Clinical Hypnotherapy in Grief Resolution - A Case Report

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ABSTRACT

Grief is one's reaction to any loss, and the coping mechanisms during grief either deplete or become maladaptive. One of the common ways to cope with grief is alcohol or substance intake. The course and resolution of grief vary depending upon many factors. Hypnotherapy has been useful and effective in addressing grief reactions as well as associated manifestation, such as sleep problems, depressive features, or post-traumatic stress disorder. It might be a good choice of treatment while dealing with patients having underlying issues or maladaptive coping mechanisms. This is a single case study design hypothesized to indicate maladaptive coping of increased alcohol consumption to deal with the death of a young son. The case had been treated as alcohol dependent syndrome with multiple hospitalizations without addressing underlying grief. The treatment approach was changed, and grief was addressed using hypnotherapy. Clinical hypnotherapy helped address grief and facilitated the index case to accept the loss. This resulted in minimizing hospitalizations, abstinence and improved day-to-day functioning along with the use of adaptive mechanisms to cope with the loss. Clinical hypnotherapy is an effective intervention to deal with underlying conflicts or issues that may not be addressed directly in a therapy setting.

Key words: *Alcohol dependence, clinical hypnotherapy, grief*

Grief is one's reaction to any loss. As per the International Classification of Mental and Behavioural Disorders, grief reaction is included under adjustment disorders (F43.2) but diagnosed as a prolonged depressive reaction (F43.21) if grief lasts longer than 6 months.[1] An individual going through grief reaction can fluctuate among the various stages of grief.[2,3] The manifestation of grief is commonly in the form of depressive features, with or without suicidality. The coping mechanisms either deplete or become maladaptive during grief. One of the common ways to cope with grief is alcohol or substance intake.[4] The course and resolution of grief vary depending upon many factors.[2,3] Cognitive behaviour therapy (CBT)[5] and some other recommended techniques are helpful in loss-oriented processes namely; Gestalt empty chair, guided imagery, writing letters, poetry, or a journal, and

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making art.[2] But all those techniques operate at the cognitive or behavioural level. Hypnotherapy is a form of intervention where communication with the mind is established through suggestions delivered directly or indirectly with the use of metaphors in an altered state of consciousness.[6,7] It has been useful and effective in addressing grief reactions in children as well as adults.[8] It is recommended therapy for addictive behaviours,[7] but its role in grief resolution has not been explored in the Indian setting. Also, individuals with associated manifestations, such as sleep problems, depressive features, or post-traumatic stress disorder (PTSD), have benefitted from the use of hypnotherapy.[9]

CASE DESCRIPTION

Mr R is a 47-year-old, diploma holder, married male hailing from an urban Hindu family of middle socio-economic status, running a real estate and construction business. Premorbidly, he was meticulous in work, having a calm and self-regulated temperament, and a member of many social and charity organizations where he often volunteered in altruistic activities. There was an occasional use of alcohol after returning from work, which helped him get sleep. He presented in out-patient department of Psychiatry for the first time in April 2012 with features of low mood, suicidal ideation, anger outbursts, disturbed sleep and poor appetite. The symptoms were precipitated by the death of his son who committed suicide in January 2012 due to failure in the 10th class exams. The reason for consultation was daily consumption of one bottle of Indian made foreign liquor (IMFL) for the last 4-5 days. His mental status examination revealed feelings of sadness, loneliness, worthlessness, and helplessness reflected in cognitions such as "He should have cremated me, but I had to cremate him", "I see no purpose in living or earning money, whom do I have to do it for?", and "I have no one; I don't want to live".

Treatment was initiated and he had 14 hospitalisations, of 10-19 days with an average of 9 days in-patient stay, in a span of 4 years. These hospitalisations had been triggered by the anniversary, examination, and festival dates. The symptom at the time of hospitalisation had been intoxicated state and binge drinking. He had attempted to commit suicide once by overdosing the prescribed medicines, but then he himself walked into the emergency services of the hospital. He had been compliant to pharmacotherapy, except for rare irregularity in follow-up.

He was advised psychotherapy at first psychiatry consultation from a psychologist to address grief. He reported that he felt extremely uncomfortable talking about the issues in therapy as it brought back memories, and after the session, his crying spells and alcohol intake persisted with intensity for about a week. Consequently, he dropped-out of psychotherapy by end of 2012.

In addition, he started having a dispute over property with his brother, who insisted the patient to write his share in the brother's name, as the patient had no heir. There had been a marital conflict with his wife, who, after the death of their son, wanted a second child, but the patient was not ready as he had been mourning. Consequently, within 3-4 months, she moved to Canada to live with her parents. The couple had been in contact via telephone. Each time, the wife insisted him to join her in Canada, while he asked her to come back to India. She refused, saying that she had no reason to return to India and did not want to be in an environment that reminded her of their son. The couple could not come to a consensus on this, and the process of filing divorce was never initiated.

FORMULATION

Hypothesising the problem

His first reaction to the loss involved shock, crying, preoccupation with thoughts of the deceased, and lack of muscular power, lasting from a few hours to 10 days. Once the rituals and other arrangements were over, while confronting the loss, he started experiencing persistent yearning, crying, feelings of helplessness, and difficulty doing day-to-day-activities. There had been symptoms of depression (depressed mood, feeling tired and weak, loss of appetite, difficulty in sleep, weight loss, and restlessness). This resulted in staying aloof and social withdrawal. There was incomplete grieving as he was stuck and had not been able to resolve it. Overall, the psychodynamic formulation of the case revealed that his underlying feeling was sadness, and the defence used by the patient was 'acting out,' where he was behaviourally indulging into alcohol consumption. The depressive symptoms and worry about the future were manifestations of unresolved grief.[10]

Defining problems and goals of therapy

The problems defined were unresolved grief, increased alcohol intake as a way of coping, interpersonal conflicts, and inadequate social support. The outcomes of the therapy targeted were grief resolution, resumption of routine functioning, and encouraging the use of alternative coping mechanisms and social participation. The index case had been stuck at the emotional level since 2012 and had been resistant to talk about the loss in awareness, leaving no room for CBT for grief resolution. Therefore, hypnotherapy was chosen to address his emotional block in a state of subconsciousness or trance. Clinical hypnotherapy

could be delivered indirectly using metaphors, and the technique of future progression could be used without mention of the past of the patient.[7] In addition, the formulation revealed that resolving the conflict is necessary to manage manifested symptoms.

Hypnotherapy was initiated in the month of June 2016 during the in-patient stay. The challenge was resistance arising out of past experience in psychotherapy. Grief resolution was taken as the first goal, as the history revealed unless the grief was resolved, other outcomes in psychotherapy could not be expected.

MANAGEMENT

Dealing with resistance

Thematic Apperception Test (TAT)[11] was done to get introduced to the patient as well as to have an objective assessment of the hypothesised problems. The assessment (TAT) was completed in three sessions as he often felt strained and was not able to sit for long. The verbal communication was minimal between the patient and the therapist, but the patient was seen daily to establish rapport. The TAT stories were complete, revealing identification of loss, interpersonal and intrapersonal conflicts, and feeling of isolation. TAT revealed a conflict between the needs for affiliation and rejection, suggesting that he wanted affection of the loved one and had to separate himself from the subject of affection.

Simultaneously, guided imagery was initiated from the first session, and he was made to practice daily. At the termination of the guided imagery session, feedback was taken from him. He reported feeling calm momentarily. The session was terminated using suggestive statements, creating a sense of hope for a positive outcome in clinical hypnotherapy (CH). He started reporting calmness after an 8-9 minutes session of guided imagery.

Finally, the consent for CH was sought on the 5th day, by addressing his concerns related to the treatment approach. He was explained how CH might be beneficial in letting go the emotional baggage that he had been carrying for the last four years as projected in the TAT findings. He was also explained how it is going to be similar to guided imagery, where he does not have to engage in dialogue(s) with the therapist. He agreed, and audio recording was used for guided imagery to make him adapt to listening to the audio-recording and prepare him for self-hypnosis practice in the future. The audio recorded file was transferred to his mobile phone. He continued the guided imagery session using the file.

Hypnotherapy sessions

On the 7th day, the patient was prepared in the morning for a hypnotherapy session to be audio recorded so that he could use the audio-recording for daily self-practice. A 90-minute session was delivered and audio recorded in a quiet and comfortable place. A hypnotic session has stages of light, medium, and deep hypnosis, and lastly, dehypnotize by making the patient aware of surroundings through sensory inputs, terminating the communication with the sub-conscious.[6,7] The audio session began with the guided imagery, aiming to enhance internal focus and defocus from external stimuli. This induces a state of trance where guardedness and reluctance become weaker, resulting in increased receptivity to the verbal suggestions communicated indirectly. The light hypnotic stage comprises of the head to toe body scan using self-guided relaxation,[12] followed by visual imagery involving the five senses.[7] By now, the patient is assumed to have entered into deep trance. The same is validated using ideomotor signalling, where a gesture, such as raising the right index finger for 'yes' and left index finger for 'no', is decided to be indicated by the patient when in the trance state so that the hypnotic stage is not interrupted. This later guided the therapist to know whether the patient wants to discontinue at any point. It is now that the patient is ready for direct or indirect verbal suggestions. The technique used was future progression and visual imagery along with metaphors such as sun, road, stones, and house. The suggestions were a mixture of direct and non-direct statements. In the second and third hypnotic stages, through imagery, he was made to walk through hills, receiving new energy from sun, to jump over and kick stones or to avoid stones like problems or challenges of life, moving forward on the path of life, to cross a bridge and empty the baggage of past into a river, and to enter his house full of darkness – as he enters, he brings light and life to it. Finally, the post-hypnotic suggestion was linked with sun rays and water, filling him with light to beat the darkness of past and move towards sense of optimism. He was dehypnotised with deep breathing. The audio recording was stopped, and he was advised to listen to the audio-recording every day in the form of self-hypnosis.

The feedback was taken, and he reported to be comfortable during the session and later while practicing self-hypnosis. He was discharged and continued to follow-up on an out-patient basis. The psychotherapy sessions were kept brief, and comprised of enquiring about the experiences of the patient while practicing self-hypnosis sessions as well as post-session. He started opening up gradually, he appeared euthymic, and intake of alcohol decreased significantly in follow-up sessions.

Relapse in management

He had one relapse to alcohol use after four months from the onset of therapy and had to be hospitalised. He approached emergency services of the hospital in an intoxicated state, which was similar to previous hospitalisations. During the psychotherapy sessions, it came forth that the first change he experiences is sleep disturbance, followed by a headache. The headache was becoming extremely severe to tolerate, leading to alcohol intake to numb the pain. The same was communicated to the Psychiatrist, and pharmacotherapy aimed primarily at sleep rather than alcohol intake or depressive symptoms was initiated. He was instructed to approach the emergency services in the early stages of sleep disturbance than seeking help at a later stage after the severity has increased. It was during this hospitalisation, after having established rapport, that the patient was psycho-educated about the cycle of grief given by Kubler and Ross, his symptoms, causing impairment in functioning. Also, the parents were included in the psychotherapy sessions, making them aware of the despair and pain experienced by the patient and his coping.

Termination and outcome of therapy

The next one year of psychotherapy comprised of the practice of self-hypnosis. Supportive therapy was used as an adjunct to achieve social participation and improve functioning.[13] His improved functioning made him use resources like family, spirituality, and altruism, instead of alcohol consumption, to cope with grief. After six months of intervention, decision making was done regarding occupation. He finished his pending financial transactions. He explored options for occupation and finally decided to do volunteer and charity work. He assertively conveyed his terms to his brother regarding property share and procured all documentary evidence to avoid legal disputes in the future. His divorce got through, and he did not suffer regular altercation. Both partners amicably settled and signed the papers.

A total of 40 sessions were taken in a span of 2 years – the distribution of these sessions was 10 daily sessions at the time of initiation of therapy, followed by 8 weekly sessions for a period of 2 months. Then, a spacing was introduced in the sessions, and four sessions every fortnight were taken. There were three booster sessions of once a month follow-up. The termination was introduced as he had been asymptomatic and functioning adequately. There was a minor turbulence when his father died, but he did not slip into any relapse and resumed routine tasks. He was now maintaining well through festivals and anniversary dates; and participated in the *shraad* (annual death ceremony ritual) of his son for the first time in the last 6 years since his death. Currently, he has been maintaining well, and the session is taken once in 3 months. The targeted treatment goals have been achieved.

DISCUSSION

The index case underwent 40 sessions in total. The outcome measures were grief resolution, symptom reduction in terms of decreased alcohol intake and decreased hospitalizations, and improved level of functioning. The use of objective outcome measures (assessment tools) was avoided, keeping in view the resistance in the patient to engage in therapy. The process of assessment and management has been explained to go parallel. It was in the index case that the assessment format was hypothesized [Table 1][2] using the file records, and the aim was to seek consent to initiate psychotherapy for grief resolution. The grief was addressed and not the resulting behavior or dysfunction. It has also been observed in the clinical setting that patients often get uneasy with repetitive clinical interviews or if clinicians are often changed. Keeping in view the chronicity of bereavement and avoidance in the index case to talk about the deceased person,[2,14] clinical hypnotherapy was planned. Clinical hypnotherapy has its roots in the psychodynamic school of psychology. This implies that his conscious mind could understand that his son had died, and he had to move on.[6] But his sub-conscious mind was not ready to accept the death of his son. These dilemmas were resolved through the use of clinical hypnotherapy,

Table 1: Case formulation using BASIC SID[2]

BASIC SID	Domains	Description for Index case
Behavior	Suicidal risk Aggressive behavior Disregard of rules	History of attempt While intoxicated Abusive and violent behavior towards the mother
Affect	Lack of awareness of own feelings Depressed mood	Not able to attribute alcohol intake to grief Sadness due to past loss
Sensation	Painful muscular tension Obsessive mental images	Intermittent headaches Of rituals and ceremonies
Imagery	Flashbacks	Of body, rituals and time spent with son
Cognition	Poor problem-solving skills	Maladaptive coping through binge drinking
Spiritual	Excessive guilt Lack of meaning and purpose in life Ambivalence over religious faith	Incapable of saving son Loneliness Stopped religious activities
Interpersonal	Social isolation Socially unacceptable behavior Marital conflict	Not interacting with parents or others Abusive and aggressive when intoxicated Ongoing divorce with wife
Drug and biological	Alcohol abuse Overweight and physically unfit	Chronic No physical activity and sedentary lifestyle

that is, communication with the subconscious or unconscious mind. It was used as an indirect approach using metaphors.

Later, supportive therapy was used as an adjunct; the techniques used were guidance, tension control, externalization of interest, prestige suggestion, and persuasion.[13] Supportive therapy was aimed at environmental manipulation and regaining the equilibrium. All other related issues and his deep fears were brought up in the session by the patient after six months of psychotherapy. This probably was after the grief resolved, his premorbid-self resurfaced, and he could talk to the therapist without any barriers.[3]

The index patient showed motivation to seek help, as is evident from his compliance to pharmacotherapy as well as psychotherapy. His one suicide attempt was seen as a sign of frustration and disappointment because his persistence in seeking help reflects optimism and willingness to get better. Therefore, this was brought up into discussion after six months of ongoing therapy sessions. Caution was taken in dealing with the index case, to avoid any therapy variables leading to drop-out. To this, he answered that he never wanted to die as he felt a sense of responsibility towards his aged parents. The assets in his personality were his social relations, association with social groups, persuasion of interests, premorbid calm and relaxed mood and his responsible attitude towards work.

CONCLUSION

Clinical hypnotherapy can be a useful and effective intervention in prolonged grief reaction. It can be used to address issues of unresolved grief in those individuals who develop any psychiatric disorder in response to prolonged grief reaction or in those who show complete avoidance to talk about the deceased.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. World Health Organization. The ICD 10 Classification of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines: Tenth Revision, 2nd ed. World Health Organization; 2004.
2. Ingram BL. Clinical case formulations: Matching the integrative treatment plan to the client. New Jersey: John Wiley and Sons; 2006. p. 36.
3. Rosner R, Pfoh G, Kotoučová M. Treatment of complicated grief. Eur J Psychotraumatol 2011;2. doi: 10.3402/ejpt.v2i0.7995.
4. Pilling J, Thege BK, Demetrovics Z, Kopp MS. Alcohol use in the first three years of bereavement: A national representative survey. Subst Abuse Treat Prev Policy 2012;7:3-7.
5. Kosminsky P. CBT for grief: Clearing cognitive obstacles to healing from loss. J Ration Emot Cogn Behav Ther 2017;35:26-37.
6. Axelrad AD, Brown D, Wain HJ. Hypnosis. In: Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Philadelphia: Lippincott Williams and Wilkins Publishers; 2009. p. 2805-32.
7. Kroger WS. Clinical and Experimental Hypnosis: In Medicine, Dentistry and Psychology. Philadelphia: J. B. Lippincott Company; 1963.
8. Manthorpe D. The management of unresolved grief. Aust J Clin Exp Hypn 1990;18:35-43.
9. Sawni A, Breuner CC. Clinical hypnosis, an effective mind–body modality for adolescents with behavioral and physical complaints. Children (Basel) 2017;4:19-30.
10. Leiper R, Psychodynamic formulation. In: Johnson L, Dallas R, editors. Formulation in Psychology and Psychotherapy. 1st ed. New York: Routledge; 2006. p. 47-71.
11. Choudhary U. Indian Modification of the Thematic Apperception Test. New Delhi: Prasad Psycho Corporation; 1960.
12. Malhotra S, Chakrabarti S, Gupta A, Mehta A, Shah R, Kumar V, *et al*. A self-guided relaxation module for telepsychiatric services: Development, usefulness, and feasibility. Int J Psychiatry Med 2013;46:325-37.
13. Wolberg LR. The Technique of Psychotherapy. 4th ed. New York: Grune & Stratton; 1988.
14. Shear K, Monk T, Houck P, Melhem N, Frank E, Reynolds C, *et al*. An attachment-based model of complicated grief including the role of avoidance. Eur Arch Psychiatry Clin Neurosci 2007;257:453-61.