitive nightmares *American Journal of Clinical Hypnosis, 35,* 161-169.

Kirsch, I., Council, J. and Moyabed, C. (1987). Imagery and response expectancy as determinants of hypnotic behaviour *British Journal of Experimental and Clinical Hypnosis, 4,* 25-31.

Kirsch, I. & Council, J. (1992). Situational and personality correlates of hypnotic responsiveness. In Fromm, E. & Nash, M. (Eds.) *Contemporary hypnosis research* New York: The Guildford Press.

Kirsch, I., Montgomery, G., and Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 63,* 214-220.

Kirsch, I. (1999). Clinical hypnosis as a non-deceptive placebo. In I.Kirsch, A.Capafons, E. Cardena-Buelna. and S. Amigo (Eds.) *Clinical hypnosis and self-regulation: Cognitive-behavioural perspectives* Washington: American Psychological Association.

Kirsch, I, (1991). The social learning or hypnosis: What do our scales really measure? *International Journal of Clinical and Experimental Hypnosis, 45,* 212-225.

Layden, M. A., Newman, C. F., Freeman, A. and Byers-Morse, S. (1993). *Cognitive therapy of borderline personality disorder* Needham Heights, MA: Allyn and Bacon.

Lazarus, A. A. (1973b). "Hypnosis" as a facilitator in behaviour therapy *The International Journal of Clinical and Experimental Hypnosis, 21,* 25-31.

Lazarus, A. A. (1989). *The Practice of Multimodal Therapy: Systematic, Comprehensive and Effective Psychotherapy* Baltimore: John Hopkin University Press.

Levitt, E. E. (1993) Hypnosis in the treatment of obesity. In S. J.Lynn, J.W., Rhue and S.J. Lynn (Eds.) *Handbook of clinical hypnosis* Washington, DC: American Psychological Association.

Lumsden, A. (1999). Treatment of PTSD utilising CBT and hypnotherapy *Australian Journal of Clinical and Experimental Hypnosis, 27,* 150-157.

Lynn, S. J. Meyer, E. and Shindler, K. (2004). Clinical correlates of high hypnotisablity In M. Heap, R. Brown and D. Oakley (Eds.) *The highly hypnotisable person* East Sussex: Brunner-Mazel.

MacKovec, F. (1984). The use of brief hypnosis for posttraumatic stress disorder: Emotional First Aid, *A Journal of Crisis Intervention, 1,* 14-22.

Marks, D. F. (1973). Visual imagery differences in the recall of pictures. *British Journal of Psychology, 64,* 17-24.

Martinz-Tendero, J., Capafons, A. Weber, V. and Cardena, E. (2001). Rapid self-hypnosis: new self-hypnosis method and its comparison with the hypnotic induction profile (HIP). *American Journal of Clinical Hypnosis*, 44 , 3-11.

McCaffrey, R.J. and Fairbank, J. A. (1985). Behavioural assessment and treatment of accident-related posttraumatic stress disorder: Two case studies. *Behaviour Therapy, 16,* 406-416.

McGinn. L.K. and Young. J.E. (1996). Schema-focused therapy. In P. Salkovskis (Ed.) *Frontiers of cognitive therapy* New York: The Guildford Press.

Meichenbaum, D. H. (1975). Self-instructional methods. In *Helping people change: a textbook of methods* (Ed. F.H. Kanfer and A.P. Goldstein) 357-91.New York: Pergamon.

Morgan, A. H. and Hilgard, J.R. (1975) Stanford Hypnotic Clinical Scale (SHCS). In E. R. Hilgard and J. R. Hilgard, *Hypnosis in the relief of pain* (209-221). Los Altos, CA: William Kaufman.

Nadon, R., Laurence, J. and Perry, C. (1987). Multiple predictors of hypnotic susceptibility, *Journal of Personality and Social Psychology, 53,* 948-960. *Neuropsychiatry, 4,* 243-265.

Nishith, P., Resick, P.A. and Griffin, M.G. (2002). Pattern of change in prolonged exposure and cognitive-processing therapy for female rape victims with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 70,* 880-886.

Oakley, D. A. (1999a). Hypnosis and conversion hysteria: A unifying model. *Cognitive Neuropsychiatry, 4,* 243-265.

Oakley, D.A., Alden, P. and Degun Mather, M. (1996) The use of hypnosis in therapy with adults *The Psychologist, 9 (11),* 502-505.

Ost, L.G. (1987). Applied relaxation: description of a coping technique and review of controlled studies. *Behaviour Research and Therapy, 25,* 397-410.

Palmer, S. and Dryden, W. (1995) *Counselling for stress problems*, London: Sage.

Palmer, S. and Woolfe, R. (Eds.) (2000). *Integrative and eclectic counselling and psychotherapy,* London: Sage.

Pekala, R.J. and Kumar, V. K. (2000). Operationalising "Trance" I: Rational and research using a psychophenomenological approach. *American Journal of Clinical Hypnosis, 43,* 107-135.

Pertaub, D-P. Slater, M. and Barker, C. (2001b). *An experiment on public speaking anxiety in response to three different types of virtual audience* Presence: Teleoperators and Virtual Environments, MIT Press.

Phillips, M. (1993). Turning symptoms into allies: Utilisation approaches with posttraumatic symptoms *American Journal of Clinical Hypnosis, 35,* 179-169.

Pitman, R. K., Altman, B., Greewald, E., Longpre, R. E., Macklin, M. L., Poire, R. E. and Steketee, G.S.(1991). Psychiatric complications during flooding therapy forposttraumatic stress disorder *Journal of Clinical Psychiatry, 52,*17-20.

Rachman, S. (1995). Emotional processing in anxiety disorders. In Craig, K. and Dobson,S. (Eds.) *Anxiety and depression in adults and children*. USA: Sage.

Rainville, P., Duncan, G. H., Price, D.D., Carrier, B., and Bushnell, C. (2002). 'Pain affect encoded in human anterior cingulated but not somasensory cortex', *Science, 277,* 969-971.

Rothschild, B. (2005). Applying the breaks. *Counselling and Psycotherapy Journal, 16,* 12-16.

Sharp, J. and Espie, C. A. (2004). Brief exposure therapy for the relief of posttraumatic stress disorder: A single case experimental design. *Behaviour and Cognitive Psychotherapy, 32,* 365-371.

Sharpe, L., Tarrier, N. & Rotundo, N. (1994). Treatment of delayed post-traumatic stress disorder following sexual abuse: A case example. *Behavioural and Cognitive Psychotherapy, 22,* 233-242.

Shapiro, F. (1995) *Eye movement desensitisation and reprocessing: Basic principles, protocols, and procedures*. New York: Guidford Press.

Sherman, J. J. (1998). Effects of psychotherapeutic treatment for PTSD: A meta-analysis of controlled clinical trials *Journal of Traumatic Stress, 11,* 413-436.

Solomon, S. and Johnson, D. (2002). Psychosocial treatment of posttraumatic stress disorder: A practice friendly review of outcome research. *Journal of Clinical Psychology / In Session: Psychotherapy in Practice, 58,* 947-959.

Spanos, N.P. (1986) Hypnosis and the modification of hypnotic susceptibility: A social psychological perspective. In P.N.J. Naish (ed) *What is Hypnosis? Current Theories and Research,* Milton Keynes: Open University Press. pp. 85 – 120.

Spiegel, H. and Speigel, D. (1978). *Trance and treatment: Clinical uses of hypnosis.* New York: Basic Books.

Spiegel, D., Frischolz, E.J., Maruffi, B., and Spiegel, H. (1981). Hypnotic responsivity and the treatment of flying phobia. *American Journal of Clinical Hypnosis, 23,* 239-247.

Spiegel, D., Hunt, T. & Dondershire, H. E. (1988). Dissociation and hypnotisability in posttraumatic stress disorder. *American Journal of Psychiatry, 145,* 301-305.

Spiegel, D., Frischolz, E.J., Fleiss, J.L. and Spiegel, H. (1993). Predictors of smoking abstinence following a single session restructuring intervention with self-hypnosis. *American Journal of Psychiatry, 150,* 1090-1097.

Spiegel, D. (1997). Hypnosis in the treatment of post-traumatic disorders. In Rhue, J., Lynn, S., and Kirsch, I. (Eds.), *Handbook of Clinical Hypnosis*. Washington, DC: American Psychological Association.

Spinhoven, P. and van Wijk, J. (1992). Hypnotic age regression in an experimental and clinical context *American Journal of Clinical Hypnosis, 35,* 40-46.

Smucker, M.R., Dancu, C. Foa, E. B., Niederee, J. L. (1995). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress *Journal of Cognitive Psychotherapy: An International Quarterly, 9.*

Strauss, B.S. (1991). The use of a multimodal image, the apple technique, to facilitate clinical hypnosis: A brief communication. *International Journal of Clinical and Experimental Hypnosis, 39,* 1-5.

Stutman, R. K. & Bliss, E. L. (1985). Posttraumatic stress disorder, hypnotisability, and imagery. *American Journal of Psychiatry, 142,* 741-743.

Szechtman, H., Woody, E., Bowers, K. S., and Namias, C. (1998). Where the imaginal appears real: A positron emission topography study of auditory hallucinations. *Proceedings of the National Academy of Science, 95,* 1956-1960.

Tarrier, N. and Humphreys, L. (2000). Subjective improvement in PTSD patients with treatment by imaginal exposure or cognitive therapy: Session by session changes. *British Journal of Clinical Psychology, 39,* 27-34.

Tarrier, N. and Somerfield, C. (2004) Treatment of chronic PTSD by cognitive therapy and exposure: 5-year follow-up *Behaviour Therapy*, 35, 231-246.

Tarrier, N., Pilgrim,H., Sommerfield, C., Faragher , B., Reynolds, M., Graham, E., and Barraclough, C. (1999). A randomised trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 67,* 13-18.

Teasdale, J.D. (1996). Clinically relevant theory: Integrating clinical insight with cognitive science. In P. Salkovskis (Ed.) *Frontiers of cognitive therapy* New York: The Guildford Press.

Tolin, D. F. and Foa, E. B. (1999). Treatment of a police officer with PTSD using prolonged exposure *Behaviour Therapy, 30,* 527-538.

Torem, M. S. (1991) "Back from the future": A powerful age-progression technique *American Journal of Clinical Hypnosis, 35,* 81-88.

Trower, P. Casey, A. and Dryden, W. (1988). *Cognitive-behavioural counselling in action,* London: Sage.

Van Etten, M.L. and Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: a meta-analysis *Clinical Psychology & Psychotherapy, 5,* 126-144.

Van der Hart, O. and Spiegel (1993). Hypnotic assessment and treatment of trauma-induced psychoses: The early psychotherapy of H. Breukink and modern views. *International Journal of Clinical and Experimental Hypnosis, 41*, 191-209.

Vaughan, K. and Tarrier, N. (1992). The use of image habitation training with post-traumatic stress disorder. *British Journal of Psychiatry, 161*, 658-664.

Vermetten and Bremner (2004). Functional brain imaging and the induction of traumatic recall: A cross-correlational review between neuroimaging and hypnosis. *The International Journal of Clinical and Experimental Hypnosis, 52,* 280-312.

Vijselar, J., and Van der Hart, O. (1992). The first report of hypnotic treatment of traumatic grief: A brief communication. *International Journal of Clinical and Experimental Hypnosis, 40,* 1-6.

Wagstaff, G. F. (1991). Compliance, belief and semantics in hypnosis: A non-state, sociocognitive perspective. In S.J. Lynne and J.W. Rhue (Eds.) *Theories of Hypnosis: Current Models and Perspectives*, New York: Guilford Press, pp 362-396.

Walters, V. J., & Oakley, D. A., (2003) Hypnosis as a possible virtual reality context for the treatment of an environmental phobia. *Clinical Case Studies, 2*, 295-305.

Walters, V.J. & Oakley, D.A. (2002). Hypnosis in post-abortion distress: An experimental case study. *Contemporary Hypnosis, 19,* 85-99.

Wark, D.M. and Kohen, D.P. (2002) A spiral curriculum for hypnosis training. *American Journal of Clinical Hypnosis, 45,*119-128.

Watkins, J. G. (1971). The affect bridge: A hypnoanalytic technique. *International Journal of Clinical and Experimental Hypnosis, 19,* 21-27.

Watkins, J. G., and Watkins H. H. (1997). *Ego States: Theory and Therapy.* New York: Norton.

Wickless, C. and Kirsch, I. (1989). The effects of verbal and experiential expectancy manipulations on hypnotic susceptibility. *Journal of Personality and Social Psychology, 57,* 762-768.

Willshire, D. (1996). Trauma and treatment with hypnosis. *Australian Journal of Clinical and Experimental Hypnosis, 24,* 125-136.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition.* California: Stanford University Press.

Wolpe, J. (1961). The systematic desensitisation treatment of neurosis *Journal of nervous and mental diseases 132,* 189-203.

Woody and Bowers, (1994). A frontal assault on dissociated control In S.J. Lynn and J.W. Rhue (Eds.) *Dissociation: Clinical and Theoretical Perspectives,* New York: Guildford Press, pp 55-9.

Yapko, M. D. (1995) *Essentials of Hypnosis*. New York: Brunner/Mazel.

APPENDIX 1

Hypnosis Case studies: PTSD

Author	Type of trauma	Gender / age	Number of sessions	Hypnotic techniques used	Assessment of PTSD / hypnotic suggestibility
Degun Mather,M. (1997)	3 experiences of violent robbery in childhood.	Female 20 years	14 No follow-up reported	Formal induction (safe place) Self-hypnosis Ideomotor finger signalling Safe remembering age regressions (x 6) Rescripting in age regression Ego–state techniques	PTSD: Diagnosis stated in reference to DSM IV criteria
Ffrench, C. (1997)	Severe electric shock	Male late 20s	5 Follow-up at 3.5 months Progress maintained	Formal induction (relaxation plus safe place) Associated cue Age regression to the trauma Transformation and elimination of physical pain felt during the trauma. Teaching of self-hypnosis. 'Consolidation or recovery' in hypnosis	Hypnotic suggestibility: SHCS (Morgan and Hilgard, 1978)
Lumsden, A. (1999)	Life threatening home invasion	Female 48 years	7 No follow-up reported	Formal induction (eye fixation, ideomotor finger signalling) Ego strengthening Safe remembering age regression Use of metaphors in hypnosis Associated cue	PTSD: Diagnosis stated in reference to DSM IV criteria Hypnotic suggestibility: SHCS (Morgan and Hilgard, 1978)
Willshire, D. (1996)	Witnessed accident	Female 39 years	13 Follow up at 3 and 6 months. Progress maintained	Sensory awareness used as an informal induction. Hypnosis included relaxation, safe place, coping statements, ego-strengthening, associated cue, meditation. Hypnotic systematic desensitisation using hierarchy of symptoms. Finger signalling in hypnosis to report anxiety levels	PTSD: Diagnosis stated in reference to DSM IV criteria Hypnotic suggestibility: SHCS (Morgan and Hilgard, 1978)

APPENDIX 2

Non-hypnosis Case studies: PTSD

Author	Type of trauma	Gender / age	Number of sessions	Hypnotic techniques used	Assessment of PTSD
Sharp,J.and Espie,A. (2003)	Violent invasion of home.	Male 25 years	1 therapist-directed 12 self-directed Follow up at 3 months. Progress largely maintained	Image Habituation Training (IHT) Audio recording of trauma memories. Five short sections verbalised followed by 30 seconds silence Client listened to tape twice a day	PDS (Foa, 1995) Revised Impact of Events Scale (Horrowitz, Wilner and Alvarez,1979)
Jaycox, Zoellner and Foa, (2002)	Rape	Female 25 years	12 Follow ups at 3 month, 6 months and 12 months	Breathing retraining Imaginal exposure 45-60minutes Audio recording of verbalised trauma memory narrative Client instructed to listen to tape once a day at least In vivo exposure Cognitive restructuring	PSS-I (Foa, Riggs, Dancu and Rothbaum, 1993) PDS (Foa, 1995)
Tolin and Foa (1999)	Multiple traumas	Male 38 years	11 Follow up at 6 months	Breathing retraining Imaginal exposure 45-60minutes Audio recording of verbalised trauma memory narrative Client instructed to listen to tape once a day at least In vivo exposure Cognitive restructuring	PSS-I () SCID (First, Spitzer,Gibbon and Williams,1996)
Feske (2001)	Witnessing shooting and death of son.	Female 42 years	9 No follow-up reported	Breathing retraining Imaginal exposure for 45-60minutes Audio recording of verbalised trauma memory narrative Client instructed to listen to tape once a day at least In vivo exposure Cognitive restructuring	SCID (First, Spitzer,Gibbon and Williams,1996) PDS (Foa, 1995) IES (Horrowitz, Wilner and Alvarez,1979)

APPENDICES

APPENDIX I

POSTER

ARE YOU FEELING DISTRESSED FOLLOWING A PREGNANCY TERMINATION?

Fortunately most women do well after a termination, but this is not true of *all* women.

We are developing our work in using **hypnosis** in **therapy** to help women who are suffering in this way, and would be pleased to offer treatment which would be of no cost to yourself.

What do I need to know about hypnosis?

Hypnosis used in therapy is not like stage hypnosis! You are not asleep and you don't feel at all out of control. It is a very comfortable, relaxing experience and it can help therapy be very effective.

How do I make an appointment?

You can contact us direct in complete confidence at the address below or ask your GP for a referral to us.

Write to:
The Secretary, Hypnosis Unit
Department of Psychology (Torrington Place)
University College London, Gower Street,
London WC1E 6BT
or telephone: 0171 391 1714

APPENDIX II

INFORMATION LEAFLETS

UNIVERSITY COLLEGE LONDON

Hypnosis Unit, Department of Psychology, Gower Street, London, WC1 6BT

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INFORMATION SHEET

CONFIDENTIAL

Study title:-

Symptomatic change in therapy for post-termination distress.

Investigators:

Val Walters* (Counsellor)
David Oakley (Clinical Psychologist)

*To whom all enquiries should be addressed.

You are invited to participate in the above study which is looking into the ways in which different procedures used in therapy affect symptoms shown by women who have suffered psychological distress following termination of pregnancy. The information you provide will assist in understanding the process of treatment and will be important in influencing the ways in which such treatment s are offered to women in the future.

If you are willing to take part in the study you will be asked to complete questionnaires before, during and after your treatment programme. These questionnaires will all relate to the problems you have experienced and to your ways of coping with them. You will also be asked to take part in a short test of creative imagination, which will give an indication of your hypnotisability. The questionnaires will only cover information that you would likely to give in the normal course of treatment and the results will be confidential. Apart from completing the questionnaires your treatment will be exactly as it would be normally.

Please note that you do not have to take part in this study if you do not want to. If you do decide to take part you may withdraw at any time without having to give a reason. Your decision whether to take part or not will not affect your care and management in any way.

All proposals for research using human subjects are reviewed by an ethics committee before they can proceed, This proposal was reviewed by the Joint UCL / UCH Committees on the Ethics of Human Research.

Please feel free to ask any questions you may have.

SOME QUESTIONS ANSWERED ABOUT THE RESEARCH PROJECT AND WHAT TO EXPECT FROM THERAPY.

Who will the project benefit?

Firstly we hope it will benefit YOU! We do not have a clear idea about the numbers of women who experience distress following pregnancy termination, but it is reasonable to expect that it is more than the numbers who ask for help. When the distress is severe and persistent, specialist help may be beneficial. This project will hopefully help us to understand more about why hypnosis seems to be a particularly effective addition to therapy for this problem.

What can I expect to experience in hypnosis?

The experience varies from person to person. Some people feel very deeply hypnotised whilst others feel it is a very ordinary experience. People describe hypnosis as a very pleasant and relaxing experience. Some people have concerns that they may feel out of control in hypnosis, but this is not the case at all. You cannot be made to do or say anything in hypnosis that you do not want to.

What can I expect from therapy?

An outline of this is as follows:

Week 1. Introductions
Explain project
Complete first questionnaire

Week 2. Complete second questionnaire
Try out some hypnosis, in order to find out the best way to use hypnosis with you.

Week 3. Beginning of therapy.
Telling your therapist about your problem in your own words
Working out your goals
Learning self-hypnosis.

General:

At first you will be helped to get in touch with some inner resources and then helped to work through your problem. Some sessions will involve hypnosis and others will not- it depends on your needs.

There will be times when you will be asked about your earlier life as this may influence how you feel about your problem.

Normally there will be approximately 6-12 sessions. The first session will start at **session 3** as the first 2 weeks are pre therapy sessions for the research project. Sessions will usually be at weekly intervals although as the therapy progresses the period

between may increase. Sessions are normally 1 hour long, whilst those that involve hypnosis usually last about 1hour 30 minutes

Weekly monitoring

- Each week, starting at week 1, you will be asked to fill in questionnaires at home to monitor your progress. **These are an essential part of the research** and we need to ask you to bring these in regularly each week. We are very grateful for your co operation with this.

- We will also encourage you to write a diary of your thoughts and feelings starting at week one. This is not a requirement for the project but it would be an extremely useful addition. If you would like to do this we would be grateful if you could bring these in each week. If you wish, we can photocopy these and give you back your original.

- At the end of each session you will be asked to fill in a summary sheet indicating what you felt was useful in the session.

Confidentiality

- You will be given a code number and this will be used for all your documentation throughout this project.

- Taping of sessions

- All sessions will need to be tape-recorded. These will only be listened to by myself or Dr David Oakley. You can request that the tape recorder is switched off at any point of the session.

Missed sessions

Please telephone Pam la Rose on **0171 391 1647** if you are unable to attend a session by Friday midday, if at all possible, please leave a message on the answer phone if you know at the weekend that you are unable to attend on a Monday.

Missed sessions

Please telephone Pam la Rose on 0171 391 1647 if you are unable to attend a session by Friday midday, if at all possible.

I agree to take part in the project as outlined above

Signed..... (client) Date.....

Signed..... (counsellor) Date.....

APPENDIX III

CONSENT FORM

UNIVERSITY COLLEGE LONDON

Hypnosis Unit, Department of Psychology, Gower Street, London WC1 6BT

CONSENT FORM

CONFIDENTIAL

Secretary: Pam La Rose
Tel: 020 7679 1017
Fax: 020 7679 1019
e-mail: p.rose@ucl.ac.uk
www.ucl.ac.uk/hypnosis

Study title:-

Symptomatic change in therapy for post-termination distress.

Investigators:

Val Walters* (Counsellor)
David Oakley (Clinical Psychologist)
*To whom all enquiries should be addressed.

To be completed by volunteer:- ***Circle as appropriate**

1.Have you read the information sheet about this study? YES NO*

2. Have you had an opportunity to ask questions and discuss this study? YES NO*

3. Have you received satisfactory answers to your questions? YES NO*

4. Have you received enough information about this study? YES NO*

5. Do you understand that you are free to withdraw from this study:- YES NO*
   i) At any time
   ii) Without giving a reason for withdrawing
   iii) Without affecting your future medical care?

6. Which doctor [or counsellor] have you spoken to about this study? YES NO*

Please give his / her name here.....

7. Do you agree to take part in this study? YES NO*

Signed..... Date.....

Name in Block Letters.....

Signature of investigator.....

APPENDIX IV

BOOKLET A (EAQa)

BOOKLET A

CLIENT CODE:.....

DATE:.....

CONFIDENTIAL

Your answers to the questions in this booklet will provide valuable information.

The questions are based on what has been said by women who have had a similar experience to yourself. We recognise that women use different words to talk about their pregnancy loss. This questionnaire refers to the pregnancy loss as a 'foetus/baby'.

Please try to answer all questions, however if there is a question that you do not feel you can answer then move on to the next one.

Thank you for completing this questionnaire.

CLIENT CODE : .....

CONFIDENTIAL

Date of birth: .....

SECTION 1

1. Please circle as appropriate:

single married separated divorced widowed living with partner remarried

2. Please list below the sex and ages of any children you have:

3. Please state your occupation: *(if you do not have a job please write NA in the space below)*

4. Details of your family a) brothers? Yes/No If 'Yes' please state ages.....

b) sisters? Yes/No If 'Yes' please state ages.....

c) mother's age .....

d) father's age .....

(if a parent is deceased please write D in the age space above followed by date of death)

SECTION 2

Please answer the following general questions:

If you have had more than one termination please answer for each one.

First termination:

1. At what stage of the pregnancy were you at the time of the termination?

I was at.....weeks

2. Date of termination.....
(approximate date if you cannot remember the actual date).

3. Did you see a pregnancy scan? YES/ NO *(please circle)*

4. The termination was carried out at, (*please circle)*

a hospital a specialist clinic other? (*please circle*)

5. I felt I was treated with sensitivity at the above.

not at all 0 1 2 3 4 5 6 7 *completely*

Second termination:

1. At what stage of the pregnancy were you at the time of the termination?

I was at .....weeks.

2. Date of termination.....
(approximate date if you cannot remember the actual date).

3. Did you see a pregnancy scan? YES/ NO *(please circle)*

4. The termination was carried out at, (*please circle)*

a hospital a specialist clinic other? (*please indicate*)

5. I felt I was treated with sensitivity at the above.

not at all 0 1 2 3 4 5 6 7 *completely*

Third termination:

1. At what stage of the pregnancy were you at the time of the termination?

I was at.....weeks

2. Date of termination.....
(approximate date if you cannot remember the actual date).

3. Did you see a pregnancy scan? YES/ NO *(please circle)*

4. The termination was carried out at, (*please circle)*

a hospital a specialist clinic other? (*please circle*)

5. I felt I was treated with sensitivity at the above.

not at all 0 1 2 3 4 5 6 7 *completely*

Fourth termination:

1. At what stage of the pregnancy were you at the time of the termination?

I was at.....weeks

2. Date of termination.....
(approximate date if you cannot remember the actual date).

3. Did you see a pregnancy scan? YES/ NO *(please circle)*

4. The termination was carried out at, (*please circle)*

a hospital a specialist clinic other? (*please circle*)

5. I felt I was treated with sensitivity at the above.

not at all 0 1 2 3 4 5 6 7 *completely*

SECTION 3

A. Please circle whichever corresponds to how you felt about yourself before the termination:

SA = strongly agree, A = agree, D = disagree, SD = strongly disagree.

1) On the whole, I was satisfied with myself.	SA	A	D	SD
2) At times I thought I was no good at all.	SA	A	D	SD
3) I felt that I had a number of good qualities	SA	A	D	SD
4) I was able to do things as well as most other people.	SA	A	D	SD
5) I felt I did not have much to be proud of.	SA	A	D	SD
6) I certainly felt useless at times.	SA	A	D	SD
7) I felt that I was a person of worth, at least on an equal basis with others.	SA	A	D	SD
8) I wish I could have had more respect for myself.	SA	A	D	SD
9) All in all, I was inclined to feel that I was a failure.	SA	A	D	SD
10) I took a positive attitude towards myself.	SA	A	D	SD

B. Please circle the number which best describes how you felt in general, before the pregnancy/termination:

e.g. 1= completely angry 4= neither angry nor not angry 7=completely not angry

1. no shame	1	2	3	4	5	6	7	shame
2. angry	1	2	3	4	5	6	7	not angry
3. not irritable	1	2	3	4	5	6	7	irritable
4. envy of others	1	2	3	4	5	6	7	no envy of others
5. not confused	1	2	3	4	5	6	7	confused
6. not anxious	1	2	3	4	5	6	7	anxious
7. depressed	1	2	3	4	5	6	7	not depressed
8. lonely	1	2	3	4	5	6	7	not lonely
9. not isolated	1	2	3	4	5	6	7	isolated

SECTION 4

Please circle whichever corresponds to how comfortable you feel about the following since your termination:

(not at all = 0, completely = 10)

1. Carrying on with normal work activities

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

2. Being with babies/ small children

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

3. Thinking about babies

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

4. Thinking of future pregnancies

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

5. Maintaining good sexual relationship with partner

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

6.Maintaining good sexual relationships in general

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

7. Watching TV programmes / listening to radio programmes about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

8. The anniversary of the expected birth

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

9. Visiting or going near the place where your termination took place

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

10. Talking to friends about your termination

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

11. Hearing or saying the word 'abortion'

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

12. Reading newspaper/ magazine articles about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

13. Hearing public debates about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

14. Hearing other peoples opinions about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

15. Your termination being recorded in your medical records

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

16. Talking to your partner about your termination

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

17. Looking at photos/ pictures of babies/ small children

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

18. Looking at photos/ pictures of foetuses

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

14. Please list below anything you feel uncomfortable seeing, hearing or doing since your termination that has not been included in this section :

SECTION 5

A. Please circle whichever corresponds to how you feel about your termination:

e.g. 1= completely happy 4= neither happy nor sad 7= completely sad

1. happy	1	2	3	4	5	6	7	sad
2. bad	1	2	3	4	5	6	7	good
3. regretful	1	2	3	4	5	6	7	not regretful
4. relieved	1	2	3	4	5	6	7	not relieved
5. guilty	1	2	3	4	5	6	7	not guilty
6. right	1	2	3	4	5	6	7	wrong
7. loss	1	2	3	4	5	6	7	no loss
8. in control	1	2	3	4	5	6	7	not in control

B. Please circle whichever corresponds to how you feel since your termination:

e.g. 1= completely angry 4= neither angry nor not angry 7=completely not angry

1. no shame	1	2	3	4	5	6	7	shame
2. angry	1	2	3	4	5	6	7	not angry
3. not irritable	1	2	3	4	5	6	7	irritable
4. envy of others	1	2	3	4	5	6	7	no envy of others
5. not confused	1	2	3	4	5	6	7	confused
6. not anxious	1	2	3	4	5	6	7	anxious
7. depressed	1	2	3	4	5	6	7	not depressed
8. lonely	1	2	3	4	5	6	7	not lonely
9. not isolated	1	2	3	4	5	6	7	isolated

C. Please circle whichever corresponds to how you feel about yourself now:

SA = strongly agree, A = agree, D = disagree, SD = strongly disagree.)

1) On the whole, I am satisfied with myself.	SA	A	D	SD
2) At times I think I am no good at all.	SA	A	D	SD
3) I feel that I have a number of good qualities	SA	A	D	SD
4) I am able to do things as well as most other people	SA	A	D	SD
5) I feel I do not have much to be proud of	SA	A	D	SD
6) I certainly feel useless at times	SA	A	D	SD
7) I feel that I am a person of worth, at least on an equal basis with others	SA	A	D	SD
8) I wish I could have more respect for myself	SA	A	D	SD
9) All in all, I am inclined to feel that I am a failure	SA	A	D	SD
10) I take a positive attitude towards myself	SA	A	D	SD

SECTION 6

Please circle whichever corresponds to what you think about and imagine:

(never = 1, very often =7)

1. I think of what he/she would have looked like,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

2. I imagine how life would have been with the baby,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

3. I imagine the foetus as a baby that continues to grow,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

4. I think of the foetus/baby as loving me,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

5. I think of the foetus/baby as hating me,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

6. I wonder if the foetus/baby felt pain during the termination,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

7. I think about what happened to the foetus/baby after the termination,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

8. Do you have other particular thoughts that you keep thinking about? YES/NO (*please circle*)

If YES, please list them in the space below:

9. When I think of the pregnancy loss I think of it as: (*please circle*)

a bunch of cells a foetus a baby a child a person a boy/girl

other ? .....(*please indicate)*

10. I have given a name to the above. YES/NO (*please circle*)

SECTION 7

1. Please briefly state below your main reason for having the termination:

Please circle the number which corresponds with your thoughts about the decision to have a termination:

2. I feel comfortable about my decision to have had a termination

1 2 3 4 5 6 7
not at all *moderately* *completely*

3. The decision to have a termination was difficult to make

1 2 3 4 5 6 7
not at all *moderately* *completely*

4. I feel I never really made a decision, I felt unsure even just before the termination

1 2 3 4 5 6 7
strongly agree *strongly disagree*

5. The decision to have a termination conflicted with my views on abortion

1 2 3 4 5 6 7
strongly agree *strongly disagree*

6. I feel confused about my decision to have an termination

1 2 3 4 5 6 7
strongly agree *strongly disagree.*

7. Did anyone try to persuade you *not* to have the termination? YES / NO. (*Please circle)*

partner parents friend doctor nurse other? (*please circle*)

8. Did anyone suggest that you may regret your decision? YES / NO. (*Please circle)*

partner parents friend doctor nurse other? (*please circle*)

9. Did anyone suggest to you having a termination was wrong?
If YES please state below who this was:

10.Did anyone persuade you to *have* the termination? YES/NO.
If YES please state below who this was:

SECTION 8

1. Your thoughts/feelings about abortion.

a) prior to your termination

1 2 3 4 5 6 7
never wrong *always wrong*

b) since your termination

1 2 3 4 5 6 7
never wrong *always wrong*

c) haven't really thought about it..... (*please tick the space if appropriate*)

d) other? *(please state in the space below).*

Please circle the number that corresponds with how you feel about the following:

2. Hearing strong views against abortion upsets me

1 2 3 4 5 6 7
very much *not at all*

3. I feel like I have committed a murder

1 2 3 4 5 6 7
strongly disagree *strongly agree*

4. I fear others will reject me for having had a termination

1 2 3 4 5 6 7
very much *not at all*

5. I accept myself for having had a termination

1 2 3 4 5 6 7
strongly disagree *strongly agree*

6. I deserve to feel better about the termination

1 2 3 4 5 6 7
strongly disagree *strongly agree*

7. My thoughts and feelings about the termination are affecting everything in my life

1 2 3 4 5 6 7
strongly disagree *strongly agree*

SECTION 9

Your feelings about religion / spirituality.

(please circle whichever corresponds best to how you feel)

A. Before the termination

1. I saw myself as religious

1	2	3	4	5	6	7
not at all			*moderately*			*very*

2. I saw myself as spiritual

1	2	3	4	5	6	7
not at all			*moderately*			*very*

B. Since the termination

1. I see myself as religious

1	2	3	4	5	6	7
not at all			*moderately*			*very*

2. I see myself as spiritual

1	2	3	4	5	6	7
not at all			*moderately*			*very*

3. It is important for me to think my foetus/baby is in a resting place

1	2	3	4	5	6	7
not at all			*moderately*			*very*

4. Religion / spirituality has helped me feel better about my termination

1	2	3	4	5	6	7
strongly agree						*strongly disagree*

5. Do you have thoughts about where your foetus/baby is now? YES / NO (*please circle*)

If YES, please state these thoughts briefly below:

6. Please state your religion in the space below, if applicable:

SECTION 10

Your thoughts about the future: (*please circle whichever corresponds best to how you feel)*

1. I feel generally optimistic about the future

1 2 3 4 5 6 7
strongly disagree *strongly agree*

2. I will feel comfortable about the termination with time

1 2 3 4 5 6 7
strongly disagree *strongly agree*

3. I will gain from the experience of the termination with time

1 2 3 4 5 6 7
strongly disagree *strongly agree*

SECTION 11

Other thoughts: (*please circle whichever corresponds best to how you feel)*

1. When I think of the termination it seems unreal

1 2 3 4 5 6 7
strongly disagree *strongly agree*

2. I think of myself as two different people- the one who had the termination and the one who finds this difficult to accept

1 2 3 4 5 6 7
strongly disagree *strongly agree*

3. Sometimes it's like I try to pretend I haven't had a termination.

1 2 3 4 5 6 7
strongly disagree *strongly agree*

4. Sometimes I find myself staring into space, in a sort of daydream, thinking about it all

1 2 3 4 5 6 7
never *often*

SECTION 12

Understanding and coping with your distress:

1. Is there anything that you *know* would help you feel better if it was possible for it happen?

YES / NO (*please circle*). If YES, please briefly state this below:

2. Are there things you do or think that help you to feel better? YES / NO (*please circle*).

If YES, please briefly state these below:

3.Please circle whichever number indicates what you believe has caused your distress about your termination:

a) I blame the situation I was in at the time for the distress I feel now

1	2	3	4	5	6	7
not at all						totally

b) It is just bad luck/chance that has caused my distress

1	2	3	4	5	6	7
not at all						totally

c) I blame other people for my distress

1	2	3	4	5	6	7
not at all						totally

d) I blame myself because of something I did or did not do

1	2	3	4	5	6	7
not at all						totally

e) I blame myself for my distress- having the termination reflects something about my character

1	2	3	4	5	6	7
not at all						totally

4. Do you have a **particular** reason(s) why you believe you have found it difficult to get over your termination? YES NO (*please circle*). If YES, please briefly state this (these) below

SECTION 13

Please circle the number that best describes how you feel, for each of the following parts to this section.

A. Support from your partner:

1) I told my partner about my decision to have a termination. YES/NO (*please circle*)

If you answered YES to the above please answer the following questions:

2) I felt my partner supported my decision

1 2 3 4 5 6 7
not at all *moderately* *totally*

3) I felt I would be able to depend on my partner for support over the months following the termination.

1 2 3 4 5 6 7
not at all *moderately* *totally*

4) **After your termination** how supportive do you feel your partner was towards you?

1 2 3 4 5 6 7
not at all *moderately* *totally*

B. Support from your family:

1) I told my family about my decision to have a termination. YES/NO (*please circle*)

If you answered YES to the above please answer the following questions:

2) I felt my family supported my decision

1 2 3 4 5 6 7
not at all *moderately* *totally*

3) I felt I would be able to depend on my family for support over the months following the termination.

1 2 3 4 5 6 7
not at all *moderately* *totally*

4) **After your termination** how supportive do you feel your family was towards you?

1 2 3 4 5 6 7
not at all *moderately* *totally*

C. Support from your friends:

1) I have told friends about the termination *(please circle appropriate amount)*

none *one* *very few* *some* *very many* *all*

If you answered one or more to the above please answer the following questions:

2) I felt my friend(s) supported my decision

1 2 3 4 5 6 7
not at all *moderately* *totally*

3) I felt I would be able to depend on my friend(s) for support over the months following the termination

1 2 3 4 5 6 7
not at all *moderately* *totally*

4) **After your termination** how supportive do you feel your friend(s) was towards you?

1 2 3 4 5 6 7
not at all *moderately* *totally*

SECTION 14

Coping at work: *(if applicable)*

1. **Before** the pregnancy/termination I was generally coping well with work

1 2 3 4 5 6 7
strongly agree *strongly disagree*

2. **Before** the pregnancy/termination I was generally enjoying work

1 2 3 4 5 6 7
strongly disagree *strongly agree*

3. **At present** I am generally coping well with work

1 2 3 4 5 6 7
strongly agree *strongly disagree*

4. **At present** I am generally enjoying work

1 2 3 4 5 6 7
strongly disagree *strongly agree*

SECTION 15

Please circle YES or NO to indicate your general health:

1. Before your termination were you generally physically well? YES / NO

2. Are you generally physically well now? YES / NO

3. Are you presently taking any medication? YES / NO (*please circle*). If YES, please briefly state below what this is for:

4. Do you suffer from any on-going health problem e.g. migraine, asthma etc for which you are not taking regular medication? If YES, please briefly state below:

5. How many units (if any) of alcohol do you drink per week?

before termination..... at present.....

Units approximately as below:

Beer, lager, cider:	*1 pint = 2 units*
Strong beer, lager cider:	*1 pint = 4 units*
Wine:	*1 glass = 1 unit*
Spirits:	*measure = 1 unit*
Sherry:	*measure = 1 unit*

How many cigarettes do you smoke (if any) per week?

before termination..... after termination.....

SECTION 16

Please indicate how frequently, if at all, you have experienced the following:

A. Approximate number per week over last 3 months :

1. nightmares.....

2. dreams about babies.....

3. panic attacks.....

4. difficulty in sleeping.....

B. Over last 3 weeks (approximately):

1. nightmares week 1..... week 2..... week 3.....

2. dreams about babies week 1..... week 2..... week 3.....

3. panic attacks week 1..... week 2..... week 3.....

4. difficulty in sleeping week 1..... week 2..... week 3.....

C. I have sudden overwhelming thoughts/ feelings about the termination,

1. over the last 3 months, approximately each week.....*(please state number)*

2. over the last 3 weeks, each week.....*(please state number)*

SECTION 17

Important life events:

Please outline significant life events/memories. Please include all events/memories that you believe may help you understand your feelings.

Age

0-5……..

6-10……

11-15……

16-20……

21-25……..

26-30……..

31-35……

36-40……

41-45……

45-50……..

51-55……

56-60……

61-65……

SECTION 18

Your experience and views about hypnosis and counselling:

Have you had 'hypnotherapy' before? YES / NO (*please circle*). If 'yes' please state briefly in the space below a) what this was for and b) how successful the hypnosis was:

Please state briefly below what you understand hypnosis is:

Please state briefly below what you think hypnosis will feel like:

Please state briefly in the space below how you think hypnosis might help you particular problem:

Please circle the number which best describes how **optimistic** you feel that hypnosis might help you?

1 2 3 4 5 6 7

not at all moderately extremely

Have you had counselling before? YES / NO (*please circle*)

If 'yes' please briefly state below how this might have helped you:

How long did you receive this counselling?.....

CONFIDENTIAL **Client code number:**.....

Contact information:

Name:.....

Address:.....

.....

.....

Telephone Numbers:

Daytime: .....

Evening:.....

Are you happy to be contacted at these numbers? YES / NO

Are you happy for messages to be left? YES / NO

NB Messages would only be left regarding appointment times etc.

Name of GP.....Tel. No. .....

Address of GP.....

.....

.....

.....

It is normal practice to have this information, for the purpose of health and safety. However if you have self- referred no routine contact will be made with your doctor.

APPENDIX V

BOOKLET C (EAQb)

BOOKLET C

CLIENT CODE:.....

DATE:.....

CONFIDENTIAL

Your answers to the questions in this booklet will provide valuable information.

Please try to answer all questions, however if there is a question that you do not feel you can answer then move on to the next one.

Thank you for completing this questionnaire.

SECTION 1

Please circle whichever corresponds to how comfortable you feel about the following :

(not at all = 0, completely = 10)

1. Carrying on with normal work activities

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

2. Being with babies/ small children

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

3. Thinking about babies

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

4. Thinking of future pregnancies

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

5. Maintaining good sexual relationship with partner

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

6.Maintaining good sexual relationships in general

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

7. Watching TV programmes / listening to radio programmes about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

8. The anniversary of the expected birth

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

9. Visiting or going near the place where your termination took place

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

10. Talking to friends about your termination

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

11. Hearing or saying the word 'abortion'

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

12. Reading newspaper/ magazine articles about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

13. Hearing public debates about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

14. Hearing other peoples opinions about abortion

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

15. Your termination being recorded in your medical records

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

16. Talking to your partner about your termination

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

17. Looking at photos/ pictures of babies/ small children

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

18. Looking at photos/ pictures of foetuses

0 1 2 3 4 5 6 7 8 9 10

not at all *completely*

19. Please list below anything you feel uncomfortable seeing, hearing or doing that has not been included in this section:

SECTION 2

A. Please circle whichever corresponds to how you feel about your termination:

e. g. 1= completely happy 4= neither happy nor sad 7= completely sad

1. happy	1	2	3	4	5	6	7	sad
2. bad	1	2	3	4	5	6	7	good
3. regretful	1	2	3	4	5	6	7	not regretful
4. relieved	1	2	3	4	5	6	7	not relieved
5. guilty	1	2	3	4	5	6	7	not guilty
6. right	1	2	3	4	5	6	7	wrong
7. loss	1	2	3	4	5	6	7	no loss
8. in control	1	2	3	4	5	6	7	not in control

B. Please circle whichever corresponds to how you feel now:

e. g. 1= completely angry 4= neither angry nor not angry 7=completely not angry

1. no shame	1	2	3	4	5	6	7	shame
2. angry	1	2	3	4	5	6	7	not angry
3. not irritable	1	2	3	4	5	6	7	irritable
4. envy of others	1	2	3	4	5	6	7	no envy of others
5. not confused	1	2	3	4	5	6	7	confused
6. not anxious	1	2	3	4	5	6	7	anxious
7. depressed	1	2	3	4	5	6	7	not depressed
8. lonely	1	2	3	4	5	6	7	not lonely
9. not isolated	1	2	3	4	5	6	7	isolated

C. Please circle whichever corresponds to how you feel about yourself now:

SA = strongly agree, A = agree, D = disagree, SD = strongly disagree.

1) On the whole, I am satisfied with myself.	SA	A	D	SD
2) At times I think I am no good at all.	SA	A	D	SD
3) I feel that I have a number of good qualities	SA	A	D	SD
4) I am able to do things as well as most other people	SA	A	D	SD
5) I feel I do not have much to be proud of	SA	A	D	SD
6) I certainly feel useless at times	SA	A	D	SD
7) I feel that I am a person of worth, at least on an equal basis with others	SA	A	D	SD
8) I wish I could have more respect for myself	SA	A	D	SD
9) All in all, I am inclined to feel that I am a failure	SA	A	D	SD
10) I take a positive attitude towards myself	SA	A	D	SD

SECTION 3

Please circle whichever corresponds to what you think about and imagine:
(never = 1, very often =7)

1. I think of what he/she would have looked like,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

2. I imagine how life would have been with the baby,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

3. I imagine the foetus as a baby that continues to grow,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

4. I think of the foetus/baby as loving me,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

5. I think of the foetus/baby as hating me,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

6. I wonder if the foetus/baby felt pain during the termination,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

7. I think about what happened to the foetus/baby after the termination,

1	2	3	4	5	6	7
never			*sometimes*			*all the time*

8. Do you have other particular thoughts that you keep thinking about? YES/NO (*please circle*)

If YES, please list them in the space below:

9. When I think of the pregnancy loss I think of it as: (*please circle*)

a bunch of cells a foetus a baby a child a person a boy/girl

other ? .....(*please indicate)*

10. I have given a name to the above. YES/NO (*please circle*)

SECTION 4

1. Please briefly state below your main reason for having the termination(s):

Please circle the number which corresponds with your thoughts about the decision to have a termination:

2. I feel comfortable about my decision to have had a termination

1 2 3 4 5 6 7

not at all *moderately* *completely*

3. The decision to have a termination was difficult to make

1 2 3 4 5 6 7

not at all *moderately* *completely*

4. I feel I never really made a decision, I felt unsure even just before the termination

1 2 3 4 5 6 7

strongly agree *strongly disagree*

5. The decision to have a termination conflicted with my views on abortion

1 2 3 4 5 6 7

strongly agree *strongly disagree*

6. I feel confused about my decision to have an termination

1 2 3 4 5 6 7

strongly agree *strongly disagree*

SECTION 5

1. Your present thoughts/feelings about abortion(s).

a) 1 2 3 4 5 6 7
never wrong *always wrong*

b) other? *(please state in the space below).*

Please circle the number that corresponds with how you feel about the following:

2. Hearing strong views against abortion upsets me
1 2 3 4 5 6 7
very much *not at all*

3. I feel like I have committed a murder
1 2 3 4 5 6 7
strongly disagree *strongly agree*

4. I fear others will reject me for having had a termination
1 2 3 4 5 6 7
very much *not at all*

5. I accept myself for having had a termination
1 2 3 4 5 6 7
strongly disagree *strongly agree*

6. I deserve to feel better about the termination
1 2 3 4 5 6 7
strongly disagree *strongly agree*

7. My thoughts and feelings about the termination are affecting everything in my life
1 2 3 4 5 6 7
strongly disagree *strongly agree*

SECTION 6

Your present feelings about religion / spirituality.
(*Please circle to indicate how you feel)*

1. I see myself as religious

1	2	3	4	5	6	7
not at all			*moderately*			*very*

2. I see myself as spiritual

1	2	3	4	5	6	7
not at all			*moderately*			*very*

3. It is important for me to think my foetus is in a resting place

1	2	3	4	5	6	7
not at all			*moderately*			*very*

4. Religion / spirituality helps me feel better about the termination

1	2	3	4	5	6	7
strongly agree						*strongly disagree*

5. Do you have thoughts about where your foetus/baby is now? YES/NO (*please circle*)

If YES, please state these thoughts briefly below:

SECTION 7

Your thoughts about the future: (*please circle whichever corresponds best to how you feel).*

1. I feel generally optimistic about the future

1	2	3	4	5	6	7
strongly disagree						*strongly agree*

2. I will feel comfortable about the termination with time

1	2	3	4	5	6	7
strongly disagree						*strongly agree*

3. I feel comfortable about the termination **now**

1	2	3	4	5	6	7
strongly disagree						*strongly agree*

4. I will gain from the experience of the termination with time

1	2	3	4	5	6	7
strongly disagree						*strongly agree*

5. I now feel I have gained from the experience of the termination

1	2	3	4	5	6	7
strongly disagree						*strongly agree*

SECTION 8

Other thoughts: (*please circle whichever corresponds best to how you feel)*

1. When I think of the termination it seems unreal

	1	2	3	4	5	6	7
strongly disagree							*strongly agree*

2. I think of myself as two different people - the one who had the termination and the one who finds this difficult to accept

	1	2	3	4	5	6	7
strongly disagree							*strongly agree*

3. Sometimes it's like I try to pretend I haven't had a termination.

	1	2	3	4	5	6	7
strongly disagree							*strongly agree*

4. Sometimes I find myself staring into space, in a sort of daydream, thinking about it all

	1	2	3	4	5	6	7
strongly disagree							*strongly agree*

SECTION 9

Understanding and coping with your distress:

1. Is there anything that you still need that would help you feel better if it was possible for it to happen?

YES / NO (*please circle*). If YES, please briefly state this below:

1. Are there things you do or think that help you to feel better?

YES / NO (*please circle*). If YES, please briefly state these below:

3.Please circle whichever number indicates what you believe caused your distress about your termination:

a) I blame the situation I was in at the time for the distress I felt

1	2	3	4	5	6	7
not at all						totally

b) It was just bad luck/chance that caused my distress

1	2	3	4	5	6	7
not at all						totally

c) I blame other people for the distress I felt

1	2	3	4	5	6	7
not at all						totally

d) I blame myself because of something I did or did not do

1	2	3	4	5	6	7
not at all						totally

e) I blame myself for my distress- having the termination reflected something about my character.

1	2	3	4	5	6	7
not at all						totally

1. Do you have a **particular** reason(s) why you believe you found it difficult to get over your termination?

YES / NO (*please circle*). If YES, please briefly state this (these) below:

SECTION 10

Please circle the number that best describes how you feel

A. Support from your partner:

1) I have told my partner about my decision to have a termination. YES/NO (*please circle*)

If you answered YES to the above please answer the following questions:

2) I feel my partner supports my decision

1 2 3 4 5 6 7
not at all moderately totally

3) I feel I am able to depend on my partner for support.

1 2 3 4 5 6 7
not at all moderately totally

B. Support from your family:

1) I have told my family about my decision to have a termination. YES/NO (*please circle*)

If you answered YES to the above please answer the following questions:

2) I feel my family supports my decision

1 2 3 4 5 6 7
not at all moderately totally

3) I feel I can depend on my family for support.

1 2 3 4 5 6 7
not at all moderately totally

C. Support from your friends:

1)I have told friends about the termination *(please circle appropriate amount)*

none *one* *very few* *some* *very many* *all*

If you answered one or more to the above please answer the following questions:

2) I feel my friend(s) support my decision

1 2 3 4 5 6 7
not at all moderately totally

3) I feel I am able to depend on my friend(s) for support

1 2 3 4 5 6 7
not at all moderately totally

SECTION 11

Coping at work: *(if applicable)*

1. I am generally coping well with work

1 2 3 4 5 6 7

strongly agree *strongly disagree*

2. I am generally enjoying work

1 2 3 4 5 6 7

strongly disagree *strongly agree*

SECTION 12

Please circle YES or NO to indicate your general health:

1. Are you generally physically well? YES/NO

2. Are you presently taking any medication? YES/NO (*please circle*).

   If YES, please briefly state below what this is for:

3. Do you suffer from any on-going health problem e.g. migraine, asthma etc for which you are not taking regular medication? If YES, please briefly state below:

4. How many units (if any) of alcohol do you drink per week at present? .....units.

   Units approximately as below:

Beer, lager, cider:	*1 pint = 2 units*
Strong beer, lager cider:	*1 pint = 4 units*
Wine:	*1 glass = 1 unit*
Spirits:	*Measure = 1 unit*
Sherry:	*Measure = 1 unit*

How many cigarettes do you smoke (if any) per week at present? .....cigarettes.

SECTION 13

Important life events:

Please outline significant life events/memories that you have become aware of that may have helped you understand your feelings better.

Age

0-5.....

6-10.....

11-15.....

16-20.....

21-25.....

26-30.....

31-35.....

36-40.....

41-45.....

45-50.....

51-55.....

56-60.....

61-65.....

APPENDIX VI

BOOKLET B

BOOKLET B

CLIENT CODE:.....

DATE:.....

CONFIDENTIAL

This booklet may seem rather thick but most of the questions will only take moments to answer. All of the sections are included for a reason, even though some of the questions may not seem to have much to do with your problem.

Thank you for completing this questionnaire.

SECTION 1

Please read each item and underline the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.

A. I feel tense or 'wound up':

Most of the time
A lot of the time
From time to time, occasionally
Not at all

B. I still enjoy the things I used to enjoy:

Definitely as much
Not quite so much
Only a little
Hardly at all

C. I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly
Yes, but not too badly
A little but it doesn't worry me.
Not at all

D. I can laugh and see the funny side of things:

As much as I always could
Not quite so much now
Definitely not so much now
Not at all

E. Worrying thoughts go through my mind:

A great deal of the time
A lot of the time
From time to time but not too often
Only occasionally

F. I feel cheerful:

Not at all
Not often
Sometimes
Most of the time

G. I can sit at ease and feel relaxed:

Definitely
Usually
Very often
Sometimes
Not at all

H. I feel as if I am slowed down:

Nearly all the time
Very often
Sometimes
Not at all

I. I get a sort of frightened feeling like 'butterflies' in the stomach:

Not at all
Occasionally
Quite often
Very often

J. I have lost interest in my appearance:

Definitely
I don't take as much care as I should
I may not take as much care
I take just as much care as ever

K. I feel restless as if I have to be on the move:

Very much indeed
Quite often
Not very often
Not at all

L. I look forward with enjoyment to things

As much as ever I did
Rather less than I used to
Definitely less than I used to
Hardly at all

M. I get sudden feelings of panic:

Very often indeed
Quite often
Not very often
Not at all

N. I can enjoy a good book or radio or TV programme:

Often
Sometimes
Not often
Very seldom

SECTION 2

Please circle the number which best corresponds to what you feel about the following:

-3	-2	-1	+1	+2	+3
strongly disagree	*disagree*	*slightly disagree*	*slightly agree*	*agree*	*strongly agree*

1.Whether or not I get to be a leader depends mostly on my ability.

-3 -2 -1 +1 +2 +3

2.I feel like what happens in my life is mostly determined by powerful people.

-3 -2 -1 +1 +2 +3

3.Whether or not I get into a car accident depends mostly on how good a driver I am.

-3 -2 -1 +1 +2 +3

4. When I make plans, I am almost certain to make them work.

-3 -2 -1 +1 +2 +3

5. Although I might have good ability, I will not be given a leadership responsibility without appealing to those in power.

-3 -2 -1 +1 +2 +3

6. How many friends I have depends on how nice a person I am.

-3 -2 -1 +1 +2 +3

7. My life is chiefly controlled by powerful others.

-3 -2 -1 +1 +2 +3

8. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.

-3 -2 -1 +1 +2 +3

9. Getting what I want requires pleasing those people above me.

-3 -2 -1 +1 +2 +3

10. If important people were to decide they didn't like me, I probably wouldn't make many friends.

-3 -2 -1 +1 +2 +3

11. I can pretty much determine what happens in my life.

- 3 -2 -1 +1 +2 +3

12. I am usually able to protect my personal interests.

-3 -2 -1 +1 +2 +3

13. Whether or not I get into a car accident depends mostly on the other driver.

-3 -2 -1 +1 +2 +3

14. When I get what I want, it's usually because I worked hard for it.

-3 -2 -1 +1 +2 +3

15. In order to have my plans work, I make sure they fit in with the desires of people who have power

-3 -2 -1 +1 +2 +3

16. My life is determined by my own actions.

-3 -2 -1 +1 +2 +3

SECTION 3

Many people have lived through or witnessed a very stressful and traumatic event at some point in their lives. Below is a list of traumatic events. Tick the space for ALL of the events that have happened to you or that you have witnessed.

1. Serious accident, fire, or explosion (for example, an industrial, farm, car, plane, or boating accident).....

2. Natural disaster (for example, tornado, hurricane, flood, or major earthquake).....

3. Non-sexual assault by a family member or someone you know (for example, being mugged, physically attacked, shot, stabbed, or held at gunpoint).....

4. Non-sexual assault by a stranger (for example, being mugged, physically attacked, shot, stabbed, or held at gun point).....

5. Sexual assault by a family member or someone you know (for example, rape or attempted rape).....

6. Sexual assault by a stranger (for example, rape or attempted rape).....

7. Military combat or a war zone.....

8. Sexual contact when you were younger than 18 with someone who was 5 or more years older than you(for example, contact with genitals, breasts).....

9. Imprisonment (for example, prison inmate, prisoner of war, hostage).....

10. Torture.....

11. Life- threatening illness.....

12. Other traumatic event.....

13. If you marked item 12, specify the traumatic event below.

.....

If you marked any of the items on the previous page, continue, if not, stop here and go to the next page

If you marked more than one traumatic event on the previous page, tick the space next to the event *that bothers you most.* If you marked only one traumatic event on the previous page, mark the same one below.

Accident……..

Disaster……..

Non-sexual assault/ someone you know……

Non-sexual assault/ stranger……

Sexual assault/ someone you know……

Sexual assault/ stranger……..

Combat……

Sexual contact under 18 with someone 5 or more years older……

Imprisonment……

Torture……

Life- threatening illness…….

Other……

In the space below, briefly describe the traumatic event you marked above

……

……

……

……

Below are several questions about the traumatic event you described on the previous page.

How long ago did the traumatic event happen? ***(circle ONE)***

1. Less than 1 month
2. 1-3 months
3. 3-6 months
4. 6 months to 3 years
5. 3-5 years
6. More than 5 years

For the following questions, circle Y for Yes or N for No.

During this traumatic event:

a) **Y N** Were you physically injured?

b) **Y N** Was someone else physically injured?

c) **Y N** Did you think that your life was in danger?

d) **Y N** Did you feel helpless?

e) **Y N** Did you feel terrified?

Did you answer a) - e) on the previous page in relation to a **termination**? **Y N** (*please circle*). If **YES** please answer i) **or** ii) below:

i) If you answered '**Y**' to '*Was someone physically injured?*' (previous page) please state below who the 'someone' was.

.....

ii) If you answered '**N**' to '*Was someone physically injured?*' please answer the following:

- Did you think that in this question 'someone' could include a foetus? **Y N** (*please circle*)

If you answered 'N' to the question immediately above please answer the following question:

What would you have answered to '*Was someone physically injured?*' if you thought that in this question 'someone' could include a foetus, **Y N ?** (*please circle)*

Below starts a list of problems that people sometimes have after experiencing a traumatic event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you IN THE PAST MONTH. Rate each problem with respect to the traumatic event you described on page number.

0 *Not at all or only one time* **2** *2-4 times a week/half the time*

1 *Once a week or less/once in a while* **3** *5 or more times a week/almost always*

0 1 2 3 Having upsetting thoughts or images about the traumatic event that came into your head when you didn't want them to

0 1 2 3 Having bad dreams or nightmares about the traumatic event

0 1 2 3 Reliving the traumatic event, acting or feeling as if it was happening again

continued from previous page

0 1 2 3 Feeling emotionally upset when you were reminded of the traumatic event (for example, feeling scared, angry, sad, guilty, etc.)

0 1 2 3 Experiencing physical reactions when you were reminded of the traumatic event (for example, breaking out in a sweat, heart beating fast)

0 1 2 3 Trying not to think about, talk about, or have feelings about the traumatic event

0 1 2 3 Trying to avoid activities, people, or places that remind you of the traumatic event

0 1 2 3 Not being able to remember an important part of the traumatic event

0 1 2 3 Having much less interest or participating much less often in important activities

0 1 2 3 Feeling distant or cut off from people around you

0 1 2 3 Feeling emotionally numb (for example, being unable to have loving feelings)

0 1 2 3 Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)

0 1 2 3 Having trouble falling or staying awake

0 1 2 3 Feeling irritable or having fits of anger

0 1 2 3 Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)

0 1 2 3 Being overtly alert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.)

0 1 2 3 Being jumpy or easily startled (for example, when someone walks up behind you)

How long have you experienced the problems you reported in this list? (*circle ONE*)

1. Less than 1 month
2. 1 to 3 months
3. More than 3 months

How long after the traumatic event did these problems begin? *(circle ONE)*

1. Less than 6 months
2. 6 or more months

Indicate below if the problems you rated in the last 2 pages have interfered with any of the following areas of your life DURING THE PAST MONTH.

*(Circle **Y** for Yes or **N** for No)*

Y N Work

Y N Household chores and duties

Y N Relationships with friends

Y N Fun and leisure activities

Y N Schoolwork

Y N Relationships with your family

Y N Sex life

Y N General satisfaction with life

Y N Overall level of functioning in all areas of your life

SECTION 4

Individuals who have experienced traumatic experiences- such as physical or sexual abuse, military combat, certain operations, serious accidents or disasters, etc. - vary considerably in their response to these events. Some people do not have any misgivings about what they did during these events, whereas other people do. They may have misgivings about what they did (or did not do), about beliefs or thoughts they had, or for having had certain feelings (or lack of feelings). The purpose of this questionnaire is to evaluate your response to your traumatic experience. All the items below are related to your termination. Please circle the answer that best describes how you feel about each statement.

1. I could have prevented what happened.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

2. I am still distressed about what happened
Always true *frequently true* *sometimes true* *rarely true* *never true*

3. I had some feelings that I should not have had.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

4. What I did was unjustified.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

5. I was responsible for causing what happened.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

6. What happened causes me emotional pain.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

7. I did something that went against my values.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

8. What I did made sense.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

9. I knew better than to do what I did.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

10. I feel sorrow or grief about the outcome.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

11. What I did was inconsistent with my beliefs.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

12. If I knew today- only what I knew when the event occurred - I would do exactly the same thing.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

13. I experience intense guilt that relates to what happened.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

14. I should have known better.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

15. I experience severe emotional distress when I think about what happened.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

16. I had some thoughts or beliefs that I should not have.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

17. I had good reason for doing what I did.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

18. Indicate how frequently you experience guilt that relates to what happened.
Never *seldom* *occasionally* *often* *always*

19. I blame myself for what happened.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

20. What happened causes a lot of pain and suffering.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

21. I should have had certain feelings that I did not have.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

22. Indicate the intensity or severity of guilt that you typically experience about the event.
None *slight* *moderate* *considerable* *extreme*

23. I blame myself for something I did, thought, or felt.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

24. When I am reminded of the event, I have strong physical reactions such as sweating, tense muscles, dry mouth etc.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

25. Overall, how guilty do you feel about the event?
Not guilty at all *slightly guilty* *moderately guilty* *very guilty* *extremely guilty*

26. I hold myself responsible for what happened.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

27. What I did was not justified in any way.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

28. I violated personal standards of right and wrong.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

29. I did something that I should not have done.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

30. I should have done something that I did not do.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

31. What I did was unforgivable.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

32. I didn't do anything wrong.
Extremely true *very true* *somewhat true* *slightly true* *not at all true*

SECTION 5

Visual imagery refers to the ability to form mental pictures, or to "see in the mind's eye". The aim of this questionnaire is to determine the vividness of your visual imagery. The items of the test will possibly bring certain images to your mind. You are asked to rate the vividness of each image by reference to the scale given below. The rating scale appears on each page and should be referred to when judging the vividness of each image. Try to rate each image separately, without reference to your rating of other images.

Complete all the items for images obtained with the eyes open and then return to the beginning of the questionnaire and rate the image obtained for each item with your eyes closed. Try and give your "eyes closed" rating independently of the "eyes open" rating. The two ratings for a given item may not in all cases be the same.

Rating scale- the image aroused by an item might be:

Perfectly clear and as vivid as normal vision

Rating 1

Clear and reasonably vivid	**Rating 2**
Moderately clear and vivid	**Rating 3**
Vague and dim	**Rating 4**
No image at all, you only "know" that you are thinking of the object	**Rating 5**

The rating scale will appear on each page for you to refer to.

Rating scale reminder:

Perfectly clear and as vivid as normal vision	**Rating 1**
Clear and reasonably vivid	**Rating 2**
Moderately clear and vivid	**Rating 3**
Vague and dim	**Rating 4**
No image at all, you only "know" that you are thinking of the object	**Rating 5**

A. In answering items 1-4, think of some relative or friend whom you frequently see (but who is not with you at present) and consider carefully the picture that comes before your mind's eye.

1. The exact contour of face, head, shoulders, and body. eyes open.....eyes closed.....
2. Characteristic poses of head, attitudes of body, etc. eyes open.....eyes closed.....
3. The precise carriage, length of step, etc., in walking. eyes open.....eyes closed.....
4. The different colours worn in some familiar clothes. eyes open.....eyes closed.....

B. In answering items 5- 6, think of looking up at the sky.

5. The sun is rising above the horizon into a hazy sky. eyes open.....closed.....
6. The sky clears and surrounds the sun with blueness. eyes open.....closed.....
7. Clouds. A storm blows up, with flashes of lightening. eyes open.....closed.....
8. A rainbow appears. eyes open.....closed.....

Rating scale reminder:

Perfectly clear and as vivid as normal vision	**Rating 1**
Clear and reasonably vivid	**Rating 2**
Moderately clear and vivid	**Rating 3**
Vague and dim	**Rating 4**
No image at all, you only "know" that you are thinking of the object	**Rating 5**

A. Think of the front of a shop which you often go to. Consider the picture that comes before your mind's eye.

9. The overall appearance of the shop from the opposite side of the road.	eyes open..... closed.....
10. A window display including colours, shapes, and details of individual items for sale.	eyes open.....closed.....
11. You are near the entrance. The colour, shape, and details of the door.	eyes open.....closed.....
12. You enter the shop and go to the counter or 'check out' The assistant serves you. Money changes hands.	eyes open.....closed.....

A. In this item think of a country scene which involves trees, mountains, and a lake. Consider the picture that comes before your mind's eye.

13. The contours of the landscape	eyes open.....closed.....
14. The colour and shape of the trees	eyes open..... closed.....
15. The colour and shape of the lake	eyes open..... closed.....
16. A strong wind blows on the trees and on the lake, causing waves	eyes open..... closed.....

SECTION 6

This section refers to the experience of a termination.

Each of the items is a statement of thoughts and feelings which some people have concerning an experience such as yours. There is no right or wrong response to these statements. For each item, circle the number which best indicates the extent to which you agree or disagree with it at the present time. If you are not certain, use the 'neither' category. Please try to use this category only when you truly have no option.

1=strongly agree, 2=agree, 3=neither agree nor disagree,

4=disagree, 5=strongly disagree

1. I feel depressed	1	2	3	4	5
2. I find it hard to get along with certain people	1	2	3	4	5
3. I feel empty inside	1	2	3	4	5
4. I can't keep up with my normal activities	1	2	3	4	5
5. I feel I need to talk about the foetus/baby	1	2	3	4	5
6. I am grieving about the foetus/baby	1	2	3	4	5
7. I am frightened	1	2	3	4	5
8. I have considered suicide	1	2	3	4	5
9. I take medicine for my nerves	1	2	3	4	5
10. I very much miss the foetus/ baby	1	2	3	4	5
11. I take medicine for my nerves	1	2	3	4	5
12. I feel I have adjusted well to the termination	1	2	3	4	5
13. It is painful to recall memories of the termination	1	2	3	4	5
14. I get upset when I think about the foetus/baby	1	2	3	4	5
15. I cry when I think about the foetus/baby	1	2	3	4	5
16. I feel guilty when I think about the foetus/baby	1	2	3	4	5

17. I feel physically ill when I think about the foetus/baby	1	2	3	4	5
18. I feel unprotected in a dangerous world since The termination	1	2	3	4	5
19. I try to laugh, but nothing seems funny anymore	1	2	3	4	5
20. Time passes so slowly since the termination	1	2	3	4	5
21. The best part of me died with the foetus/baby	1	2	3	4	5
22. I have let people down since the termination	1	2	3	4	5
23. I feel worthless since the termination	1	2	3	4	5
24. I blame myself for the termination	1	2	3	4	5
25. I get cross at my friends and relatives more than I should	1	2	3	4	5
26. Sometimes I feel like I need a professional counsellor to help me get my life back together again	1	2	3	4	5
27. I feel as though I'm just existing and not really living since the termination	1	2	3	4	5
28. I feel so lonely since the termination	1	2	3	4	5
29. I feel somewhat apart and remote, even among friends	1	2	3	4	5
30. It's safer not to love	1	2	3	4	5
31. I find it difficult to make decisions since the termination	1	2	3	4	5
32. I worry about what my future will be like	1	2	3	4	5
33. Being a woman who has had a termination means being a "Second-class citizen"	1	2	3	4	5
34. It feels great to be alive	1	2	3	4	5

SECTION 7

To respond to this questionnaire, please have the thoughts and feelings about your termination in mind and how you used the following in the past week.

Key: 0=Does not apply or not used **1= Used somewhat**

2=Used quite a bit **3= Used a great deal**

Please try to respond to every question.

1. I just concentrated on what I had to do next.	0	1	2	3
2. I did something to help myself that I didn't think would work, but at least I was doing something.	0	1	2	3
3. I talked to someone to find out more about my type of problem.	0	1	2	3
4. I criticised or lectured myself.	0	1	2	3
5. I hoped for a miracle that would help me feel better.	0	1	2	3
6. I thought of my problem as fate; sometimes I just have bad luck.	0	1	2	3
7. I went on as if the termination hadn't happened.	0	1	2	3
8. I tried to keep my feelings to myself.	0	1	2	3
9. I looked for the silver lining, so to speak; I tried to look on the bright side of things.	0	1	2	3
10. I slept more than usual.	0	1	2	3
11. I expressed anger to the person(s) who caused my problem.	0	1	2	3
12. I accepted sympathy and understanding from someone.	0	1	2	3
13. I was inspired to do something creative about the problem.	0	1	2	3

14. I tried to forget the whole thing.	0	1	2	3
15. I got professional help.	0	1	2	3
16.I changed or grew as a person.	0	1	2	3
17. I tried to make amends for having the termination.	0	1	2	3
18. I made a plan of action and followed it.	0	1	2	3
19. I let my feelings out somehow.	0	1	2	3
20. I told myself I had brought the problem on myself.	0	1	2	3
21. I felt I had come out of the experience better than I went in.	0	1	2	3
22. I talked to someone who could do something concrete about my problem.	0	1	2	3
23. I tried to make myself feel better by eating, drinking, smoking, using drugs, or medications, etc.	0	1	2	3
24. I took a big chance or did something very risky to solve the problem.	0	1	2	3
25. I tried not to act too hastily.	0	1	2	3
26. I found new faith.	0	1	2	3
27. I maintained my pride and kept a stiff upper lip.	0	1	2	3
28. I rediscovered what is important in life.	0	1	2	3
29. I changed something so I would feel better.	0	1	2	3
30. I generally avoided being with people.	0	1	2	3
31. I didn't let it get to me; I refused to think too much about it.	0	1	2	3
32. I asked advice from a relative or friend I respected.	0	1	2	3
33. I kept others from knowing how bad things were.	0	1	2	3
34. I made light of the situation; I refused to get too serious about it.	0	1	2	3
35. I talked to someone about how I was feeling.	0	1	2	3

36. I stood my ground and fought for what I wanted.	0	1	2	3
37. I took it out on other people.	0	1	2	3
38. I drew on my past experiences to help me cope.	0	1	2	3
39. I knew what had to be done, so I doubled my efforts to make things better.	0	1	2	3
40. I refused to believe that it had happened.	0	1	2	3
41. I promised myself that things would be different in the future.	0	1	2	3
42. I came up with a couple of different solutions to the problem.	0	1	2	3
43. I accepted the situation, since nothing could be done.	0	1	2	3
44. I tried to keep my feeling about the problem. from interfering with other things.	0	1	2	3
45. I wished that I could change what had happened or how I felt.	0	1	2	3
46. I changed something about myself.	0	1	2	3
47. I wished that the situation would go away or somehow be over with.	0	1	2	3
48. I had fantasies or wishes about how things might turn out.	0	1	2	3
49. I prayed.	0	1	2	3
50. I went over in my mind what I would say or do.	0	1	2	3
51. I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
52. I tried to leave things open somewhat.	0	1	2	3
53. I tried to get the person who upset me to change his/her mind.	0	1	2	3

APPENDIX VII

BOOKLET D

Pages 2-15 as Booklet B

BOOKLET D

CLIENT CODE:.....

DATE:.....

CONFIDENTIAL

SECTION 5

This section refers to the experience of a termination.

Each of the items is a statement of thoughts and feelings which some people have concerning an experience such as yours. There is no right or wrong response to these statements. For each item, circle the number which best indicates the extent to which you agree or disagree with it at the present time. If you are not certain, use the 'neither' category. Please try to use this category only when you truly have no option.

1=strongly agree, 2=agree, 3=neither agree nor disagree,

4=disagree, 5=strongly disagree

1. I feel depressed	1	2	3	4	5
2. I find it hard to get along with certain people	1	2	3	4	5
3. I feel empty inside	1	2	3	4	5
4. I can't keep up with my normal activities	1	2	3	4	5
5. I feel I need to talk about the foetus/baby	1	2	3	4	5
6. I am grieving about the foetus/baby	1	2	3	4	5
7. I am frightened	1	2	3	4	5
8. I have considered suicide	1	2	3	4	5
9. I take medicine for my nerves	1	2	3	4	5
10. I very much miss the foetus/ baby	1	2	3	4	5
11. I take medicine for my nerves	1	2	3	4	5
12. I feel I have adjusted well to the termination	1	2	3	4	5
13. It is painful to recall memories of the termination	1	2	3	4	5
14. I get upset when I think about the foetus/baby	1	2	3	4	5
15. I cry when I think about the foetus/baby	1	2	3	4	5

16. I feel guilty when I think about the foetus/baby	1	2	3	4	5
17. I feel physically ill when I think about the foetus/baby	1	2	3	4	5
18. I feel unprotected in a dangerous world since the termination	1	2	3	4	5
19. I try to laugh, but nothing seems funny anymore	1	2	3	4	5
20. Time passes so slowly since the termination	1	2	3	4	5
21. The best part of me died with the foetus/baby	1	2	3	4	5
22. I have let people down since the termination	1	2	3	4	5
23. I feel worthless since the termination	1	2	3	4	5
24. I blame myself for the termination	1	2	3	4	5
25. I get cross at my friends and relatives more than I should	1	2	3	4	5
26. Sometimes I feel like I need a professional counsellor to help me get my life back together again	1	2	3	4	5
27. I feel as though I'm just existing and not really living since the termination	1	2	3	4	5
28. I feel so lonely since the termination	1	2	3	4	5
29. I feel somewhat apart and remote, even among friends	1	2	3	4	5
30. It's safer not to love	1	2	3	4	5
31. I find it difficult to make decisions since the termination	1	2	3	4	5
32. I worry about what my future will be like	1	2	3	4	5
33. Being a woman who has had a termination means being a "Second-class citizen"	1	2	3	4	5
34. It feels great to be alive	1	2	3	4	5

SECTION 6

To respond to this questionnaire, please have the thoughts and feelings about your termination in mind and how you used the following in the past week.

Key: 0=Does not apply or not used **1= Used somewhat**

2=Used quite a bit **3= Used a great deal**

Please try to respond to every question.

1. I just concentrated on what I had to do next.	0	1	2	3
2. I did something to help myself that I didn't think would work, but at least I was doing something.	0	1	2	3
3. I talked to someone to find out more about my type of problem.	0	1	2	3
4. I criticised or lectured myself.	0	1	2	3
5. I hoped for a miracle that would help me feel better.	0	1	2	3
6. I thought of my problem as fate; sometimes I just have bad luck.	0	1	2	3
7. I went on as if the termination hadn't happened.	0	1	2	3
8. I tried to keep my feelings to myself.	0	1	2	3
9. I looked for the silver lining, so to speak; I tried to look on the bright side of things.	0	1	2	3
10. I slept more than usual.	0	1	2	3
11. I expressed anger to the person(s) who caused my problem.	0	1	2	3
12. I accepted sympathy and understanding from someone.	0	1	2	3
13. I was inspired to do something creative about the problem.	0	1	2	3

14. I tried to forget the whole thing.	0	1	2	3
15. I got professional help.	0	1	2	3
16.I changed or grew as a person.	0	1	2	3
17. I tried to make amends for having the termination.	0	1	2	3
18. I made a plan of action and followed it.	0	1	2	3
19. I let my feelings out somehow.	0	1	2	3
20. I told myself I had brought the problem on myself.	0	1	2	3
21. I felt I had come out of the experience better than I went in.	0	1	2	3
22. I talked to someone who could do something concrete about my problem.	0	1	2	3
23. I tried to make myself feel better by eating, drinking, smoking, using drugs, or medications, etc.	0	1	2	3
24. I took a big chance or did something very risky to solve the problem.	0	1	2	3
25. I tried not to act too hastily.	0	1	2	3
26. I found new faith.	0	1	2	3
27. I maintained my pride and kept a stiff upper lip.	0	1	2	3
28. I rediscovered what is important in life.	0	1	2	3
29. I changed something so I would feel better.	0	1	2	3
30. I generally avoided being with people.	0	1	2	3
31. I didn't let it get to me; I refused to think too much about it.	0	1	2	3
32. I asked advice from a relative or friend I respected.	0	1	2	3
33. I kept others from knowing how bad things were.	0	1	2	3
34. I made light of the situation; I refused to get too serious about it.	0	1	2	3
35. I talked to someone about how I was feeling.	0	1	2	3
36. I stood my ground and fought for what I wanted.	0	1	2	3

37. I took it out on other people.	0	1	2	3
38. I drew on my past experiences to help me cope.	0	1	2	3
39. I knew what had to be done, so I doubled my efforts to make things better.	0	1	2	3
40. I refused to believe that it had happened.	0	1	2	3
41. I promised myself that things would be different in the future.	0	1	2	3
42. I came up with a couple of different solutions to the problem.	0	1	2	3
43. I accepted the situation, since nothing could be done.	0	1	2	3
44. I tried to keep my feeling about the problem. from interfering with other things.	0	1	2	3
45. I wished that I could change what had happened or how I felt.	0	1	2	3
46. I changed something about myself.	0	1	2	3
47. I wished that the situation would go away or somehow be over with.	0	1	2	3
48. I had fantasies or wishes about how things might turn out.	0	1	2	3
49. I prayed.	0	1	2	3
50. I went over in my mind what I would say or do.	0	1	2	3
51. I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
52. I tried to leave things open somewhat.	0	1	2	3
53. I tried to get the person who upset me to change his/her mind.	0	1	2	3

APPENDIX VIII

THE HOPKIN'S SYMPTOM CHECKLIST & COMFORT WITH ABORTION DECISION QUESTIONNAIRE

Weekly check list - please fill in one of these three page checklists on the same day of each week.

IMPORTANT Please bring this to your next session.

Client code:..... **Day**..... **Date**.....

SECTION 1

I feel comfortable about my decision to have a termination

1	2	3	4	5	6	7
not at all			*moderately*			*completely*

SECTION 2

Please circle the number which best describes how you have felt during the last week

0 = not at all, 1 = a little bit, 2= moderately, 3 = quite a bit, 4 = extremely.

1. Headaches	0	1	2	3	4
2. Nervousness or shaking inside	0	1	2	3	4
3. Faintness or dizziness	0	1	2	3	4
4. Loss of sexual interest or pleasure	0	1	2	3	4
5. Feeling easily annoyed or irritated	0	1	2	3	4
6. Pains in the heart or chest	0	1	2	3	4
7. Feeling low in energy or slowed down	0	1	2	3	4
8. Thoughts of ending your life	0	1	2	3	4
9. Trembling	0	1	2	3	4
10.Crying easily	0	1	2	3	4

11.Feeling of being trapped or caught	0	1	2	3	4
12.Suddenly scared for no reason	0	1	2	3	4
13.Temper outbursts that you could not control	0	1	2	3	4
14.Blaming yourself for things	0	1	2	3	4
15.Pains in lower back	0	1	2	3	4
16.Feeling lonely	0	1	2	3	4
17.Feeling blue	0	1	2	3	4
18.Worrying too much about things	0	1	2	3	4
19.Feeling no interest in things	0	1	2	3	4
20.Feeling fearful	0	1	2	3	4
21.Heart pounding or racing	0	1	2	3	4
22.Nausea or upset stomach	0	1	2	3	4
23.Soreness of your muscles	0	1	2	3	4
24.Trouble getting your breath	0	1	2	3	4
25.Hot or cold spells	0	1	2	3	4
26.Numbness or tingling in parts of your body	0	1	2	3	4
27.A lump in your throat	0	1	2	3	4
28.Feeling hopeless about the future	0	1	2	3	4
29.Feeling weak in parts of your body	0	1	2	3	4
30.Feeling tense or keyed up	0	1	2	3	4
31.Heavy feelings in your arms or legs	0	1	2	3	4
32.Having urges to beat, injure, or harm someone	0	1	2	3	4
33.Having urges to break or smash or things	0	1	2	3	4
34.Feeling everything is an effort	0	1	2	3	4
35.Spells of terror or panic	0	1	2	3	4

36.Getting into frequent arguments	0	1	2	3	4
37.Feeling so restless you couldn't sit still	0	1	2	3	4
38.Feelings of worthlessness	0	1	2	3	4
39.Shouting or throwing things	0	1	2	3	4
40.The feeling that something bad is going to happen to you	0	1	2	3	4
41.Thoughts and images of a frightening nature	0	1	2	3	4

APPENDIX IX

MOST HELPFUL ASPECT OF THERAPY FORM

SESSION NUMBER .....DATE.....CLIENT NO.....

Please briefly state below what you felt was the most helpful aspect of this session:

SESSION NUMBER .....DATE.....CLIENT NO.....

Please briefly state below what you felt was the most helpful aspect of this session:

SESSION NUMBER .....DATE.....CLIENT NO.....

Please briefly state below what you felt was the most helpful aspect of this session:

SESSION NUMBER .....DATE.....CLIENT NO.....

Please briefly state below what you felt was the most helpful aspect of this session:

SESSION NUMBER .....DATE.....CLIENT NO.....

Please briefly state below what you felt was the most helpful aspect of this session:

APPENDIX X

THERAPIST'S EVALUATION OF MOST HELPFUL ASPECT OF THERAPY

SESSION NUMBER …….DATE…….CLIENT NO…….

Counsellors view of what was the most helpful aspect of this session

SESSION NUMBER …….DATE…….CLIENT NO…….

Counsellor's view of what was the most helpful aspect of this session

SESSION NUMBER …….DATE…….CLIENT NO…….

Counsellor's view of what was the most helpful aspect of this session:

SESSION NUMBER …….DATE…….CLIENT NO…….

Counsellor's view of what was the most helpful aspect of this session:

SESSION NUMBER …….DATE…….CLIENT NO…….

Counsellor's view of what was the most helpful aspect of this session:

APPENDIX XI

USEFULNESS OF HYPNOSIS QUESTIONNAIRE

CLIENT CODE:..... **DATE:.....**

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). Many thanks.

What we did in hypnosis	**What did this feel like?**	**How might this have helped?**

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?**

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?

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?

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?

1 2 3 4 5

not at all helpful very helpful

APPENDIX XII

EVALUATION OF COUNSELLING QUESTIONNAIRE

Evaluation of Counselling Questionnaire.

Participant Code number:..... Date.....

1. Do you consider that the main problem(s) you resolved at the end of counselling remains resolved? *(Please circle)*

Not at all slightly moderately mostly completely

2. If not 'completely' please give brief details in the space below about what is unresolved and how this might affect your life.

3. Was there any aspect of the counselling that you now feel was particularly *helpful* to you?

4. Was there any aspect of the counselling that you now feel was unhelpful to you?

5. Were there any hypnosis sessions that you now feel were particularly helpful to you?

6. Were there any hypnosis sessions that you now feel were particularly unhelpful to you?

7. Overall how would you rate the success of your therapy? *(Please circle)*

Not at all slightly moderately very extremely

8. Do you use self-hypnosis techniques? *(Please circle)*

Never occasionally sometimes fairly often frequently

9. If you use self-hypnosis at all please indicate what sort of purpose you use this for.

Please indicate how useful you find this self-hypnosis. *(Please circle)*

Not at all slightly moderately very extremely

Thank you for completing this form

APPENDIX XIII

PERINATAL GRIEF SCALE SUBSCALES (CHAPTER 5)

Perinatal Grief Scale : Summary Pre, Post Therapy and Follow-up Scores (Potvin et al., 1988)

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
Active Grief					
2891	43	30	31	29	29
1069	48	28	17	13	21
1085	49	22	15	12	-
2314	46	15	26	20	-
2553	45	35	33	37	-
Mean	***46.2***	***26.0***	***24.4***	***22.2***	-
Difficulty in coping					
2891	44	27	28	28	22
1069	50	34	15	12	11
1085	49	22	15	11	-
2314	52	22	27	19	-
2553	34	29	33	32	-
Mean	***45.8***	***26.8***	***23.6***	***20.4***	-
Despair					
2891	44	27	29	29	29
1069	47	25	15	12	12
1085	49	22	15	11	-
2314	48	14	14	15	-
2553	33	28	26	18	-
Mean	***44.2***	***23.2***	***20***	***17***	-

APPENDIX XIV

TRAUMA RELATED GUILT INVENTORY SUBSCALES (CHAPTER 5)

Trauma Related Grief Inventory: Summary Pre, Post Therapy and Follow-up Scores: (Kubany et al., 1996)

	Pre Therapy	Post Therapy	Follow-up no.1	Follow-up no.2	Follow-up no.3
Global Guilt					
2891	3.8	1.3	1.8	2.0	1.8
1069	3.8	1.0	.75	1.0	1
1085	3.0	1.0	.75	0	-
2314	3.8	0.8	1.0	0.8	-
2553	3.5	1.0	1.8	2.0	-
Mean	***3.6***	***1.0***	***1.8***	***1.2***	-
Guilt Cognitions					
2891	3.1	1.5	2.0	2.0	2
1069	3.0	0.7	0.3	0.4	.14
1085	2.8	.86	0.4	0.8	-
2314	3.7	.3	0.4	0.5	-
2553	2.4	2.4	1.4	1.7	-
Mean	***3***	***1.2***	***0.9***	***1.1***	-
Distress					
2891	3.7	2.2	1.7	2.7	0.2
1069	3.7	1.3	0.3	0.5	.5
1085	3.5	0.9	0.8	0.5	-
2314	3.7	1.0	1.0	0.7	-
2553	2.8	2.8	2.3	2.5	-
Mean	***3.5***	***2.1***	***1.2***	***1.4***	-
Hindsight Bias/Responsibility					
2891	3.3	1.3	1.9	1.9	2.0
1069	4.0	1.6	0.7	0.7	0.4
1085	3.0	0.9	0.6	0.9	-
2314	4.0	.3.0	1.1	1.0	-
2553	2.3	1.9	1.9	2.0	-
Mean	***3.5***	***1.6***	***1.2***	***1.4***	-
Lack of Justification					
2891	3.5	1.5	2	1.8	2.8
1069	1.5	0.5	.25	0.3	0
1085	2.0	1.5	0.6	1.0	-
2314	3.3	0.8	0.5	0.5	-
2553	2.5	2.8	1.3	1.5	-
Mean	***2.9***	***1.42***	***.9***	***1.0***	-
Wrongdoing					
2891	2.4	2.2	1.6	2.0	1.6
1069	2.8	0.8	0.2	0.6	0
1085	2.0	0.7	0.2	0.2	-
2314	3.8	0.2	0.2	0.6	-
2553	2.2	2	1.4	2.2	-
Mean	***2.6***	***1.2***	***0.7***	***1.1***	-

APPENDIX XV

SELF-HYPNOSIS GUIDELINES

SELF-HYPNOSIS FOR RELAXATION

The script outlined below will help you to remember the routine you were taught in your session today.

Listen to the sounds outside the room……gradually focus inward.

Breathe with emphasis on your **out** breath

Breathe with emphasis on breathing out tension/adrenaline. Think of a colour for this.

Imagine the warmth the sun on your face etc.

Relax your face muscles and then relax all your muscles downwards to toes. Imagine deep neck/shoulder massage if it helps or use your own imagery. Think of warmth and comfort spreading.

Walk down 10 steps, feel them warm under your bare feet. Breathe out going down each one. Going down towards your relaxing place. Try to feel a **downward** feeling.

In your relaxing place try to be aware of sights, sounds, scents/ smells, sensations and tastes. Just go with it. Note the ones which feel most real.

Associate these feelings of relaxation to rubbing your finger and thumb together. Tell yourself something useful that will help you to overcome your stress. Let your mind come up with a word to help you feel calm / relaxed. Give yourself a post-hypnotic suggestion: 'I can feel this calmness and relaxation any time I need it, when I rub my thumb and finger together /when I bring that word to mind /when I touch this object [a small reminder appropriate to your 'Special Place'], these feelings will come back'….

Give yourself some space to enjoy your relaxation for as long as you wish, then follow by repeating your post-hypnotic suggestion.

Count backwards from 3-1then open your eyes on the count of 1,or simply open your eyes!

- There is no need to stick to this routine. Once you have got the hang of this just do whatever you feel is helpful to recapture the feeling you have achieved or to make it stronger. Also it helps to vary your 'special place' to avoid boredom.

In your 'special place' you can.....

- Visualise yourself in the future, coping well with stressful situations , thinking beyond the stress and doing the things you want to do, feeling good about yourself.

- Visualise past accomplishments and bring those good feelings into the present. This is useful at times of self-doubt (which everyone has).

- Let your mind wander and come up with a feeling or thought that may help you.

- Repeating helpful 'self-talk' helps to break the cycle of negative thoughts that maintains stress.

APPENDIX XVI

CREATIVE IMAGINATION SCALE

The Creative Imagination Scale (CIS)

The CIS can be administered in either a clinical or experimental setting, to an individual or a group, by oral presentation or by tape recording, with or without an induction procedure. One way of introducing the test is via a 'think with' procedure in which the subjects are encouraged to think along with the suggestions and to avoid negative thoughts. There is some evidence that such a procedure facilitates not only CIS, but also more general hypnotic responding.

1. Arm Heaviness "By letting your thoughts go along with these instructions you can make your hand and arm feel heavy. Please close your eyes and place your left arm straight out in front of you at shoulder height with the palm facing up."

(Begin timing) "Now imagine that a very heavy dictionary is being placed on the palm of your left hand. Let yourself feel the heaviness. Your thoughts make it feel as if there is a heavy dictionary on your hand. You create the feeling of heaviness in your hand by thinking of a large heavy dictionary. Now think of a second large heavy dictionary being placed on top of the first heavy dictionary. Feel how heavy your arm begins to feel as you push up on the dictionaries. Push up on the heavy dictionaries as you imagine the weight; notice how your arm feels heavier and heavier as you push up on them. Now tell yourself that a third big heavy dictionary is being piled on top of the other two heavy dictionaries in your hand and your arm is very, very heavy. Let yourself feel as if there are three heavy dictionaries on the palm of your hand and your arm is getting heavier and heavier and heavier. Feel your arm getting heavier and heavier and heavier, very, very, very heavy, getting heavier and heavier and heavier ... very heavy." (Approximately 1'20" since beginning of timing.)

"Now tell yourself that your hand and arm feel perfectly normal again and just let your hand and arm come back down and relax.

2. Hand Levitation "By directing your thoughts you can make your hand feel as if it is rising easily, without effort. Keep your eyes closed and place your right arm straight out in front of you at shoulder height with the palm facing down."

(Begin timing) "Now, picture a garden hose with a strong stream of water pushing against the palm of you right hand, pushing up against the palm of your hand. Think of a strong stream of water pushing your hand up. Let yourself feel the strong stream of water pushing up against the palm of your hand, pushing it up. Feel the force of the water, pushing your hand up. Feel it pushing against the palm of your hand. Tell yourself that the force of the water is very strong, and, as you think about it, let your hand begin to rise. Feel your hand rising as you imagine a strong stream of water pushing it up, and up, and up, higher and higher. Tell yourself that a strong stream of water is pushing your hand up and up, raising your arm and hand higher as the strong stream of water just pushes it up, just rises and pushes and just pushes it up, higher and higher." (End of timing: about 1'10'.)

"Now tell yourself its all in your own mind and just let your hand and arm come back down and relax."

3. Finger Anaesthesia "By focusing your thinking you can make your fingers feel numb. Please place your left hand in your lap with the palm facing up. Keep your eyes closed so you can focus fully on all the sensations in the fingers of your left hand.:

(Begin timing.) "Now, try to imagine and feel as if a local anaesthetic has just been injected into the side of your left hand next to the little finger so that your little finger will begin to feel like it does when it 'falls asleep.' Focus on the little finger. Become aware of every sensation and the slight little changes as you think of the anaesthetic slowly beginning to move into your little finger, just slowly moving in. Notice the slight little changes as the little finger begins to get just a little numb and a little dull. The little finger is becoming numb as you think of the anaesthetic moving in slowly."

"Now think of the anaesthetic moving into the second finger next to the little finger. Tell yourself that the second finger is getting duller and duller, more and more numb as you think of how the anaesthetic is beginning to take effect."

"Tell yourself that these two fingers are beginning to feel kind of rubbery and losing feelings and sensations. As you think of the anaesthetic moving in faster, the fingers feel duller and duller ... more and more numb... dull, numb and insensitive. As you think of the anaesthetic taking effect, the two fingers feel duller and duller ... more and more numb... dull ... numb... insensitive."

"Keep thinking that the two fingers are dull, numb, and insensitive as you touch the two fingers with your thumb. As you touch the two fingers with your thumb notice how they feel duller and duller, more and more numb, more and more insensitive."

"Keep thinking that the two fingers are dull, numb, and insensitive as you touch the two fingers with your thumb. As you touch the two fingers with your thumb notice how they feel duller and duller, more an more numb, more and more insensitive... dull, numb, rubbery and insensitive." (End of timing: about 1'50")

"Now tell yourself its all in your own mind and you're going to bring the feeling back; bring the feeling back into the two fingers."

4. Water "Hallucination" "Keep your eyes closed. By using your imagination constructively you can experience the feeling of drinking cool, refreshing water."

(Begin timing.) "First, imagine you've been out in the hot sun for hours and you're very, very thirsty and your lips are dry and you're so thirsty. Now, picture yourself on a mountain where the snow is melting, forming a stream of cool clear water. Imagine yourself dipping a cup into this mountain stream so you can have a cool, refreshing drink of water. As you think of sipping the water tell yourself it's absolutely delicious as you feel it going down your throat ... cold and beautiful and delicious. Feel the coolness and beauty of the water as you take a sip. Now, think of taking another sip of water and feel it going over your lips and tongue, going down your throat, down into your stomach. Feel how cool, refreshing, delicious and beautiful it is as you take another sip... so cool... cold... sweet ...beautiful... delicious and refreshing. Think of taking another sip now and feel the cool water going into your mouth, around your tongue, down your throat and down into your stomach... so beautiful and cool and wonderful ... absolutely delicious.... absolute pleasure." (End of timing: about 1'30".)

5. Olfactory-Gustatory "Hallucination" "Keep your eyes closed. By using your imagination creatively, you can experience the smell and taste of an orange."

(Begin timing.) "Picture yourself picking up an orange and imagine that you're peeling it. As you create the image of the orange, feel yourself peeling it and let yourself see and feel the orange skin on the outside and the soft white pulp on the inside of the skin. As you continue peeling the orange, notice how beautiful and luscious it is and let yourself smell it and touch it and feel the juiciness of it. Now think of pulling out one or two of the orange sections with your fingers. Pull out part of the orange and bite into it. Experience how juicy, luscious and flavourful it is as you imagine taking a deep, deep bite. Let yourself smell and taste the orange and notice that it's absolutely delicious. Let yourself feel how delicious, beautiful, and luscious it is. Just the most beautiful, juicy orange... absolutely juicy and wonderful. Let yourself taste and smell the juicy orange clearly now as you think of taking another large bite of the delicious, juicy orange." (End of timing: about 1'30".)

6. Music "Hallucination" "Keep your eyes closed."

(Begin timing.) "Now, think back to a time when you heard some wonderful, vibrant music; it could have been anywhere, and by thinking back you can hear it even more exquisitely in your own mind. You make it yourself and you can experience it as intensely as real music. The music can be absolutely powerful ... strong...exquisite...vibrating through every pore of your body...going deep into every pore...penetrating through every fibre of your being. The most beautiful, complete, exquisite, overwhelming music you ever heard. Listen to it now as you create it in your own mind." (End of timing: about 45")

(15 second pause) "You may stop thinking of the music now."

7. Temperature "Hallucination" "Keep your eyes closed and place your hands in your lap with the palms facing down and resting comfortably on your lap. By focusing your thinking you can make your right hand feel hot."

(Begin timing.) "Picture the sun shining on your right hand and let yourself feel the heat. As you think of the sun shining brightly, let yourself feel the heat increasing. Feel the sun getting hotter and feel the heat penetrating your skin and going deep into your hand. Think of it getting really hot now... getting very hot. Feel the heat increasing. Think of the sun getting very, very hot as it penetrates into your hand ... getting very hot. Tell yourself, 'The rays are increasing...the heat is increasing... getting hotter and hotter.' Feel the heat penetrating through your skin. Feel the heat going deeper into your skin as you think of the rays of the sun increasing and becoming more and more concentrated... getting hotter and hotter. Feel your hand getting hot from the heat of the sun. Its a good feeling of heat as it penetrates deep into your hand...hot, pleasantly hot, penetrating your hand now. It's a pleasantly hot feeling, pleasantly hot." (End of timing: about 1'15".)

"Now tell yourself it's all in your own mind and make your hand feel perfectly normal again."

8. Time Distortion "Keep your eyes closed. By controlling your thinking you can make time seem to slow down."

(The following is to be read progressively more and more slowly, with each word drawn out and with long. 2-6 second, pauses between statements

(Begin timing.) "Tell yourself that there's lots of time, lots of time between each second. Time is stretching out and there's lots of time ... more and more time between each second. Every second is stretching out. There's lots of time between each second... lots of time. You do it yourself, you slow time down." (End of timing: about 1'40".)

(The following is to be read at a normal rate.) "And now tell yourself that time is speeding back up to its normal rate again as you bring time back to normal."

9. Age Regression "Keep your eyes closed. By directing your thinking you can bring back the feeling that you experienced when you were in primary school - in first, second, third or fourth year."

(Begin timing.) "Think of time going back, going back to primary school and feel yourself becoming smaller and smaller. Let yourself feel your hands, small and tiny, and your legs and your body, small and tiny. As you go back in time feel yourself sitting in a big desk. Notice the floor beneath you. Feel the top of the desk. You may feel some marks on the desk top, or maybe it's smooth, cool surface. There may be a pencil slot and perhaps a large yellow pencil. Feel the under side of the desk and you may feel some chewing gum. Observe the other children around you, and the teacher, the black-board, the notice board, where the cloak room is and the windows. Smell the chalk dust or the paste. You may hear the children and the teacher speaking. Now just observe and see what happens around you." (End of timing: about 1'20")

(15 second pause) "Now tell yourself it's all in your own mind and bring yourself back to the present."

10. Mind-Body Relaxation "Keep your eyes closed. By letting your thoughts go along with these instructions you can make your mind and body feel very relaxed."

(The following is to be read slowly.) (Begin timing.) "Picture yourself on a beautiful, warm summer day lying under the sun on a beach of an ocean or lake. Feel yourself lying on the soft, soft sand or on a beach towel that is soft and comfortable. Let yourself feel the sun pleasantly warm and feel the gentle breeze touching your neck and face. Picture the beautiful clear blue sky with fluffy little white clouds drifting lazily by. Let yourself feel the soothing, penetrating warmth of the sun and tell yourself that your mind and body feel completely relaxed and perfectly at ease ... peaceful, relaxed, comfortable, calm, so at ease, at peace with the universe... completely relaxed... relaxed, peaceful, lazy, tranquil...calm...comfortable. Your mind and body are completely relaxed... completely relaxed... calm, peaceful, tranquil, flowing with the universe." (End of timing: about 2'05".)

"Now you can open your eyes let yourself continue to feel relaxed and yet perfectly alert.... peaceful, alert, normal again. Open your eyes."

Creative Imagination Scale

You have just been asked to imagine 10 different experiences. What we would like you to do now is to rate each of these imagined experiences in terms of how similar you thought they were to real experiences. Please circle the (0, 1, 2, 3, or 4) which corresponds to the statement which most nearly matches your experience.

---

1 When you were asked to imagine dictionaries on your hand, how similar was the experience to actually having dictionaries piled on your hand?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

2 When you were asked to imagine the stream of water pushing up your hand, how similar was the experience to actually having water pushing up your hand

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

3 When you were asked to imagine your finger feeling numb, how similar was the experience to that of actually having your fingers numb?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

4 When you were asked to imagine drinking cool water, how similar was the experience to that of actually drinking cool water?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

5 When you were asked to imagine smelling and tasting an orange, how similar was the experience to that of actually smelling and tasting an orange?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

6 When you were asked to imagine listening to some music, how similar was the experience to that of actually listening to some music?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

7 When you were asked to imagine the sun shining on your hand and making if feel hot, how similar was the experience to how you would actually feel if the sun was shining on your hand, making if feel hot?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

8 When you were asked to imagine time slowing down, how similar was the experience to that of time actually slowing down?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

9 When you were asked to imagine that you were a child at primary school, how similar was the experience to that of actually being a child in primary school?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

---

10 When you were asked to imagine yourself relaxing on the beach, how similar was the experience to that of actually relaxing on the beach?

0 = not at all the same | 1 = a little the same | 2 = between a little and much the same | 3 = much the same | 4 = almost exactly the same

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Participant code (BLOCK CAPITALS):

If you have any comments on your experience which might help please write them overleaf. Thank you

APPENDIX XVII

HYPNOTIC INDUCTION

THE HYPNOTIC INDUCTION.

Before the hypnosis the participant was asked to nominate a place where they would feel particularly comfortable or relaxed. It could be a real place they had encountered in the past or an imaginary one, outdoors or indoors. They were asked to describe some of its main features and to say whether they would be sitting, lying, floating etc in order to avoid the therapist making inappropriate comments when setting the scene in hypnosis. The script below describes the type of induction used for a participant who described a beach where she relaxed by walking into the sea and floating on her back.

Imagery for breathing techniques and muscle relaxation was also checked with the participant in preparation for the hypnosis routine, as was the type of descent imagery preferred by the participant. .

To begin the induction the participant was asked to close her eyes. The following procedure was then used.

'Breathe out a colour that symbolises any tension you may be experiencing, any adrenaline or any feelings you'd rather not have. Watch this colour drift up to a cloud way, way above your head and when the cloud has filled with all these things watch it move away and now see that it is replaced by a bright sunny, optimistic looking sky.

Now feel that sun warming and comforting your body. Notice that your whole face is bathed in warmth and sunshine and feel that feeling of comfort on your forehead, eyelids and lips, spreading to the top of your head down to your neck, shoulders and arms. Now feel this spread right down to your finger tips Feel a colour of warmth and comfort in your hands and notice this feeling is now spreading to your chest and stomach and then all the way down your legs – right to the tips of your toes.

Now notice that you are standing at the top of a flight of steps which lead down to the beach you described to me earlier. When you have the feeling of being there in the garden at the top of the steps leading into the other part of the garden please nod your head so that I know .
In a moment or two ... when I say ..... I would like you to begin to walk down the steps towards the beach. As you walk down the steps you slip more deeply into a pleasant state of relaxation.

Down, down. Deeper into this very special place. All the sights, sounds and scents even more pleasant and relaxing than before. And you relax more and more. Down, down. Deeper and deeper. Your whole body becoming even more relaxed as you descend deeper than ever before into hypnosis and relaxation. Deeper and deeper. More and more relaxed.

I would like you to go now to the beach you described to me.
Begin to imagine and then to see, hear, smell and feel all of the sensations which are associated with that scene.
All other sounds and sensations which are not part of the beach becoming less important and eventually disappearing.
It is warm and a gentle breeze is blowing over you making you feel good and calm.
You are walking down the beach past the small rock towards the water.

The sand is warm beneath your feet.
You are feeling good and confident.
As you begin to enter the water ... the warmth of the water soothes your toes ..... and as you move deeper the muscles of your legs feel warmed and begin to relax more and more.
Deeper in the water and deeper into relaxation. Deeper and deeper.
More and more relaxed. Calm and happy.
The whole of your body feels relaxed as you lie back and begin to float. Supported safely and securely by the sea water.
You are quite safe to float where you are - there is no danger that you will float out to sea. And you can leave behind all everyday thoughts and simply enjoy the feeling of being completely relaxed, completely safe, completely secure.
And as you float there you may hear sounds of the sea birds in the distance - soothing pleasant sounds.
And you may be able to see the rocks and sand as you look around.
There are people around if you need them .... but they are in the distance and you are happy to be alone ... and safe ... and secure.
Relaxing in the warmth of the sun and the breeze.
Floating gently .... the movement of the sea rocking your body.
Gently and soothingly ..... becoming more and more relaxed.
Deeper and deeper into a pleasant state of relaxation and hypnosis. The waves moving your body gently as you float safely and securely. Feeling good .... feeling relaxed.
Deeper and deeper .... more and more relaxed.
Etc.'

This routine was followed by whichever intervention was planned for the therapy session.

The participant was alerted at the end of the completed hypnotic intervention by re-orientating her slowly back to the 'real life' environment. Suggestions were given that she would feel alert and refreshed when she opened her eyes following the therapist counting backwards from 3 to 1.

APPENDIX XVIII

Hypnosis In Post-Abortion Distress: An Experimental Client Study

(Photocopy of published version)

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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; Jonhnson 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 (PSDS; 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 selfs — 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 dissoci-

Table 1. Pre- and post-therapy scores

	Pre-therapy	Post-therapy	Follow-up 1 (3 months)	Follow-up 2 (12 months)
	PTSD classified as 'severe'	Criteria for PTSD not met	Criteria for PTSD not met	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

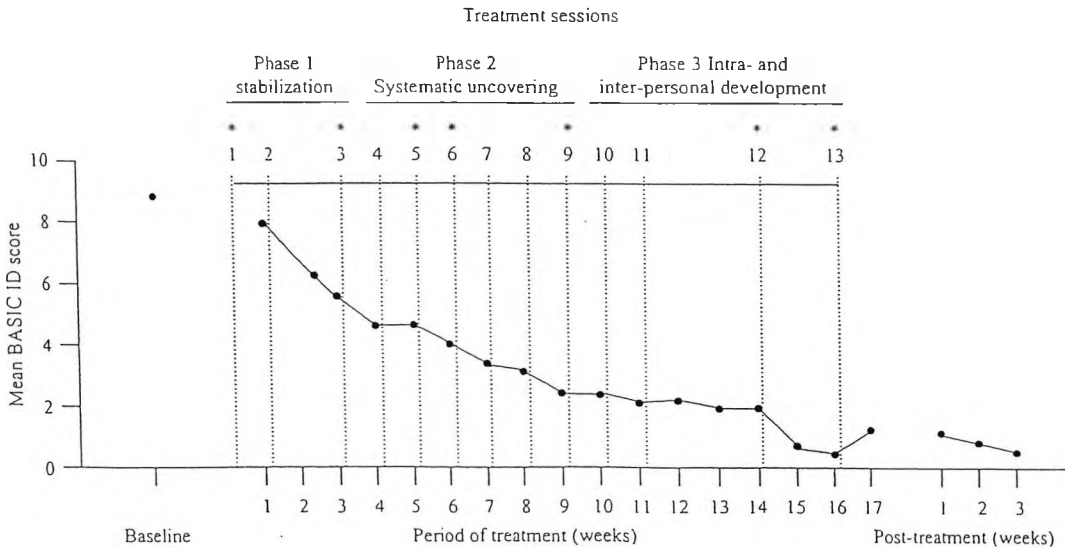

Figure 1. Mean scores based on S's weekly self-report ratings of the 39 symptoms derived from the BASIC ID (Lazarus, 1989), see text for further details.

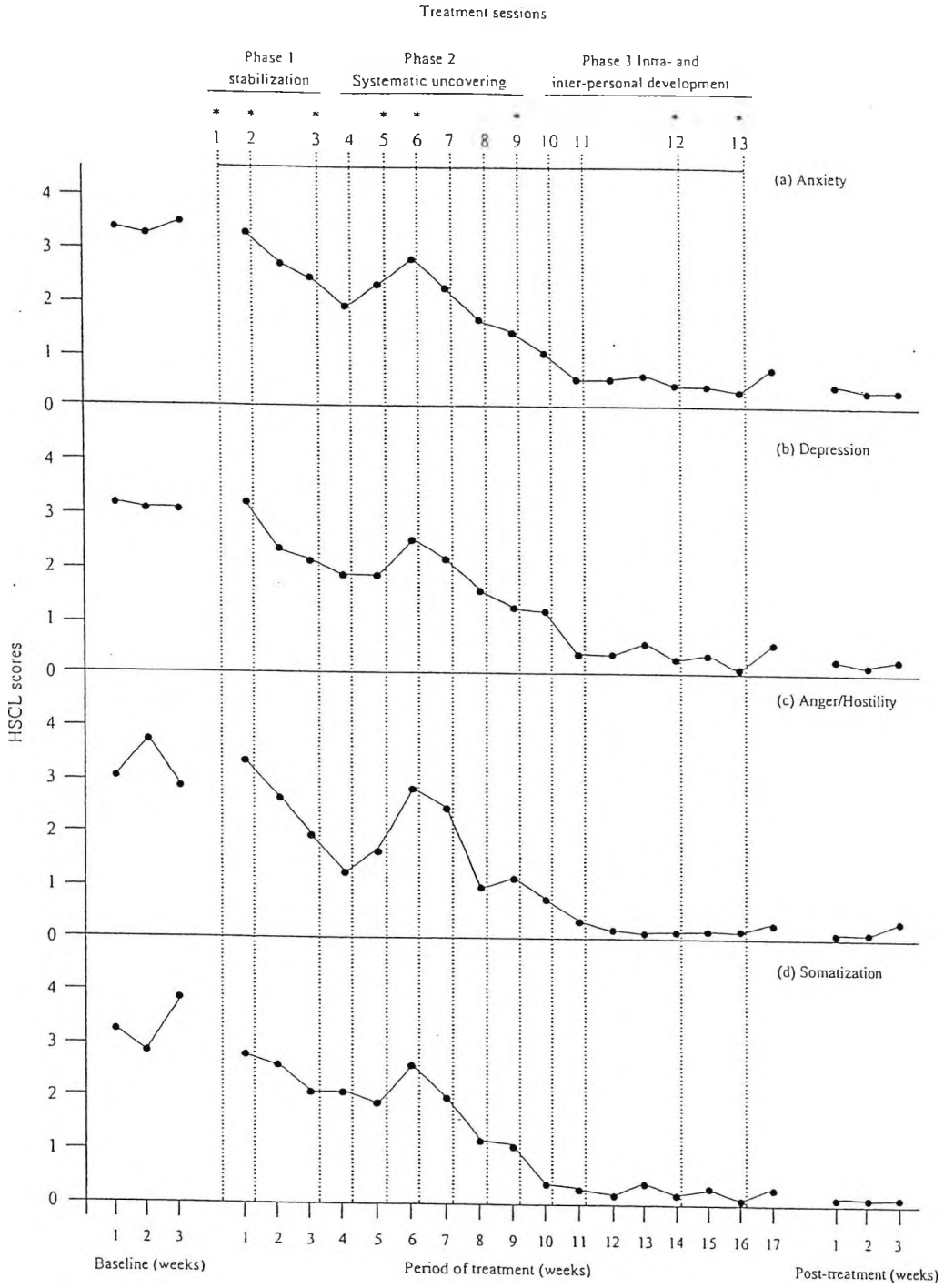

Figure 2 Graphs (a–d) illustrate S's anxiety, depression anger/hostility and somatization scores on the HSCL during the baseline period, the 17 weeks which spanned the course of therapy and post-treatment over three weeks. Three baseline measures were taken at weekly intervals before therapy commenced. The course of therapy involved 13 sessions, seven of which included an hypnotic intervention (the sessions involving hypnosis are marked with an asterisk). The HSCL 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?	
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'	*'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 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.'*	4
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.	*'Felt very vivid to see myself and remember the experience of my birthday. It made me happy to remember feeling carefree and happy.'*	*'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.'*	4
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.	*'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'd never previously "won" against my bullies and this felt empowering. I never thought that I'd be able to do this.'*	4
Week 7/Session 6. You went back to the experience of your termination. Your older self comforted you.	*'Again this was terrifying. It was very vivid and "real". My older self was able to help and provide comfort.'*	*'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.'*	5
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.	*'Challenging. I felt a mixture of emotions: sad, attachment, lonely, grief, relief and peace.'*	*'I had not given myself the opportunity to say "good-bye" and had not felt I was able to until this point.'*	5
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.	*'Felt frightened at first as it seemed very clear and vivid but I was able to cope with it.'*	*'Helped conquer a "demon" that had caused prolonged disturbed sleep and left me feeling shaky and upset on waking.'*	4
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.	*'I felt strong enough to reface or face bad feelings I had experienced and I felt better; a sense of relief.'*	*'Felt able to divorce myself from these feelings and felt released from them.'*	5

References

Araoz, D.L. (1981) Negative self-hypnosis. Journal of Contemporary Psychotherapy 12: 45–52.

Ashton, J.R. (1980) The psychological outcome of induced abortion. British Journal of Obstetrics and Gynaecology 82: 1115–22.

Barber, T.X., Wilson, S.C. (1978) The Barber Suggestibility Scale and the Creative Imagination Scale: experimental and clinical applications. American Journal of Clinical Hypnosis 21: 84–108.

Braffman, W. Kirsch, I. (1999) Imaginative suggestibility and hypnotizability; an empirical analysis. Journal of Personality and Social Psychology 77: 578–87.

Brende, J.O., Benedict, B.D. (1980) The Vietnam Combat Delayed Stress Syndrome: hypnotherapy of 'dissociative symptoms'. American Journal of Clinical Hypnosis 23: 34–40.

Brien, J., Fairbairn, I. (1996) Pregnancy and Abortion Counselling. London: Routledge.

Brown, D. (1995) Pseudomemories: the standard of science and the standard of care in trauma treatment. American Journal of Clinical Hypnosis 37: 1–2.

Cardena, E. (2000) Hypnosis in the treatment of trauma: a promising, but not fully supported, efficacious intervention. International Journal of Clinical and Experimental Hypnosis 48: 225–38.

Derogatis, L.R., Lipman, R.S., Rickels, K., Uhlenhuth, E.H., Covi, L. (1974) The Hopkins Symptom Checklist (HSCL): a self-report symptom inventory. Behavioral Science 19: 1–15.

Dolan, Y. (1991) Resolving Sexual Abuse. New York, NY: Norton.

Foa, E.B., Kozak, J. (1986) Emotional processing of fear: exposure to corrective information. Psychological Bulletin 99: 20–35.

Foa, E. (1995) Post Traumatic Stress Diagnostic Scale. USA: National Computer Systems, Inc.

Folkman, S., Lazarus, R. S. (1988) Manual for the Ways of Coping Questionnaire. Palo Alto, CA: Consulting Psychologists Press.

Johnson, M.P., Puddifoot, J.E. (1998) Miscarriage: is vividness of visual imagery a factor in the grief reaction of the partner? British Journal of Health Psychology 3: 137–46.

Kirsch, I., Montgomery, G., Sapirstein, G. (1995) Hypnosis as an adjunct to cognitive–behavioral psychotherapy: a meta-analysis. Journal of Consulting and Clinical Psychology 63: 214–20.

Kubany, E.S., Abueg, F.R., Brennan, J.M., Haynes, S.N., Manke, F.P., Stahura, C. (1996) Development and validation of the trauma-related guilt inventory (TRGI). Psychological Assessment 8: 428–44.

Lazarus, A. (1981) The Practice of Multimodal Therapy. Baltimore, MD: The John Hopkins University Press.

Levenson, H. (1981) Differentiating among internality, powerful others and chance. In: Lefcourt, H.M. (Ed.), Research with the Locus of Control Construct (Volume 1). New York, NY: Academic Press; 15–63.

Major, B., Cozzarelli, C. (1992) Psychosocial predictors of adjustment to abortion. Journal of Social Issues, American Journal of Psychiatry 48: 121–42.

Major, B., Cozzarelli, C., Sciacchitano A., Cooper, M., Testa, T., Mueller, M. (1990) Perceived social support, self-efficacy, and adjustment to abortion. Journal of Personality and Social Psychology 59: 452–63.

Marks, D.F. (1973) Visual imagery differences in the recall of pictures. British Journal of Psychology 64: 17–24.

Meuller, P., Major, B. (1989) Self-blame, self-efficacy, and adjustment to abortion. Journal of Personality and Social Psychology 57: 1059–68.

Paintin, D. (1997) Twenty Questions About Abortion. London: Birth Control Trust.

Parry, G., Shapiro, D.A., Firth, J. (1986) The case of the anxious executive: a study from the research clinic. British Journal of Medical Psychology 59: 221–33.

Potvin, L., Lasker, J., Toedter, L. (1989) Measuring grief: a short version of the perinatal grief scale. Journal of Psychotherapy and Behavioral Assessment 11: 29–45.

Rosenberg, M. (1965) Society and the Adolescent Self-Image. Princeton, NJ: Princeton University Press.

Rusch, M.D., Grunert, B.D., Mendelsohn, R.A., Smucker, M.R. (2000) Imagery rescripting for recurrent, distressing images. Cognitive and Behavioral Practice 7: 173–82.

Speckard, A.C., Rue, V. M. (1992) Postabortion syndrome: an emerging public health concern. Journal of Social Issues 48: 95–119.

Spiegel, D. (1997) Hypnosis in the treatment of post traumatic disorders. In: Rhue, J., Lynn, S., Kirsch, I. (eds), Handbook of Clinical Hypnosis. Washington, DC: American Psychological Association; 493–508.

Van der Hart. O. (1988) An imaginary leave-taking ritual in mourning therapy: a brief communication. International Journal of Clinical and Experimental Hypnosis 36: 63–9.

Walters, V.J. (1999) The Usefulness Of Hypnosis Questionnaire: An investigation of the Effectiveness of Hypnosis as an Adjunct to Therapy for Post-Abortion Distress. Unpublished MSc Dissertation, University of London.

Walters, V.J., Oakley. D.A. (in press) Hypnosis as a possible 'virtual reality' context in cognitive behavioural therapy for an environmental phobia. Clinical Case Studies.

Watkins, J.G., Watkins H.H. (1997) Ego States: Theory and Therapy. New York, NY: Norton.

Zigmund, A.S., Snaith, R.P. (1983) The hospital anxiety and depression scale. Acta Psychiatrica Scandinavica 67: 361–70.

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APPENDIX XIX

Does Hypnosis Make *In Vitro, In Vivo*? Hypnosis as a Possible 'Virtual Reality' Context in Cognitive Behavioural Therapy for an Environmental Phobia.

(Photocopy of published version)

Does Hypnosis Make In Vitro, In Vivo?

Hypnosis as a Possible Virtual Reality Context in Cognitive Behavioral Therapy for an Environmental Phobia

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Abstract: This case illustrates the use of hypnosis as an adjunct to therapy in phobia treatment. Interventions conducted in an hypnotic context included cue-controlled relaxation and covert desensitization, in which the client reframed her fears and transformed fear-related images into benign stimuli. These interventions were experienced by the client as having an "as real" quality and were successful in reducing her long-standing fear of the wind to a normal level within three sessions. This improvement was maintained at 18 months follow-up. This outcome is discussed in relation to virtual reality approaches to phobia treatments and ways in which hypnosis may facilitate cognitive behavioral techniques.

Keywords: hypnosis; virtual reality; phobia; cognitive-behavioral therapy

1 THEORETICAL AND RESEARCH BASIS

Although cognitive behavioral therapy (CBT) is the treatment of choice for phobic disorders, a meta-analysis by Kirsch, Montgomery, and Sapirstein (1995) indicates that the addition of a hypnotic context to CBT leads to greater effectiveness of therapy for a range of disorders. Included in the studies examined in the meta-analysis was the treatment of phobia. This case illustrates the possible advantages of the hypnotic context when using hypnosis as an adjunct to treating an environmental phobia.

Weitzenhoffer (1972) asserted that hypnosis was useful in behavior therapy because it facilitated relaxation, increased suggestibility, and heightened vividness of imagery (see also Spinhoven, 1987). More important, suggested experiences in hypnosis have a more "as real" quality to them than when the same events are simply imagined.

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A recent brain imaging study (Szechtman, Woody, Bowers, & Namias, 1998) has shown that sounds suggested to high hypnotizables in hypnosis produce similar brain activation to that present as when the same sounds are actually heard. This effect was not present when the same participants were asked to imagine the sound as vividly as possible. The capacity to experience suggested situations in hypnosis as real events may be a key factor when considering hypnosis as a useful adjunct to the treatment of phobias.

The potential benefit of providing phobic clients with "as real" experiences in therapy is reflected in a number of studies in which technological advances have facilitated the creation of virtual environments to explore (Pertaub, Slater, & Barker, 2002; Slater, Pertaub, & Steed, 1999) and to treat (e.g., Anderson, Rothbaum, & Hodges, 2000; Kahan, Tanzer, Darvin, & Borer, 2000; Rothbaum, Hodges, Smith, Lee, & Price, 2000; Wiederhold & Wiederhold, 2000) a variety of phobias.

2 CASE PRESENTATION

This case illustrates the use of hypnosis as an adjunct to therapy in phobia treatment.

3 PRESENTING COMPLAINT

Sarah was 38 years old when she self-referred for therapy to the hypnosis unit to overcome an extreme fear of the wind, which she had experienced for the previous 2 years. She could identify no particular cause for her fear but remembers its onset coinciding with a stressful Christmas period when the weather had been very windy. Sarah was completely preoccupied with the weather, and when it was windy she felt unable to carry out normal everyday tasks such as cooking, washing up, or taking a shower.

4 HISTORY

Sarah lived on a narrow boat, moored close to a 60-foot alder tree, for more than 20 years. Initially she lived on a different mooring with her previous partner, Tim, who died suddenly 6 years ago on the night of the move to her present mooring nearby. In addition, around the time of her partner's death there were four other family deaths. Her phobia developed 4 years later. Since Tim's death, Sarah had met a new partner with whom she had a good relationship.

5 ASSESSMENT

Sarah met the *DSM-IV* (American Psychiatric Association, 1994) diagnostic criteria for a specific phobia. Self-reported scaling was used to measure the following associated physiological, behavioral, and subjective symptoms (Lang, 1968):

Physiological: When the weather was windy, she felt physically shaken and sick, and the muscles in her back and neck seized up.
Behavioral: She avoided situations in which she would be outside on windy days but was preoccupied with listening out for the sound of the wind and felt compelled to watch the tree swaying and the clouds moving.
Subjective: Anticipation of adverse consequences of the wind—recurrent thoughts such as "The branches will fall off and damage the boat"—caused her intense anxiety.

Lynn, Kirsch, Barabasz, Cardena, and Patterson (2000) suggested that to further our understanding of the efficacy of hypnosis, assessment should address such matters as hypnotic suggestibility, expectancies, and motivation. Sarah's hypnotic ability was not formally measured, but her ability to become thoroughly absorbed in books and films, her excellent self-motivation, and a positive view about hypnosis and self-referral for hypnosis as an adjunct to treatment were factors indicating that hypnosis was likely to be an appropriate context for therapy. Sarah had once seen a demonstration of hypnosis used for pain management but had not previously experienced hypnosis herself.

6 CASE CONCEPTUALIZATION

Natural environmental phobias generally have a childhood onset (*DSM-IV*), but a traumatic event at any age may be a predisposing factor. One hypothesis was that the weather might have been windy when her partner had died (though she had no recollection of this) and that windy weather, coinciding with Sarah's stressful Christmas some years later, had triggered fearful feelings associated with the boat and her partner's sudden death.

Sarah was mildly curious about why her fear had developed but identifying the cause was not a goal of therapy for her. However, if her symptoms were resistant to change, it was agreed that hypnosis would be used as an adjunct to a psychodynamic approach in which we would work toward identifying and resolving any underlying issues that might have caused the fear (e.g., Watkins, 1971).

7 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

SESSION 1

After taking her history, the therapist asked Sarah to identify her fears and list them in the following hierarchical order, the first being the worst:

the noise of the wind,
the movement of the tree and a fear of the branches breaking off and hitting the boat,
hearing the weather forecast, and
the movement of the boat.

Sarah described how she would constantly listen out for sounds of the wind, and as soon as she believed she could hear it she would feel compelled to watch the movements of the alder tree while crouching on the kitchen floor of the boat. Any news reports of trees falling down terrified her. She also would feel driven to listen to distant sounds of trains or airplanes until she was certain that these sounds were not sounds of the wind. Another aspect of the fear was her need to wear a hat tied down by a scarf when outside when windy. Furthermore, when outside in the wind, she would have to rush back indoors, and on occasions this resulted in her missing important meetings.

Sarah identified coping strategies that she was already using, such as telling herself that it will stop being windy and reminding herself that trees are flexible and that the roots are deep. Thoughts of the tree growing made her fear worse (because she felt it might break more easily with age), as did thoughts of the clouds moving speedily across the sky.

The rationale for using hypnosis was given, for example, that her fear had been learned (Wolpe, 1958, 1961) and that hypnosis would provide her with vivid experiences in which she could unlearn this habit. It also was explained that since she had become stuck in a particular way of thinking (Salkovskis, 1996), hypnosis would assist in overcoming her problem by giving her an opportunity to understand it in a different way.

SESSION 2

Sarah was introduced to hypnosis. In preparation for this, the therapist asked her to describe a place in which she could feel relaxed and safe. Sarah gave a vivid description of a stately home garden, including a wonderful "Botticelli's Venus" fountain with water trickling from a clamshell. She described sounds of water trickling ("a sort of musical sound"), birds singing, and the distant sounds of the occasional car. She was also able to describe a smell of dampness, moss, and privet. She wanted to use this setting as her special place where she could sit on the damp grass quite happily by herself.

Hypnotic Procedure 1: Introduction to Hypnosis

Hypnotic induction included breathing techniques (including "breathing out" a color of tension), muscle relaxation using imagery of the warmth and comfort from a gentle sun, and being counted down a flight of 10 steps to her special place. Each count was timed to coincide with her out-breath. The hypnosis lasted 25 minutes but she experienced it as approximately 10 minutes, which indicated absorption in the hypnotic experience. She reported feeling heavy and also that she had "felt the warmth from the sunshine traveling to each part of my body." She felt as if she was really there in the garden. In this context, it is interesting to note that although the therapist had suggested that the steps were warm (making the assumption that they had be warmed by the sun) Sarah had reported that she had actually experienced the steps in hypnosis as feeling very cold. Sarah was encouraged by this experience and was happy to proceed to another hypnotic procedure that would address the fear listed lowest on her list.

Hypnotic Procedure 2: Desensitization

The same hypnosis induction procedure was repeated, and Sarah was encouraged to talk during it. After reaching her special place in hypnosis, the therapist asked Sarah to find herself transported to her boat and to have the experience of "being there." She described in detail the interior of the sitting room, and she said that she was sitting on the floor. It was suggested that the boat was beginning to move with the wind. The therapist then asked her to rate fear on a scale of 0 to 10 (10 being the worst), and she reported it was at 5. She felt a great need to tie the boat tighter to the mooring to stop the movement, but the therapist asked her to think of her special place and relax and suggested that the more she relaxed the more she could resist tying the boat tighter. She was then asked to let the "back part of her mind" come up with a statement that would be helpful for her to hear. She said "I don't need to look out of the window" had come to mind. The therapist then asked where her fear was on the scale, and she reported that it was now at 1, which she said felt fine.

In view of her success in dealing with this first item on her hierarchy, the therapist asked Sarah if she was ready to tackle the next fear on her list. She agreed to this. The therapist suggested that she was still on her boat and about to hear the weather forecast. She reported tension in her stomach, neck, and face muscles when she was asked to describe how she was feeling. She was asked to rate her fear when it was suggested that the forecast was predicting strong winds. She reported this to be 7 or 8 on the scale of 0 to 10. The therapist suggested that she bring back all the calm, safe, and relaxed feelings of her special place while the back part of her mind would, without her trying, tell her something that she needed to hear. She heard the statement "It doesn't matter if it's windy." Following this action, she rated her fear on the scale as between 2 and 3. She was given further suggestions to evoke feelings of relaxation associated with her special place and physical relaxation, and her self-statement was repeated. Following these sugges-

tions, she rated her fear at 0. Sarah was then alerted. She described the hypnotic experience and her sense of being there inside the boat, feeling the texture of the wood and rough carpet.

At the end of this session, Sarah was feeling very confident that hypnosis would work for her. She was instructed in the safe use of the induction, relaxation, and special place routine as her own self-hypnosis procedure and was encouraged to practice this regularly at home.

SESSION 3 (2 WEEKS LATER)

Sarah reported that she was less aware of the wind. On the occasions that she had noticed it she had thought, "It's windy, so what!" She described the shift in her feelings as being as if someone had "switched off a switch." She was doing regular self-hypnosis but had been distracted by the noises of birds, swans, and neighbors—everyday sounds that she normally enjoyed. The therapist suggested that she use these sounds to bring feelings of familiarity, comfort, and safety and to focus on them rather than try to block them out. She had not been able to test her greatest fear of very strong winds because the weather had been fairly good since the last session. She had become aware, however, that now when she heard the sound of an airplane she heard it only as an airplane rather than as the rumbling of a gust of wind. She had not felt the need to look out of the window at the alder tree, and when she spotted the same tree from a train window on her way home from work, she had noticed that she had not felt at all concerned. She also noticed that on occasions when the weather had been breezy, she had been able to go out without feeling anxious, something she could not have done prior to therapy. However, she felt that she still needed to convince herself that the tree could move a lot more without breaking. It was decided to progress to the two items she had identified as being the highest on her fear hierarchy.

Hypnotic Procedure 3: Further Desensitization

After the induction and special place procedures, the therapist suggested that Sarah feel herself to be on her boat and that the wind was blowing strongly. She said she was aware of things moving, cutlery clanking together, and noises in the chimney. She then became aware of sounds outside the boat. She described the sound of the wind building up and gradually getting closer. She began to feel tension in the muscles of her back and stomach, and she was at 6 or 7 on her fear scale. She was told to look at the tree and see that it could twist and bend without breaking. Her fear then reduced to 4 to 5 on the scale. The therapist then suggested that she listen to the trickling fountain that she so much enjoyed in her special place and that this would bring feelings of calm and relaxation. Her fear then reduced to 2 or 3 on her fear scale. Finally, the therapist suggested that the tree was dancing to the trickling sound. She then reported that her fear had dropped to 1.

After Sarah was alerted, she commented that she was struck by how much the sound of the trickle of the fountain had helped. She also reported that she had also found the concept of the tree dancing to be a very gentle, relaxing thought. It was particularly interesting that during the procedure the gentle sound of the fountain had been transformed, without suggestion, into a roaring waterfall, "like standing under Niagara Falls." She appeared very surprised, not only that this had sprung to mind but also because it had felt as if she was really hearing the sound of the waterfall. She then commented that this was a wonderful sound that very much reflected her love of nature and the outdoors. She said that this sound was all she needed to imagine to overcome her anxiety.

Sarah felt very hopeful at the end of the session. She was looking forward to the difference that overcoming her fear would make to her life. She commented that since the first session in which hypnosis had been used (Session 2) she had been able to do things that she had not done for 2 years in windy weather, for instance washing up, having a shower, and having the concentration to play Trivial Pursuit with her partner. She felt as if she could carry on as normal. Once again she described this as a feeling that someone had "flicked a switch."

She was pleased that people at work had noticed a change in her, especially as she would now go out at lunchtime when it was windy, something that she could not do for the past 2 years, even in a slight breeze. She also was delighted that she no longer needed to wear the hat and scarf when out and about.

The therapist decided in this session that Sarah would report back in 2 or 3 weeks after testing her recovery in windy weather. This she did, and she did not need further sessions because her improvement had been maintained.

8 COMPLICATING FACTORS

There were no complicating factors in this case. Sarah enjoyed good health, and although she described herself as generally "quite anxious," she did not experience any other psychological problems.

9 FOLLOW-UP

One year later, Sarah was delighted to report that her progress had been maintained and remarked that her concentration also had improved now that she was no longer distracted by a preoccupation with the weather. All her symptoms, such as feeling compelled to crouch inside the boat and watch the speed of the clouds during the night, feeling shaken and sick and experiencing muscle tension, and avoiding going out in the wind, were gone. She said she now felt the sound of the wind was an annoyance but did not cause her any fear. She felt her anxiety about branches falling off the tree was now at

an entirely normal level and remarked that not being concerned about a very old tree dropping its branches on one's boat would be rather foolhardy.

Sarah commented that one of the techniques she learned in therapy, that of visualizing things that frightened her as something that she could draw comfort from (like changing the wind sounds into waterfall sounds), also had been useful. It not only helped her overcome her fear of the wind but she also used it to stop feeling panicky when driving on the motorway by changing the sound of the car engine into comforting sounds of a waterfall and water.

Eighteen months after treatment, Sarah wrote "I still use the techniques you taught me, although not for the original reason [the wind phobia]—that is now totally under control."

10 TREATMENT IMPLICATIONS OF THE CASE

Studies frequently cite the positive role of expectancy in therapeutic outcome (Kirsch, 1990, 1997; Schoemberger, 1999). Labeling a therapy as *hypnotic* can raise clients' expectation of its efficacy (Wagstaff & Royce, 1994), and Sarah had come to therapy with the expectation that hypnosis would be helpful to her. Vividness of imagery has sometimes been referred to as somewhat secondary to expectations (Lynn et al., 2000). However, in the light of recent neurological studies, such as by Szechtman et al. (1998), we need to consider the extent to which the level of subjective "realness" of the hypnotic experience may contribute to therapeutic change. Sarah reported her experience in hypnosis, of being on the boat and so forth, as one of "being there" and of being directly engaged with the fearful situations as they unfolded and developed. She also had the experience of using her coping strategies in vivo and of demonstrating their effectiveness in "real" situations to herself. This felt realness or virtual reality of the hypnotic experience may be crucial in facilitating a positive experience of mastery, accompanied by all the relevant mental processing. This is arguably more effective than using simply imagined situations, which, as indicated by the data of Szechtman et al. (1998), are not experienced subjectively or neuropsychologically as real and so arguably do not provide the equivalent rehearsal experience.

Schoemberger (1999), in discussing expectancy and fear, commented that once expectancy of anxiety is reduced, clients are more prepared to progress to in vivo exposure in which they learn to build on skills developed by the use of imagery techniques. The vividness of a suggested hypnotic experience may accelerate this process by giving the in vitro imagined situations set up by the therapist an in vivo quality. This in turn would be expected to facilitate the transfer of coping skills to actual everyday situations. The degree of felt realness may thus be a contributing factor in moderating the speed at which clients are able to achieve mastery over a phobia.

It also was notable that Sarah's self-statements developed in hypnosis had such a profound effect, especially because they were of a very ordinary nature. Indeed, Sarah

had used self-statements prior to her therapy, such as telling herself that it will stop being windy and reminding herself that trees are flexible and that the roots are deep, but although these statements had been useful coping strategies, she continued to experience the fear. The self-statements elicited in hypnosis, "I don't need to look out of the window" and "It doesn't matter if it's windy," were on the face of it no more profound or insightful but, in contrast to the ones she had used previously, had tremendous effect. It may be that the context of hypnosis increased the significance of these self-statements and consequently their effectiveness.

Another observation was the ease with which Sarah was able to transform a frightening sound into a comforting one. Notably, she had arrived at the idea of transforming the sound of the wind to the sound of a waterfall herself after the therapist's reference to the tree dancing in the wind. It is possible that this was the result of a series of associations that began when it was suggested that the wind was blowing and that she look at the tree moving. It may be further speculated that this frightening image triggered a physiological response. The therapist then reframed the feared image to a pleasant image of the tree dancing in the wind, building on the client's imagery of the musical sound of the fountain. This suggestion successfully reduced her level of arousal. The resulting feeling of comfort may have encouraged Sarah to become more intensely focused on sounds while experiencing an increasing sense of mastery. It is possible that this sense of mastery enabled her to then focus on the reality of the sound of the strong wind, leading her to associate this with a more congruent sound of a roaring waterfall.

11 RECOMMENDATIONS TO CLINICIANS

The style of language used in this study encouraged Sarah, in hypnosis, to experience situations rather than simply to imagine them. This distinction is an important one, and in general terms it seems worth considering more carefully the detail of language used in interventions in accounts of clinical cases. The distinction between imagining and experiencing is also a consideration when pacing therapy. It may, for example, be appropriate in some cases of severe trauma, especially when the client is highly hypnotizable, to use hypnotic interventions that suggest a client "imagine" before progressing to suggestions of "experiencing" to avoid the risk of overwhelming him or her with negative feelings.

It has been generally recognized that the use of in vivo procedures (including virtual reality procedures), whenever possible, is likely to be more effective therapeutically than employing in vitro, imaginal procedures. It can similarly be claimed that there are advantages in using computerized virtual reality over real situations in the treatment of phobia (see Pertaub et al., 2002). For instance, endless types of useful situations can be set up in which the client can rehearse unlearning his or her fear. This advantage is also one that can be claimed for hypnotic approaches. Furthermore, it is noteworthy that participant comments describing the virtual experience quoted by Pertaub et al. (2002) are

very similar to those of clients describing the realness of a hypnotic experience. Studies using virtual reality in the treatment of phobia are exciting, but we should be mindful that hypnosis would appear to offer the additional advantage of providing virtual reality without the need for technology and expensive programming.

Not all cases of phobia treatment with the adjunctive use of hypnosis progress as rapidly as the one we have described in this article. Indeed, we go to great lengths to inform clients that hypnosis is not a magic pill. However, some clients do experience recovery as if they have flicked a switch. We suggest in this article that one factor that may contribute to such rapid change is the in vivo quality conferred on in vitro procedures by conducting a standard form of treatment in a hypnotic context.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anderson, P. L., Rothbaum, B. O., & Hodges, L. (2000). Virtual reality: Using the virtual world to improve quality of life in the real world. *Bulletin of the Meninger Clinic, 65*(1), 78-91.

Kahan, M., Tanzer, J., Darvin, D., & Borer, F. (2000). Virtual reality-assisted cognitive-behavioural treatment for fear of flying: Acute treatment and follow-up. *Cyberpsychology and Behaviour, 3*(3), 387-392.

Kirsch, I. (1990). *Changing expectations: A key to effective psychotherapy*. Belmont, CA: Brooks/Cole

Kirsch, I. (1997). Response expectancy theory and application: A decennial review. *Applied and Preventive Psychology, 6*, 69-79.

Kirsch, I., Montgomery, G., & Sapirstein, G. (1995) Hypnosis as an adjunct to cognitive behavioural psychotherapy: A meta-analysis. *Journal of Consulting & Clinical Psychology, 63*, 214-220.

Lang, P. J. (1968). Fear reduction and fear behaviour: Problems in treating a construct. In J. M. Schien (Ed.), *Research in psychotherapy* (Vol. 111, pp. 90-103). Washington, DC: American Psychological Association.

Lynn, S. J., Kirsch, I., Barabasz, A., Cardena, E., & Patterson, D. (2000). Hypnosis as an empirically supported clinical intervention: The state of the evidence and a look to the future. *International Journal of Clinical and Experimental Hypnosis, 48*(2), 239-259.

Pertaub, D.-P., Slater, M., & Barker, C. (2002). An experiment on public speaking anxiety in response to three different types of virtual audience. *Presence: Teleoperators and Virtual Environments, 11*(1), 68-78.

Rothbaum, O. S., Hodges, L., Smith, S., Lee, J. H., & Price, L. (2000). A controlled study of virtual reality exposure therapy for the fear of flying. *Journal of Consulting and Clinical Psychology, 68*, 1020-1026.

Salkovskis, P. (1996). The cognitive approach to anxiety: Threat beliefs, safety-seeking behavior, and the special case of health anxiety and obsessions. In P. Salkovskis (Ed.), *Frontiers of cognitive therapy*. New York: Guilford.

Schoemberger, N. (1999). Expectancy and fear. In I. Kirsch (Ed.), *How expectancies shape experience*. Washington, DC: American Psychological Association.

Slater, M., Pertaub, D -P., & Steed, A. (1999). Public speaking in virtual reality: Facing an audience of avatars. *IEEE Computer Graphics and Applications, 19*, 2-5.

Spinhoven, P. (1987). Hypnosis and behaviour therapy: A review. *International Journal of Clinical and Experimental Hypnosis, XXXV*(1), 8-31.

Szechtman, H., Woody, E., Bowers, K. S., & Namias, C. (1998). Where the imaginal appears real: A positron emission topography study of auditory hallucinations. *Proceedings of the National Academy of Science, 95*, 1956-1960.

Wagstaff, G. F., & Royce, C. (1994). Hypnosis and the treatment of nail biting: A preliminary trial. *Contemporary Hypnosis, 11*, 9-13.

Watkins, J. G. (1971). The affect bridge: A hypnoanalytic technique. *International American Psychologist*, 40, 1189-1202.

Weitzenhoffer, A. M. (1972). Behaviour therapeutic techniques and hypnotherapeutic methods. *American Journal of Clinical Hypnosis, 15*, 71-82.

Wiederhold, B. K., & Wiederhold, M. D. (2000). Lessons learned from 600 virtual reality sessions. *Cyberpsychology and Behaviour*, 3(3), 393-400.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Palo Alto, CA: Stanford University Press.

Wolpe, J. (1961). The systematic desensitisation treatment of neurosis. *Journal of Nervous and Mental Diseases*, 132, 189-203.

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