

BRIEF PSYCHOTHERAPY UTILIZING HYPNOSIS TO REDUCE NEGATIVE EMOTIONS TRIGGERING A STRESS RESPONSE, EXACERBATING A CHRONIC SKIN COMPLAINT—LICHEN SCLEROSUS OF THE VULVA

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A recent diagnosis, being a second chronic illness, of a skin condition on the genitals of a 40-year-old woman, triggered a stress response of heightened emotions including: anxiety, grief, guilt and anger. Her goal was specifically to treat the anger. The process of brief psychotherapy using the language of narrative therapy was the framework for treatment. Content of therapy specifically utilized self-hypnosis and the indirect hypnotic approach of metaphor. This allowed us to refer to sexual intimacy in a symbolic way. Therapeutic outcome was positive at six months' follow-up.

BACKGROUND

Sally was a 40-year-old mother. She had married later in life and lived with her husband and her two children, a 15-year-old daughter and a two-year-old son. Sally and Barry had recently married. He was the father of two-year-old Timmy. Twenty-five years ago, while still at high school, Sally contracted another chronic disease, hepatitis C, which had only been diagnosed eight years ago.

Sally and her family had Christmas commitments and she wanted to contain her current levels of distress over the next few weeks. She thought she needed to be “psychoanalyzed” because she thought she was definitely doing something wrong with how she lived her life and did not want to develop a third associated chronic disease in the future. This was an intolerable thought, producing intense negative emotions.

CASE FORMULATION

Hypnosis can be used successfully to treat the related stress but not always the organic cause of skin diseases (Brown & Fromm, 1987). Skin diseases are complex with many interrelated causes. Some causes are unknown, as in this case, but can include psychological factors—the combination of negative emotional responses and the autonomic nervous system. For example, redness, swelling, sweating and the sebaceous glands, functioning together, can be a clear factor in the aetiology of some skin complaints like neurodermatitis. Yet they are unknown in others, such as lichen sclerosis.

Successful use of conversational therapies including psychotherapy and hypnosis when treating skin diseases requires purposefully identifying and utilizing the client's goals. Sally's goal was to reduce her feelings of "anger" and "meanness." When the symptom has a limited defensive function, outcomes are much more favourable. (Wolberg, 1948, p.1).

Sally's negative emotions of "anger" and "meanness" are conceptualized here as expressions of a defensive function. She had currently adopted these negative emotions to try to gain control of her fears and keep functioning as a parent and spouse. In her developmental history Sally spoke about identifying with the "mean girl" who bullied her in high school. It appeared she had adopted the defensive function of identifying with the aggressor (see "Personal History" for more detail).

The concept of emanation was important when formulating treatment in this case (Hlywa, 1998). Emanation refers to the emphasis and priority given to suggestions using the client's own words, consistent with their values and beliefs (Hlywa, 2009/2010, 2010). For Sally, that was to express less anger and meanness to those closest to her. Her therapy could not just be conducted as "an exercise in order to satisfy perimeters of some theories" (Hlywa & Dolan, 2008, p. 6).

REFERRAL INFORMATION

Sally had recently been diagnosed with lichen sclerosis (LS), which she found very difficult, following prolonged symptoms. LS is a skin condition but not an infection and cannot be passed on to anyone else. It may involve any part of the skin, but in this case it was found on the genital area. This disturbed Sally—she felt "guilty and evil." It is not an internal disease and never extends into the vagina. It can occur at any age. Most cases are found in adult women. Causes are unknown. The tendency could be inherited because this disease

may reoccur in families (NSW Department of Health, 2008).

The typical appearance is of whitened skin around the vulva, perineum and anus. There may be lesions that look like blisters and bruises. It is not uncommon for the skin to split open easily. There can be soreness and pain with intercourse. LS may cause scarring resulting in loss of labia minora (inner lips of the vagina) and reduction in size of the vaginal opening.

People who suffer from LS can face an increased risk of cancer of the vulva. They may also suffer from “autoimmune” diseases like systemic lupus erythematosus and thyroid disease (NSW Department of Health, 2008). These associations are not common, but still Sally needed to discuss her fear of contracting a third chronic illness with her medical practitioner. Sally was very upset about the possibility of the future development of these symptoms or associated diseases. Educational information about LS intensified her anxiety. Sally feared the worst.

LS is treated with cortisone cream. Treatment is continuous. Intercourse is possible again once LS is being treated. (NSW Department of Health, 2008). The prognosis for most patients with LS is very good. It nearly always responds quickly to treatment and if this were continued, with time Sally was assured by her GP she would need less medication to remain symptom free. From the perspective of using hypnosis, this was a strong positive suggestion from which to begin treatment.

PRESENTING SYMPTOMS

The physical symptoms Sally experienced were itch and atrophy or early aging of the genitals. Cortisone cream was helping with the itch. No underlying cause was identified. The LS had made her feel very fragile and disturbed because she had a chronic disease, which she said she “will have to learn to deal with.” This was on top of a previous diagnosis of hepatitis C, also a chronic disease. She had coped quite well with the hepatitis C up until this point. She now reported feeling overwhelmed, isolated and was having difficulty managing.

Sally’s general practitioner was supportive. Sally found this GP after a number of difficult consultations with other doctors. She kept seeking new opinions until she gained definitive answers. She did not need to discuss medical issues around her disease management. Sally recognized her need for ongoing counselling and emotional support. Sally was highly motivated by her current situation and the need for symptom-free functioning was a powerful

incentive in itself. Her anger or “meanness to those closest” was a safer coping mechanism than expressing the grief created by the current diagnosis.

In early consultations Sally reflected on her life (see “Personal History”). She feared her LS was a punishment for the life she lived prior to her marriage. She referred to herself as a “wild child,” when settling down in a committed relationship with a male was not important. Sally was afraid of the negative emotions present, which were overwhelming. Her underlying guilt and sadness could lead to despair and feeling trapped by her illness. It was important to Sally that she could externalize her anger in therapy and for the therapist to respect this coping mechanism (Hlywa, 2004). This was the only safe place where she could display her anger.

Gibney (2003, p. 142) reports Bieber’s opinion that “there are many cases in which transference develops quickly and confrontingly ... in the first forty-five minutes” of therapy. This was evident in this case. Experiencing the energy of the anger between us was where the transference and counter-transference quickly developed. There was no need to react to this but simply for the therapist to be aware and informed. This anger gave her energy to keep functioning as mother and partner. Leaving out the anger would leave Sally feeling misunderstood. The depth and resonance of therapy would lack intensity and completeness. Sally especially expressed how she “wanted to be less mean and more positive and loving to those closest” to her (symptom-free functioning), as they were so supportive of her (powerful incentive). Treasuring her family was important. There was no suicidal ideation, present or past. Sally informed me she had never been to a counsellor or psychologist before.

Sally and Barry’s relationship was reported to be good. They had recently married. She reported that her husband was supportive about all her health issues. He was not afraid of these affecting their sexual relationship. Sally admitted she had fears about this. At present, Sally reported that her anger and meanness were preventing her from being more loving toward her husband. Sally did not want to talk about LS in detail or answer intimate questions about how LS was affecting her. Questioning felt like an interrogation and inadvertently mimicked the recent ordeal experienced, during the process of reaching this diagnosis.

Psychometric Testing

We completed genograms for family of origin and family of creation, talking about relationship dynamics while proceeding to draw diagrams. Results on

the Depression Anxiety and Stress Scale (DASS) showed moderate levels of depression and stress. Anxiety levels were medium to low. These results came from the referring GP.

The Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI) were completed. Sally's scores showed mild levels of anxiety and depression. Her sleep and appetite were good. Sally's negative thoughts about herself were expressed as self-blame and shame.

PERSONAL HISTORY

Sally grew up in an intact family, with an older sister and younger brother. She referred to herself as the "wild child." Her sister rang me and made the referral and appointment time. Sally saw her older sister as the "good girl" and herself as the "bad girl" in the family. Sally's 15-year-old daughter was also good like her older sister.

Sally became a single parent when her daughter was born. She learnt how to provide for herself and her daughter as that partner was not capable of supporting himself.

Sally, who was a qualified high school English teacher, was passionate about poetry. She had been a casual teacher before her son was born. Sally's primary occupation now was "family caregiver." Currently she was tutoring and babysitting in the evenings because she wanted to be there for her son during the day. By working part-time, Sally wanted to reduce any stress that would exacerbate her symptoms.

Sally talked about being bullied when she was in high school because of noticeable facial hair on her upper lip that developed during puberty. To cope she became the bully's or "mean girl's best friend." As a result, Sally said she spent her adolescence being "angry and mean." During the last few years, she had saved and had paid for laser hair removal, as treatment to rectify that problem permanently.

Sally was happy with her appearance. She was pretty, well groomed, looked healthy and 10 years younger than her chronological age. She explained how she was very health conscious with her diet, exercise and meditation. This was because she wanted to manage her hepatitis C, "the best she could." She had always kept up with the latest research, asked her GP for advice and had joined a support group for those diagnosed with hepatitis C.

Sally explained how her family had always been supportive of her. She wanted to appreciate her "daughter's strength and parents' support instead of

being angry and mean about it.” She had observed her father as a stoic man when facing crises in his life. They shared this trait. She described her mother as being very private, like Sally had become due to her diagnoses. Sally, in hindsight, was sure her mother also had LS. To date, neither had disclosed this to the other. It was something to consider. That openness was not the way her family operated. Now she could appreciate more fully why this may have been so.

Due to Christmas celebrations and the long summer school holidays starting, time was at a premium for Sally and her family at present.

TREATMENT APPROACH

The initial session was on a Friday and Sally asked to see me on Monday, Wednesday and Friday of the next week, just before Christmas and holiday commitments. Psychoeducation about the possible therapies that could be provided was presented and discussed. Financial viability and restraints around time were negotiated.

Knowing a therapeutic effect can be increased and that therapy duration can be reduced using hypnosis, it was considered appropriate (Baker & Nash, 2008; Barber, 2008). Sally was a highly motivated client, which is an important factor when considering how hypnosis can enhance the inherent capabilities and potential of an individual (Spiegel & Spiegel, 1978).

Sally’s priority was to communicate better with her loved ones. Her goal was to “get rid of the mean communication and anger” she expressed toward her closest supporters, especially her daughter and husband. She was wondering how her chronic diseases and aggression to those closest to her related to how she had internalized past bullying and earlier dangerous, intimate relationships during adolescence. She wanted to “find her real self.”

Sally disclosed a series of abusive and reckless relationships in adolescence and early adulthood. The hepatitis C was contracted as a result of the activities which took place that bound these relationships together.

Gibney (2003, pp. 110–111) refers to Gustafson’s “malignant basic fault” in relation to those clients who deteriorate on entering long-term psychotherapy. They have been treated harshly and inconsistently in earlier intimate relationships. Once offered support and containment in therapy, they become afraid they will be too vulnerable with the therapist and any long-term therapy creates problems for both parties in the therapeutic alliance.

At this point in time it was important to allow Sally to request contact,

rather than the therapist, so she did not feel overwhelmed by positive affect in the therapeutic relationship. Anger could increase stress, negative emotions and itching. This could be triggered by those closest to her. So I was not prepared to enter such a parallel process. At this point, any long-term approach was deferred until symptoms abated.

Even though Sally's initial request was for "psychoanalysis," there was no other indication that she wanted long-term therapy for the treatment of the problem. This stance emanated from Sally but, in terms of her presentation, is clearly justifiable with respect to the psychological literature.

During conversational therapy it became important for the therapist to balance catastrophizing with containment (Gibney, 2003) and for the client to reframe angry thoughts instead of distracting herself or ruminating about them (Denson, 2009). Containment was achieved by respectful, empathic listening, which helped the client address and work through angry thoughts.

We worked on the grief regarding her current diagnosis. We talked about how a past diagnosis was also affecting the current levels of grief in her life. We used a narrative approach to re-author the past. Redefining Sally's understanding of the past would in turn help her to reconstruct the present and allow her to realize that she could look forward, with hope, to the future (White, 1989).

Sally used self-hypnosis. Between sessions, she used this before going to sleep at night, similar to the way she had been using daytime meditation. This was specific, linked to her desires, was goal-oriented and engendered hope. Sally was very concerned about privacy and confidentiality and was secretive about aspects of her life. These concerns highlight the importance of the use of self-hypnosis, where the client wants to be self-directed in a very private way.

Sally particularly enjoyed using imagery in a creative way to address her itch. Her literary background and experience as a high school teacher had predisposed her favourably to the use of metaphor. This indirect hypnotic approach (Kane & Olness, 2004), allowed us to refer to sexual matters in a symbolic way, as Sally found it hard to put private activities into words.

SUITABILITY FOR HYPNOSIS

The Hypnotic Induction Profile (HIP) (Spiegel & Spiegel, 1978) was used in the second session to elicit Sally's level of hypnotizability. She was successful in all categories. She was highly hypnotizable.

There were no contraindications. Sally had come for treatment to prevent

developing a reactive depression. Sally was:

- an English teacher thoughtful and intelligent with the use of words,
- highly creative in the mediums of poetry and paint,
- able to enjoy Buddhist meditation tapes at home,
- a highly private and secretive person with two very personal and chronic illnesses,
- highly responsive to suggestions in conversational therapy,
- highly motivated, and
- developing good rapport.

Her profile suggested that positive outcomes would result from utilizing hypnosis during therapy. This would empower Sally and optimize our brief therapeutic alliance.

SESSION 1

I was able to reflect back, or seed positive suggestions and hypotheses about what may have been going on for Sally in her life. When bullied and teased as a teenager, being angry and mean was a way of keeping her true self hidden but safe. This in itself was why she was a successful high school teacher, because she understood what it was like to suffer as a student.

Sally was also very self-reflective. I was easily able to emphasize patterns or recurring themes in her life by carefully listening to the words she repeated about different chapters of her life and which emanated from her. Those most often repeated were “anger” and “meanness.”

We continued to reframe these negative emotions using psychoeducation around grief. We talked about her diagnoses creating loss of health and early transition of aging genitalia and how this led to feelings of sadness and guilt. She felt she was being punished for her reckless past. These emotions in turn can be masked by anger and meanness. This was a normal grief response. Sensibly, she was seeking support to prevent developing an entrenched reactive depression.

As therapist, the language I used to begin to enhance self-efficacy took a narrative approach by externalizing the problem of anger and meanness. Narrative therapy relates significantly to “postmodernism,” which believes there is no one objective “truth.” Within a narrative approach our lives are multi-storied as opposed to single-storied. Narrative therapists see stories as events, linked in sequence, across time according to a plot. The meaning we have attributed to them forms the plot. As the story develops it invites the

teller to further select only certain information, while ignoring other events, as the same story is repeatedly told. Epston and White (1992) see these stories as describing and shaping people's perspectives on their lives' past, present and future. These stories can be oppressive or inspiring. A person coming to therapy has a "problem-saturated" story that can become their negative identity.

Narrative therapy does not focus on experts solving problems. It is collaborative and non-blaming. The questions used when mapping the influence of the problem externalize the problem. The problem is the problem. The person or relationship in question is not seen as the problem. Externalizing the problem reduces guilt and blame.

Externalizing the problem enables the narrative therapist to focus on people working together and discovering through conversations the hopeful, preferred, and previously unrecognized and hidden, possibilities contained within themselves as, so far, unnoticed story-lines. In essence White (1989) referred to this as the "re-authoring" of people's stories and their lives.

It is important to emphasize that the brief rendition of narrative therapy below does not adequately express the disorderly process of this sort of conversation—the ups and downs of the narrative journey we can refer to as brief psychotherapy in this case. Gibney (2003, p. 142) refers to psychotherapy which can be brief and just as effective as long-term psychotherapy. The process of the transference and countertransference developed within the first session in this case richly informed the narrative content, allowing ideas to flow quick and fast.

During conversational narrative therapy (Epston & White, 1992) we could use the positive way Sally had managed her chronic disease hepatitis C (past new-old story) to deconstruct the thought attributed to her feelings of inadequacy and of not being capable of managing LS (present problem-saturated story). Sally was reminded, with gentle unique outcome questioning, that she had managed the hepatitis C competently in the past (new-old story). Sally could do this again with LS (future re-authoring). She had a map in her head and was very resilient because she remained competent with up-to-date information and connected with her doctors, support group, therapist and family.

We took the same narrative approach regarding Sally as being an authentic, calm, competent and capable caregiver (a new-old dominant story), rather than someone who was always angry and mean (old problem-saturated story). When Sally was a high school teacher she decided that being bullied as an adolescent at school better informed her about how high school students

can suffer (past deconstruction). Therefore this experience contributed to her being a much more competent and caring teacher than if she had never been bullied as a student (new-old story). We conversed about stories of her being a calm and capable tutor and babysitter (present reconstruction). Exploring unique outcome questions, Sally could consider herself to be an authentic and loving mother, wife and daughter (future re-authoring) (White, 1989).

When deconstructing the old story and using the re-authoring approach described above, the therapist is “not simply pointing out positives. Instead, this approach actively engages persons in unravelling mysteries that the therapist can’t solve” (White, 1991, p. 33).

Recalling experiences of the new story in the past will strengthen the new story. The significance is about the person deciding “whether they want to maintain the ‘old story’ as their dominant story or side step that story (path) and give another well-trodden path (the new-old story) dominance in the future” (Hewson, 1991, p. 7).

The conversational therapeutic work done in the first session was followed up with hypnosis in sessions 2, 3 and 4. It was important to affirm the cognitive changes already achieved. These ideas, which emanated from Sally herself, were seeded to become positive suggestions during hypnosis.

This first session became an extended session. A lot was achieved in the first hour. It was important Sally rejoin her children, who were playing in the nearby park, with a reduction in negative emotions present. She was stiff and fidgeting with anger. She wanted to achieve something tangible. In the additional half hour, we utilized an affect bridge (Desland, 2008) using an indirect approach to induce hypnosis.

Affect Bridge

Sally closed her eyes and recalled the excessive negative emotions of grief, guilt, anger and anxiety she felt when telling her sister about her current diagnosis. She reported feeling “tight and stiff all over” her body. She found other memories of being “furious” with her parents recently, then feeling “impatient” with her children and “annoyed” with her husband. She left the house saying to them she needed time to herself, “a swim”... her “joke of water therapy.” This then stirred memories of childhood. When sick with a temperature her mother would “cool her down” with a cold facecloth. Her mother used to say how they needed to go for a swim in their pool after long, hot, trying days at school in summer ... she remembered being “cranky and

tired before going swimming ... cool, calm and refreshed after ... like a new person ... laughing and happy.” A smile appeared on her face. I suggested she feel that smile as “joy in your heart and that whenever you smile your anger and meanness will dissipate.” She opened her eyes when ready. She had relished that joy in silence for a good five minutes. When debriefing I asked what she remembered. Sally said she “enjoyed having a peaceful rest floating freely in the water.” She presented as being in a light trance. The phenomena noted were relaxation, eye closure and slowing of muscular control and activity.

SESSION 2

The HIP was also used to allow Sally to experience and enjoy the hypnotic experience. Her hand levitation created an intense smile. Other parts of this procedure became cues for her to induce trance under self-hypnosis. We recorded the session so she could practise at home. Sally also practised a guided self-hypnosis in this session. She decided to anchor this procedure by watching her hand touch her forehead when wanting to go into trance, then close her eyes and lower her hand to her lap taking three deep breaths and going into a deeper trance. Then she would consider whatever she most desired at a particular time and place in her life. This could be reducing anger in situ or planning to be calm during a future stressful day.

After session 2, Sally practised hypnosis between sessions before going to sleep at night, in a similar way to her earlier use of daytime meditation.

We used her cues for this self-hypnosis to induce and deepen trance at each session. Sally had total control of this. I would use yes-sets, to prime her about “looking forward to going into trance.”

A yes-set refers to a technique used by Milton Erickson (Kane & Olness, 2004). It involves three to four questions placed together in conversation about truisms. The conversation between the therapist and client is structured so that the client must respond with the word “Yes.” The effect of yes-sets is to enhance the client’s suggestibility and trance effect.

At the end of the trance phenomena, I would make an indirect suggestion, instructing Sally, “And anything else you need to hear, you can hear now. And then come on back, knowing it will be okay.”

SESSION 3

Sally returned smiling and the most relaxed I had seen her. She reported being calm and thoughtful when her two-year-old son had a tantrum that morning.

She said she wanted to feel as peaceful as possible for the entire session.

We taped guided imagery I had pre-prepared, taken from Hammond (1990, pp. 223, 228) for the treatment of itch and reducing other dermatological irritation. I was able to use resources gained from the affect bridge made in the first session—her idea of “water therapy.” Living in the same locality, I knew what the most available stimuli were. The “ocean, waterfalls, creeks, rock pools, sea breeze, sand, sea grass, mud and clay” were all natural experiences Sally often enjoyed. In various situations, Sally could be “enjoying floating or bathing, sitting or standing in water”; using words like “cool,” “refreshing,” “relaxing,” “comforting” and “relieving.”

We also had Sally “making a cooling, healing ointment from moist clay, wet sand or mud” depending on where her imagery had taken her. She would apply this to her “affected areas of skin, how she wanted and when she wanted.” It was a very private experience with no ideomotor signalling.

SESSION 4

Sally had requested recording another script with different ideas for the last session. We were going to address her intimate relationship with her husband in a non-directed way. I used a script by Dr Kay F Thompson, described by Kane and Olness (2004), titled “Rose.” Auld (2008) rewrote the version I closely followed. This script proved an effective utilization of indirect hypnosis. This method was highly appropriate for a very personal and private problem (Appendix 1).

This script uses the metaphor of a seed growing, struggling and developing thorns (possibly representing anger in Sally’s case) to protect itself. Eventually it produces a bud, which opened to become an exquisite rose (possibly representing the vulva in Sally’s case) with beautiful colour, perfume and full soft petals. Direct positive suggestions stating her goals were made as posthypnotic suggestions. Milton Erickson emphasizes “speaking the client’s experiential language” (Lankton, 2008, p. 474). This was applied in this case (Appendix 2).

Feedback, while still in trance immediately after the metaphor, included Sally saying the experience was almost “orgasmic” as she felt tightness flow out of all body parts, including her genitals. Debriefing after coming fully out of trance, Sally said she would make the spare room in her house her private space for herself to paint, write, meditate and use self-hypnosis. It would be her space. She enjoyed this session most of all. The calm disposition Sally

displayed as she said goodbye was the most striking change noted from the restlessness and her stiff, tight physical appearance of late. The mean and angry expression on her face and in her voice, ever present over the past few days, had also disappeared.

OUTCOMES

The affective component of Sally's trance response, that of feeling "orgasmic," appears to express a specific aspect of Sally's problem that she was not willing to discuss openly. This important component of Sally's trance response has the potential to be utilized to enhance her therapy goals because "orgasmic" sexual excitement is directly linked to her very personal concerns around sexual intimacy which are at the core of her problem. Being highly hypnotizable, Sally is able to use trance with the therapist and via self-hypnosis as a resource for establishing and rehearsing better alternatives: "love and understanding," as developed during psychotherapy, rather than "anger and meanness" from her own previous problem-saturated experience.

Sally did not return for long-term psychotherapy. After six months, a follow-up phone call was made. Sally was happy with her progress and using self-hypnosis most evenings before going to sleep at night. She had not been using the cortisone cream during the cooler months, but knew she may need to again in summer, when her itch was exacerbated by hot humid weather. She felt she was as free of anger and meanness as the "average mother." She was fortunate to experience "joy" in her heart "most days."

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APPENDIX 1

ROSE

(After Dr Kay F Thompson, Kane & Olness, 2004; Auld, 2008)

It will flow very, very well, and very comfortably ... flowing into a performance that is like the real stage play of your life ... where you know exactly every line, every angle, every move and everything will go very, very well.

When you think about it ... it's almost as though four years ago, somebody planted a seed ... and that seed had to struggle and dig in, because it was planted on some ground that was pretty rocky,

and didn't have much soil around for nourishment. And the seed survived, and it sprouted, and that tentative little plant started up ... and it really had a rough time in that rocky ground as it worked its way up ... turning this way and that, looking for the warmth of the sunlight among the rocks that stood there trying to beat it down and prevent its growth.

And then, even though it needed the rain, the rain was very hard when it came, so that it was overwhelming in its lesson of moisture and absorption. It was pelting, overpowering, pushing the seedling down, exhausted.

And the wind came along, too, and would blow it one way, and then the other way, and it would have to go the way of each gust, blowing that direction until it had to change.

But it was persistent, and it struggled, and it worked, and it grew.

Then it had to learn to look out for the little-green-sprout-eating animals, the rabbits, the deer. And finally the rocks came in handy, because it could hide behind them to protect itself. And gradually it developed a protective device of its own. It grew thorns, so that the animals would not be able to feed from it anymore.

And so the thorns helped it, and it was stronger and taller to withstand the rain and snow, and the yearly seasonal beatings ... down it got. And every once in a while, there was a little more sunshine, and some warmth. And finally summer came along.

And the sun shone bright and warm, and everything was so easy and friendly and nice ... and what do you know? The sprout grew a bud, and the bud became a blossom, and the flower was a rose of such exquisite and subtle beauty and colour that everyone stopped to exclaim!

And it was so surprising in its beauty, its strength and its colour that people could admire—saying, “Gee, I never would have believed something this good could have come from that seed.” But only the thing that was responsible for the seed being planted originally could look, and think, “Of course, I knew it could do just this.”

And maybe this is kind of where you are, because you have blossomed with this kind of struggle for survival, and you're still here, and you value the survival even more. Anything that has this much invested in its growth has to be stronger for it. What you have now is worth so much more because of what you have gone through to get it.

And you have a right to say, “Hey, I'm proud of myself, I've made it ... and when I [insert client's goals here] I'm going to be able to be calm, secure and display my competence and capabilities. And for some reason I don't need to be able to understand, I can be content.” And you can say this because it's okay for you to believe in yourself, just as you know I know you will do whatever you need to do. And anything else you need to hear, you can hear now. And then come on back, knowing it will be okay.

APPENDIX 2

Near the end of this script, Sally's goals were embedded into the script as a posthypnotic suggestion: *When I communicate with my loved ones, especially my husband and daughter, I will get rid of meanness and anger and communicate with love and understanding.* Here, this client is able to picture her maladaptive coping mechanism disappearing and being replaced by a better alternative, developed during brief psychotherapy, resulting in symptom-free functioning—a powerful incentive in itself.