# Chapter 25
# Facilitating Psychological Well-Being Through Hypnotherapeutic Interventions

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An important goal of positive psychology is the enhancement of well-being. Interventions to reach this aim have proliferated since the inception of the field, ranging from brief exercises (Lyubomirsky, 2008; Sin & Lyubomirsky, 2009) to more comprehensive approaches, such as positive psychotherapy (Seligman, Rashid, & Parks, 2006), well-being therapy (Ruini & Fava, 2004), and quality of life therapy (Frisch, 2006). Positive psychology has also gradually become incorporated into existing therapeutic approaches, such as psychodynamic therapy (Summers & Barber, 2010) and cognitive therapy (Ingram & Snyder, 2006).

Another therapeutic modality that could be implemented to enhance well-being is hypnotherapy. Hypnosis has often been associated with negative portrayals in popular media (Horowitz, 2006). However, it is frequently applied in therapeutic contexts to ameliorate certain physical and psychological disorders, to manage stress, and to treat acute and chronic pain (Mendoza & Capofons, 2009). Hypnosis can also be integrated into the context of psychotherapy in general (Yapko, 2003). Recently, some suggestions for implementing hypnosis to enhance well-being have been offered (Burns, 2010; Guse, 2012; Ruysschaert, 2009), but substantiating research has been limited. The purpose of this chapter is (a) to outline how both the Ericksonian approach to hypnosis and ego-state therapy can serve as frameworks for the promotion of psychological well-being, and (b) to describe the presence of and changes in psychological well-being of survivors of childhood sexual abuse who received hypnotherapy.

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## What Is Hypnosis and Hypnotherapy?

Hypnosis has long been burdened by a plethora of different definitions, ranging from simple to complex. Erickson and Rossi (1980, p. 54) described hypnosis as a "special state of conscious awareness" in which specific behaviours occur. It has also been defined as a system of skilled, interactive, and influential communication (Yapko, 2003) and a heightened state of internal concentration (Lankton, 2008).

The American Psychological Association (APA) offered a comprehensive official definition of hypnosis, formulated by Green, Barabasz, Barrett, and Montgomery (2005), describing the procedure of hypnosis and some characteristics of being in hypnosis. Briefly put, hypnosis consists of an introduction to the procedure, informing the client that suggestions for imaginative experiences will be offered. This is followed by the hypnotic induction which includes further suggestions to use one's imagination. The clinician guides the client to respond to "…suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behavior" (Green et al., 2005, p. 263). If an individual responds to hypnotic suggestions, it is generally accepted that hypnosis has been induced, and that the client is in a hypnotic state. Recent research utilizing fMRI has lent support to hypnosis being a specific state of consciousness or awareness (Halsband, Mueller, Hinterberger, & Strickner, 2009)

Being in hypnosis is not sufficient alone for creating therapeutic change (Nash, 2008; Yapko, 2003). Rather, it is the communication and suggestions provided by the clinician while the client is in hypnosis that brings about any change. Hypnotherapy thus occurs when the clinician utilizes hypnosis to reach therapeutic goals by applying therapeutic skills in the environment of hypnosis (Nash). The benefit of hypnotherapy is that hypnosis bypasses the habits and resistances of the conscious mind faster than other therapeutic modalities, leading to quicker results (Barrett, 2010). Hypnosis also provides the possibility of intensified experiential learning (Mende, 2009).

Hypnosis and hypnotherapy are now firmly established as scientific fields in mainstream psychology (Lynn & Kirsch, 2006). Reviewing existing research, Mendoza and Capofons (2009) concluded that hypnotherapy seems to be an efficacious treatment for pain management. In addition, hypnosis also seems to decrease negative affect and increase positive affect when applied for pain management (Schnur et al., 2009). It thus seems timely to consider hypnotherapy as an intervention to enhance well-being. Two approaches to implementing hypnotherapy that are particularly well-suited to facilitate psychological well-being are the Ericksonian approach and ego-state therapy.

## The Eriksonian Approach and Ego-State Therapy as Therapeutic Frameworks for Facilitating Well-Being

The Ericksonian approach to hypnotherapy is based on the work of Milton Erickson (1901–1980) and was later expanded on by Zeig (1985) and Lankton (e.g., Lankton 2008; Lankton & Lankton, 1983), among others. Erickson developed unique perspectives and creative applications of hypnosis and strategic psychotherapies (Frederick & McNeal, 1999).

Certain principles of an Ericksonian approach can be aligned with the assumptions of positive psychology and could be included in interventions to enhance well-being. The approach holds a nonpathological stance to viewing clients and implementing psychotherapy (Lankton, 2008), and posits that clients have many psychological resources and that hypnosis could potentiate these resources (Erickson & Rossi, 1980). Further, symptoms are viewed as messages about possible directions of growth and change. Specifically, hypnosis can assist in guiding a client's focus of attention to aspects of behaviour and functioning that are relevant to well-being (Erickson & Rossi).

The Ericksonian approach is solution-oriented, with the aim to help clients move to a state of health as soon as possible (Lankton, 2008). The emphasis of therapy is on goals and the future, as opposed to a focus on past failures and problems. This future orientation of the Ericksonian approach can be aligned with Snyder's (2002) Hope theory because hypnotherapy may facilitate both agency (motivation) and pathways (routes) to desired endpoints through offering specific suggestions, rather than a focus on past problems. In implementing therapy, a therapist would further utilize both problems and strengths presented by the client. The permissive nature of this approach and its emphasis on adapting therapy to client's individual needs fits with recent findings which suggested that positive psychology interventions need to be individualized for maximum effect (Cohn & Frederickson, 2010; Schueller, 2010).

Ego-state therapy (J. G. Watkins & Watkins, 1997) is a therapeutic approach, most often applied in hypnosis, which posits that the personality consists of different parts which the individual moves into and out of throughout the day. According to ego-state theory, specific *parts* of the personality—referred to as ego states—are focused on in therapy, as indicated by therapeutic goals.

J.G. Watkins and Watkins (1997) defined an ego state as an organized system of behaviours and experiences, a kind of subself that has some individual autonomy in relation to other states and to the personality as a whole. According to this view, the ego consists of a dynamic constellation of related subselves that are separated from each other by more or less permeable boundaries (Frederick & McNeal, 1999; Phillips & Frederick, 1995). Ego states may develop as a reaction to childhood trauma (J.G. Watkins & Watkins), but could form at any stage of development and could serve as resources (Frederick & McNeal).

In ego-state therapy, ego states are activated by means of hypnosis and then worked with therapeutically (Frederick & McNeal, 1999). One of the techniques often applied during the course of ego-state therapy is ego strengthening, defined as "… the process of extending the scope and influence of the ego and increasing the effectiveness of ego functions" (Frederick & McNeal, p. 136). This may lead to the self being experienced as stronger, more adequate, and more effective in coping with life. Ego strengthening is not a new technique, and has long been considered important in the process of psychotherapy (Erickson, Rossi, & Rossi, 1976). However, the value of ego strengthening techniques in ego-state therapy lies in their ability to increase the interplay between positive, helpful aspects of the personality (McNeal & Frederick, 1993).

Another important facet in ego-state therapy is the mobilization of resourceful ego states. Frederick and McNeal (1999) described various ways in which ego states

can serve as internal resources, such as through activation of helpful ego states and through access to conflict-free ego states. An example of a conflict-free ego state is *inner strength*, a part of the personality connected with the person's deepest survival instincts (McNeal & Frederick, 1993). Other possible conflict-free inner resources include the *safe place*, *inner advisor*, and *inner love* (Frederick & McNeal, 1999). Ego strengthening could serve to access and strengthen these facets of the self, which could facilitate well-being through increasing a sense of self-efficacy (utilizing inner strength and inner advisor) and the experience of positive emotions (utilizing safe place and inner love).

Guse (Guse 2012; Guse & Fourie, 2008) recently outlined how an Ericksonian approach and ego-state therapy can be implemented with the aim to enhance psychological well-being. Specifically, Guse and Fourie described how several character strengths could be accessed and mobilized through hypnotherapy, using the metaphor of the *resourceful self*. Guse elaborated on accessing and facilitating the strengths of hope and gratitude and increasing the experience of positive emotions through hypnotherapeutic interventions. Specifically, Guse suggested that strengths could be seen as parts of the self, as suggested by ego-state theory. It is evident that hypnotherapy may be a valuable avenue towards increasing positive psychological functioning.

## Research Findings

Research on the enhancement of psychological well-being through hypnotherapy is scarce, yet there has been a call for more empirical work in this field (Guse, 2012). Some existing studies referred to the effect of hypnosis on the well-being of women with breast cancer, but the operationalization of well-being remained embedded in a pathogenic paradigm (e.g., Bakke, Purtzer, & Newton, 2002; Laidlaw, Bennet, Dwivedi, Naito, & Gruzelier, 2005). Recently Willemsen, Haentjens, Roseeuw, and Vanderlinden (2011) reported that hypnotherapy can increase the psychological well-being of patients with dermatological problems, but enhanced functioning was conceptualized only as a by-product of symptom reduction.

Schnur et al. (2009) investigated the effect of hypnosis on both negative and positive affect in patients who received radiotherapy for breast cancer. They reported that hypnosis, combined with cognitive behavioural therapy, led to an increase in positive affect and a decrease in negative affect, which can be seen as an increase in hedonic facets of psychological well-being. No other international studies implementing hypnosis to enhance psychological well-being could be located.

In a South African study, Guse, Wissing, and Hartman (2006) developed and evaluated a prenatal hypnotherapeutic programme based on Ericksonian and ego-state therapy approaches. The specific aim of the study was to evaluate the effect of the hypnotherapeutic intervention on postnatal psychological well-being of first

time mothers. Psychological well-being was conceptualized as the absence of psychopathology as well as the presence of life satisfaction, positive affect, and sense of coherence. Guse et al. (2006) reported that the hypnotherapeutic intervention contributed to a significant improvement in first-time mothers' psychological well-being at 2 weeks postpartum, and that they maintained this improvement at 10 weeks postpartum.

The study also compared the experimental group with a control group on mean differences in prenatal versus postnatal scores. At 2 weeks postpartum, mothers in the experimental group exhibited a significant improvement on all variables except one when compared to the control group. However, at 10 weeks postpartum, differences between the two groups were less significant. Guse et al. (2006) concluded that hypnotherapeutic interventions could contribute to enhancing psychological well-being during the transition to motherhood. The small sample size and the fact that the participants were not completely randomly selected prevent generalization of the findings. Still, results from this study suggest that the implementation of hypnotherapy to facilitate psychological well-being warrants further research attention.

In another South African study, Fourie and Guse (2011) described and evaluated the effect of an integrated hypnotherapeutic model for the treatment of individuals who experienced childhood sexual abuse (CSA) by presenting a case study. This model combined two existing hypnotherapeutic approaches: Hartman's (2002) general therapeutic model based on Ericksonian and ego-state therapy; and the SARI model (Frederick & McNeal, 1999; Phillips & Frederick, 1995), which is essentially an ego-state model applied to address psychological trauma. To broaden the focus of these therapeutic approaches, specific hypnotherapeutic suggestions and communication patterns aimed at eliciting psychological strengths and enhancing psychological well-being were included. Some strengths and resources that were focused on during the application of the model included the activation of helpful or positive ego states and conflict-free ego states, as well as abilities from the past, present, and future. What follows is a description of the presence of psychological well-being before and after the intervention in women who received hypnotherapy for the treatment of CSA, based on Fourie and Guse's model.

## *The Presence of Psychological Well-Being in Adult Survivors of Childhood Sexual Abuse Treated in a Hypnotherapeutic Context*

The occurrence of CSA is widespread (Pereda, Guilera, Forns, & Gomez-Benito, 2010; Richter, Dawes, & Higson-Smith, 2004) and associated with many adverse psychological, social, and biological consequences in adulthood (Briere & Jordan, 2009). Several theoretical frameworks for the psychological treatment of CSA have been proposed (e.g., Briere, 2002; Kritsberg, 2000), including hypnotherapeutic approaches (e.g., Dolan, 1994; Hartman, 1995).

Although the reduction of distress and symptomatology remains an important goal in the treatment of CSA, enhancing facets of positive psychological functioning as part of an intervention has been neglected. A focus on pathology alone is of limited value in the healing process (Walters & Havens, 1994) and there have been calls for a greater focus on the utilization and mobilization of strengths and resources during psychotherapy (Havens & Walters, 2002; Joseph & Linley, 2006), which is especially relevant in working with the sexually traumatized individual. This could be viewed as a fortigenic perspective (cf. Guse et al., 2006) of the therapeutic process. Consequently, Fourie and Guse (2011) developed and described an integrated hypnotherapeutic model as treatment for female adult survivors of CSA, based on a strengths perspective. In this study, the main research question is: How does psychological well-being come to the fore in female adult survivors of CSA who received hypnotherapy based on Fourie and Guse's model?

### *Aim*

The aim of this study is to describe the presence of and changes in psychological well-being of adult women who experienced CSA before and after the implementation of Fourie and Guse's (2011) hypnotherapeutic model.

## Method

### *Design*

A multiple case study research design (Miles & Huberman, 1994) was implemented. Qualitative and quantitative methods were used to gather and analyse the data in a pragmatic manner. In this approach, methodological triangulation (Flick, 2009) was employed. For the quantitative component of the study, participants completed a set of questionnaires before the intervention commenced, and again after therapy was terminated. Data for the qualitative component of the study consisted of three interviews and the therapeutic process.

### *Participants*

Five white female participants who had experienced childhood sexual abuse took part in the study and were obtained by means of purposive sampling. Participants were obtained from the second author's client base and from referrals from

colleagues. The age of the participants ranged from 28 to 44 years. Three of the participants were married, one was cohabiting with a partner, and one had recently terminated a relationship. The therapy was conducted by the second author, who is a registered counselling psychologist with advanced training in hypnotherapy.

## *Data Collection*

For the quantitative component of the study, participants completed the Trauma Symptom Inventory™ (TSI; Briere, 1995) and the General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979) to evaluate possible psychopathology as an indicator of the absence of well-being. They also completed indices of psychological well-being; namely, the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffen, 1985), Affectometer 2–Short Form (AFM–SF; Kammann & Flett, 1983), and the Sense of Coherence scale (SOC; Antonovsky, 1987). Before commencing hypnosis, the Stanford Hypnotic Clinical Scale–Adult (SHCS: Adult; Morgan & Hilgard, 1978) was administered to establish the level of hypnotic responsiveness. All the measuring instruments have satisfactory psychometric properties, as reported in previous studies (e.g., Guse et al., 2006; Poon, 2009).

Data for the qualitative component was obtained from individual interviews and the therapeutic process. Three interviews were held with each participant. The first interview took place at the beginning of therapy. The second interview took place during the first therapy session after the sexual abuse incident(s) had been addressed. The final interview was scheduled at least 1 month after the termination of therapy. The number of therapy sessions varied for each participant. During the interviews and the therapeutic process, the possible presence of and changes in psychological well-being were continuously noted by attending to the words and language, thoughts, and behaviour of the participants that indicated psychological well-being. The interviews and the therapy process were recorded on video, notes were taken, and the information was transcribed.

## *Ethical Considerations*

The participants provided written informed consent and were told that information related to their therapy process would be used for research purposes. They were also told that such information would be used confidentially and anonymously, and that they could withdraw from the study at any stage. Participants did not pay any fees for receiving the therapeutic intervention.

### *Data Analysis*

Concerning the quantitative data, each participant's scores on indices of psychopathology and psychological well-being before and after the intervention were compared. Because quantitative data was included to confirm and complement the findings of the qualitative inquiry, no statistical analyses were performed.

The qualitative data was analysed by means of thematic analysis (Braun & Clarke, 2006). Data was read and re-read, and initial codes were generated. Each case study was analysed individually, followed by a cross-case analysis. Four main themes were predetermined based on existing literature regarding facets of psychological well-being: symptoms of psychopathology and distress, experience of life satisfaction, experience of positive and negative affect, and experience of a sense of coherence.

## Results

### *Symptoms of Psychopathology and Distress*

As can be seen in Table 25.1, the results obtained from the TSI™ profiles (Briere, 1995) indicated symptoms of Post-traumatic Stress Disorder (PTSD), including intrusive, avoidant, and autonomic hyper-arousal components. Scores of more than 65 are considered clinically significant. The participants' elevated scores on the subscales anxious arousal (AA), depression (D), anger/irritability (AI), intrusive experiences (IE), avoidance (DA) and dissociation (DIS) mirrored responses of distress associated with the impact of traumatic events and processes. The scores on tension reduction behaviour (TRB, participants 2, 3, and 4) and impaired self-reference (ISR, participants 1, 2, and 3) pointed to the participants' not having enough self-resources to regulate or deal with such distress. Thus, the assessment indicated that all the participants suffered from symptoms of post-traumatic stress as well as a deficiency in psychological resources. Results from the GHQ also indicated the presence of symptoms of pathology in all five participants, as scores from 5 to 28 increasingly suggest psychopathology (Goldberg & Hillier, 1979).

After the intervention, all the participants experienced markedly decreased scores on the previously elevated clinical scales. Except for participant 3, who showed elevated AA, AI, SC, and DIS scores, and participant 4's heightened D score, the results indicated no scores that could be interpreted as clinically significant. The compared results of the GHQ confirmed a notably lowered level of symptomatology, and therefore more positive mental health in participants 1, 2, and 5, but a continued heightened level of psychopathology for participants 3 and 4. On the whole, all the participants experienced a lowered degree of trauma symptoms after the intervention, which could also be seen as an increase in well-being, but the improvement was more pronounced for participants 1, 2, and 5.

**Table 25.1** Indices of psychopathology before and after the hypnotherapeutic intervention

| | Participant 1 | | Participant 2 | | Participant 3 | | Participant 4 | | Participant 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Measures | Pre | Post | Pre | Post | Pre | Post | Pre | Post | Pre | Post |
| *TSI*™ | | | | | | | | | | |
| Anxious Arousal (AA) | 66 | 45 | 76 | 35 | 81 | 74 | 58 | 60 | 74 | 49 |
| Depression (D) | 78 | 38 | 71 | 38 | 71 | 63 | 73 | 69 | 69 | 48 |
| Anger/Irritability (AI) | 62 | 43 | 67 | 37 | 80 | 72 | 78 | 62 | 74 | 54 |
| Intrusive Experiences (IE) | 77 | 50 | 79 | 39 | 79 | 63 | 55 | 45 | 81 | 41 |
| Defensive Avoidance (DA) | 73 | 50 | 71 | 42 | 71 | 61 | 55 | 45 | 77 | 38 |
| Dissociation (DIS) | 67 | 49 | 71 | 39 | 77 | 67 | 50 | 51 | 83 | 49 |
| Sexual Concerns (SC) | 52 | 42 | 65 | 42 | 80 | 71 | 56 | 54 | 86 | 44 |
| Dysfunctional Sexual Behaviour | 44 | 44 | 52 | 44 | 44 | 44 | 54 | 49 | 54 | 47 |
| Impaired Self-Reference (ISR) | 66 | 42 | 81 | 41 | 68 | 64 | 61 | 49 | 63 | 42 |
| Tension Reduction Behaviour (TRB) | 54 | 45 | 69 | 42 | 69 | 63 | 69 | 63 | 87 | 51 |
| *GHQ* | | | | | | | | | | |
| Somatic Symptoms | 4 | 0 | 0 | 0 | 7 | 5 | 2 | 0 | 7 | 2 |
| Anxiety and Insomnia | 5 | 0 | 3 | 0 | 5 | 5 | 6 | 1 | 6 | 0 |
| Social Dysfunction | 6 | 0 | 3 | 0 | 7 | 7 | 0 | 1 | 2 | 2 |
| Severe Depression | 7 | 0 | 5 | 0 | 3 | 3 | 3 | 2 | 7 | 4 |
| Total score | 22 | 0 | 11 | 0 | 22 | 20 | 11 | 4 | 22 | 8 |

*Note*: *TSI* Trauma Symptom Inventory, *GHQ* General Health Questionnaire

Qualitatively, the data obtained from the interviews and the therapeutic process confirmed that all the participants experienced high levels of distress before the intervention. For example, participant 1 mentioned, "I feel abused and guilty", while participant 3 said, "I become very irritated and aggressive and it makes me feel sick. I often get a pain in my shoulder, and I suffer from insomnia". After the interventions, all participants reported some relief and decrease in distress. Participant 2 reported, "… now I feel more comfortable. I can again connect with people … I feel much more in control". Participant 4 reflected, "I have definitely dealt with …the abortion and sexual abuse…I almost never think about it anymore. Previously I used to lie on my bed thinking about it, therefore I feared to lie awake at night".

## *Experience of Life Satisfaction*

In Table 25.2, the participants' experiences of psychological well-being before and after the interventions are presented. It is evident that all participants experienced relatively low levels of life satisfaction before the intervention. After receiving

**Table 25.2** Indices of psychological well-being before and after the intervention

| | Participant 1 | | Participant 2 | | Participant 3 | | Participant 4 | | Participant 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Measures | Pre | Post | Pre | Post | Pre | Post | Pre | Post | Pre | Post |
| SWLS | 10 | 31 | 10 | 30 | 6 | 8 | 12 | 7 | 16 | 24 |
| AFM Positive affect | +22 | +46 | +29 | +48 | +18 | +20 | +32 | +26 | +28 | +41 |
| AFM Negative affect | −32 | −15 | −34 | −11 | −34 | −38 | −28 | −33 | −22 | −20 |
| AFM Affect Balance | −10 | +31 | −5 | +37 | −16 | −18 | +4 | −7 | +6 | +21 |
| SOC | 77 | 161 | 88 | 139 | 72 | 80 | 109 | 107 | 129 | 129 |

*Note*: SWLS Satisfaction with Life Scale, AFM Affectometer, SOC Sense of coherence scale

therapy, participants 1, 2, and 5 showed increased levels of life satisfaction, while participants 3 and 4 showed no change. These shifts, or lack thereof, were also evident in the interviews and the therapeutic process.

Before the intervention, participant 2 stated, "I feel so unhappy and dissatisfied with myself and my life", while at the conclusion of therapy, she said "I feel excited about every day … I feel more satisfied and optimistic about life". Similarly, participant 1 initially remarked, "I experience distrust, jealousy and low self-confidence, and feel discontented". After the intervention, she said "I have gained self-confidence and have solved many of my problems, which make me feel much more satisfied with my life". Participant 3 described how many current stressors contributed to a lowered sense of life satisfaction at the beginning of therapy: "…my son has learning problems, suffers from depression, and can also become very oppositional and aggressive…I experience very difficult times with him every day". Although there was no quantitative increase in life satisfaction, after the intervention she stated, "I am very happy in our new house", which may suggest some increase in life satisfaction.

## *Experience of Positive and Negative Affect*

All participants experienced more negative than positive affect before treatment, as shown in Table 25.2. Participants 1, 2, and 5 again showed a shift towards a positive affect balance after treatment. However, participant 3's affect balance remained relatively unchanged, with a preponderance of negative affect. Further, participant 4 showed as slight increase in negative affect. These scores could be seen as indicators of persistent, lowered psychological well-being.

The participants' responses before the intervention commenced also suggested relatively low levels of positive affect and a preponderance of negative affect. Participant 5 mentioned, "I only want to sleep or cry. I feel very sad and often become upset and angry with my mother". Participant 2 stated: "…the sexual abuse … affects my mood in a very negative way." After the therapeutic process was completed, participant 5 said, "I have worked through the repressed [negative]

feelings…I feel much more comfortable". Participant 2 described her positive affect clearly: "I have an overwhelming positive feeling".

Although participant 3 experienced more negative than positive affect, she still mentioned experiences of positive affect at the end of therapy: "I like the sea, music, rain, hot chocolate, and I like to cuddle my dog. It makes me feel happy". However, for participant 4, negative affect remained pronounced: "Every now and then I feel as if I am drowning". At the time, this participant was on the verge of a divorce.

### *Experience of a Sense of Coherence*

As reflected in Table 25.2, there was an increase in participants 1 and 2's scores on SOC after the hypnotherapeutic intervention, while participant 3 showed a slight increase. Participant 5 showed an unchanged mean score and participant 4's score decreased minimally.

Qualitatively, participant 3 initially stated, "I can't think of a meaningful goal for my life", while participant 4 said, "I often have the feeling that there's little meaning in the daily things I do". After therapy was completed, participant 1 indicated that her life was more goal-directed and purposeful. Additionally, she made the following remark: "One can always find a solution to painful things in life". Participant 2 also seemed to experience more comprehensibility, control, and a sense of meaningfulness when she remarked, "I just feel human again … my own very self … and I am on this journey of exploration …I feel in control". Participant 3 said, "I now look at the traumatic incidents from a different perspective". Participant 4 continued to experience a sense of meaningless and lack of control because of her persistent marital problems. "My attempts to do something about our stuck relationship are ignored by my husband… I feel very lonely."

## Discussion

The aim of this study was to describe the presence of psychological well-being of women who experienced CSA as it unfolded in the context of a hypnotherapeutic intervention proposed by Fourie and Guse (2011). Data from questionnaires measuring facets of well-being as well as qualitative data are discussed and integrated here. Overall, it was evident that all the participants experienced lowered psychological well-being at the onset of treatment. Three participants (participants 1, 2, and 5) experienced an increase in most facets of psychological well-being at the conclusion of the intervention, while for two participants (participants 3 and 4), symptoms of psychopathology and distress decreased, but relatively low levels of psychological well-being persisted.

Concerning symptoms of psychopathology and distress, both the quantitative and qualitative data indicated heightened symptomatology and thus decreased well-being before the implementation of therapy. These included emotional facets

(depression and self-destructive behaviour), cognitive facets (dissociation), physical facets (insomnia and hyper-arousal), interpersonal problems, and problems regarding sexual functioning. These negative mental health outcomes are generally associated with the experience of CSA (Briere & Jordan, 2009). Therefore, the initial experience of psychological well-being of the participants could be considered as languishing (cf. Keyes, 2002, 2005) because of high levels of distress. At the conclusion of treatment, all the participants experienced a decrease in symptoms of pathology; however, only participants 1, 2, and 5 may have moved towards flourishing because symptoms of pathology were still present for participants 3 and 4.

In terms of the experience of life satisfaction, all the participants were able to describe positive elements in their lives before the intervention, but results from the SWLS suggested a general dissatisfaction with life. After therapy was concluded, participants 1, 2, and 5 experienced an increase in life satisfaction, as suggested by scores on the SWLS, while participants 3 and 4 did not. This pattern was also present in their responses in the interviews. Although participants 3 and 4 indicated that their concerns regarding the experience of CSA had been addressed, current life circumstances, including serious financial difficulties and marital discord, seemed to contribute to continued lowered life satisfaction. Diener and Biswas-Diener (2008) reported that social relationships are important for the experience of subjective well-being, while Diener, Ng, Harter, and Arora (2010) noted that a lack of fulfilment of basic needs may lead to dissatisfaction with life. These factors seemed to be prominent in the lives of participants 3 and 4, suggesting that the enhancement of psychological well-being may be influenced by contextual variables outside of the therapeutic process. However, for the other participants, a focus on strengths may have contributed to increased life satisfaction, similar to other positive interventions (e.g., Frisch, 2006; Seligman et al., 2006).

As far as the experience of positive and negative affect is concerned, all the participants initially experienced more negative than positive affect, as reflected in their scores on the AFM and responses in the interviews. This was expected in light of previous studies suggesting that the experience of CSA is associated with a depressed mood (Briere & Jordan, 2009). After the hypnotherapeutic intervention, participants 1, 2, and 5 experienced a preponderance of positive affect over negative affect. This change could possibly be explained through Frederickson's (2001) Broaden and Build theory. As the therapeutic process progressed, these three participants described more positive emotions as well as an awareness of newfound resources. Thus, in terms of Broaden and Build theory (Frederickson) the therapeutic process may have facilitated an upward spiral of increased resilience and well-being. Further, positive emotions may have served as generators and indicators of therapeutic change (Fitzpatrick & Stalikas, 2008). Conversely, participant 3 experienced almost no change in positive affect, while participant 4 seemed to experience less positive affect than before the intervention. This may be due to the fact that both participants were experiencing current problems, which they perceived as overwhelming and ongoing life stressors. It is also possible that the women's current concerns required more explicit psychotherapeutic attention, in addition to the treatment of CSA, to be able to facilitate an increase in positive affect.

Finally, in exploring participants' SOC, it seemed that participants experienced a relatively low SOC before therapy commenced. Their mean scores on the questionnaires were lower than those reported by Strümpfer and Wissing (1998) and were confirmed by their qualitative responses. At the completion of therapy, participants 1 and 2 showed an increase in SOC, as quantitatively measured and as reflected in their verbal accounts. Participant 5's initial mean score was maintained, but was close to the average range to start out with. Studies evaluating the effect of interventions on SOC also reported increases (Guse et al., 2006; Vastamäki, Moser, & Paul, 2009), which suggest that this facet of well-being is malleable and could be strengthened. In contrast, participant 3 showed only a small increase in SOC in the quantitative evaluation, while participant 4's mean score decreased slightly. The fact that these participants still experienced ongoing stressors could partly explain these lowered scores. There seems to be a correlation between SOC and close relationships (Olsson, Hansson, Lundblad, & Cederblad, 2006), and these participants experienced continued distress in their interpersonal relationships, which may partly explain their low levels of SOC. However, the qualitative responses rendered by participant 3 indicated that she did experience some increase in a sense of meaningfulness and comprehensibility after therapy was completed. These experiences may not have been pronounced enough to be reflected in the quantitative evaluation, but still suggest some increase in well-being.

## *Limitations of the Study*

This study had several limitations. First, it was a small study with only five white female participants, which does not reflect the diversity of the South African population and therefore prevents generalization. The quantitative scores should also be interpreted with caution due to the small sample. Second, the measurement of psychological well-being did not include the mental health continuum, as proposed by Keyes (2002, 2005), which could have provided a clearer picture of the participants' possible movement to flourishing. Finally, because the participants were not followed longitudinally, it is unclear whether increases in well-being were maintained.

## *Conclusion*

Implementing hypnotherapy from a fortigenic perspective seemed to have contributed to enhanced psychological well-being for three participants. The other two participants experienced a decrease in distress, but less pronounced increases in psychological well-being. It appeared that current life stressors, including interpersonal and financial difficulties, may have contributed to their experience of persistently low levels of psychological well-being. Hypnotherapeutic interventions to

enhance well-being with clients experiencing more severe distress in several areas of functioning may need to be implemented over a longer period of time to facilitate psychological well-being.

### *Future Directions*

Practitioners of hypnotherapy are encouraged to utilize positive facets of psychological functioning in implementing treatment because these facets could contribute to enhanced well-being. This seems to hold true for both clients experiencing distress and symptomatology and clients experiencing developmental transitions.

Future research could focus on extending these findings to larger samples and to other groups of clients, including children, adolescents, and males, as the studies mentioned above only included female participants. In the South African context it is also imperative to explore the application of hypnotherapy in general, and applied from a positive psychology perspective specifically, to enhance the well-being of clients from other population groups. Further questions include: Can positive psychology exercises (cf. Lyubomirsky, 2008; Schueller, 2010) be implemented in a hypnotic trance, and what is the outcome in comparison to implementing these exercises when the client is not in hypnosis? How stable are increases in psychological well-being when facilitated by means of hypnotherapeutic interventions over time? Much remains to be explored in understanding the application of hypnotherapy for the enhancement of psychological well-being.

## Concluding Summary

Hypnotherapeutic interventions provide several opportunities to facilitate psychological well-being, specifically when implemented from an Ericksonian and ego-state therapy framework, and when including a fortigenic perspective. Limited research exists, but nonetheless it appears that a focus on accessing and activating psychological strengths in the context of hypnosis may contribute to enhanced well-being for clients experiencing life transitions as well as for those who present with more severe distress, such as psychological trauma.

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