A Spiritual-Hypnosis Assisted Treatment of Children with PTSD after the 2002 Bali Terrorist Attack

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Abstract

The aim of this study was to assess the effectiveness of a spiritual-hypnosis assisted therapy (SHAT) for treatment of posttraumatic stress disorder (PTSD) in children. All children, age 6-12 years (N=226; 52.7% females), who experienced the terrorist bomb blasts in Bali in 2002, and subsequently were diagnosed with PTSD were studied, through a longitudinal, quasi-experimental (pre-post test), single-blind, randomized control design. Of them, 48 received group SHAT (treatment group), and 178 did not receive any therapy (control group). Statistically significant results showed that SHAT produced a 77.1% improvement rate, at a two-year follow up, compared to 24% in the control group, while at the same time, the mean PTSD symptom score differences were significantly lower in the former group. We conclude that the method of spiritual-hypnosis is highly effective, economic, and easily implemented, and has a potential for therapy of PTSD in other cultures or other catastrophic life-threatening events.

Keywords: Spiritual-Hypnosis, SHAT, PTSD, treatment, terrorism, children.

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Spiritual-Hypnosis Therapy of PTSD

The psychological trauma arising from life threatening events and their sequelae can wield a severe blow to a child’s sense of security and self. These include the child’s central organizing fantasies and the child’s formation of cognitive meaning structures. In the current study, we assessed the effectiveness of a spiritual-hypnosis assisted therapy (SHAT) as a valuable culturally-sensitive alternative intervention for the treatment of PTSD in children.

Prevalence and symptoms of PTSD

PTSD comprises a set of symptoms that develop after a person experiences an extremely traumatic stressor. It can occur at any age, including childhood. PTSD is an acute, chronic, delayed, debilitating, and complex mental disorder. It involves altered states of awareness, detachment, dissociative states, ego fragmentation, personality changes, paranoid ideation, trigger events, and vivid intrusive traumatic recollections. PTSD is often co-morbid with major depression, dysthymia, alcohol or substance abuse, and generalized anxiety disorder. The person reacts to this experience with fear and helplessness, sleep disturbances, hyperarousal and hypervigilance, persistent reliving of the event, through graphic and magnified horrific flashbacks and intrusive thoughts, and unsuccessful attempts to avoid being reminded of it. The above symptoms must last for more than a month and must significantly affect important areas of life in order for someone to be diagnosed with PTSD (American Psychiatric Association, 2000).

Epidemiological research reveals that up to 90% of citizens in the United States are exposed to at least one traumatic event (as defined in DSM-IV-TR) in the course of their lives (Breslau & Kessler, 2001). Several factors, in addition to the trauma itself, can affect whether an event results in PTSD, including the characteristics of the traumatic experience, the psychological make-up of the victim, the environment, and the availability of social and family support (Deykin, 1999).

The prevalence of PTSD is related to kinds of disasters experienced, measurement tools, study methods, timing of assessment, and sampling procedures. PTSD has been described in as few as 2%–4% of survivors of natural disasters, such as tornadoes (North, Smith, McCool, & Lightcap, 1989), volcanoes (Shore, Tatum, & Vollmer, 1986), and mudslides (Canino, Bravo, Rubino-Stipece, & Woodbury, 1990). Two years after the terrorist bombing in Oklahoma City, 16% of children who lived within an approximate radius of 100 miles from the disaster center reported significant PTSD symptoms (Pfefferbaum et al., 2000). Finally, studies on the psychological effects of the September 11, 2001 attacks in New York City have produced various estimates of PTSD prevalence, ranging between 8%–20% in the Manhattan population and 3%–4% in areas beyond the immediate area of collapse of the twins towers (Breslau, 2001; Galea et al., 2002; Schlenger et al., 2002; Schuster et al., 2001).

Studies have found that willful human acts, bombing in particular, have the greatest impact in terms of evoking mental health consequences (e.g. Baum, Fleming, & Davidson, 1983; North et al., 1999; Otto et al., 2007), while traumatic events such as natural disasters and technological accidents resulting from human error appear to have a lesser impact (North, Smith, McCool, & Lightcap, 1989; Shore, Tatum & Vollmer, 1986; Sloan, 1988). However, there is no universal agreement on the degree of impact because traumatic events may be considered to consist of several factors in addition to the primary event.

Treatment of PTSD

Currently, there is relatively little empirical research on the use of medications to treat children with PTSD (Donnelly, Amaya-Jackson, & March, 1999; March, Amaya-Jackson, & Pynoos, 1997). Pharmacologic agents that have been suggested and tried in children and
adolescents include propranolol (Famularo, Kinscheiff, & Fenton, 1988), clonidine (Harmon & Riggs, 1996), guanfacine (Horrigan & Barnhill, 1996), carbamazepine (Looff, Grimley, Kuiler, Martin, & Shonfield, 1995), tricyclic antidepressants (TCAs), and serotonergic agents (Pfefferbaum, 1997). Researchers agree that an appropriate trial of initial drug therapy has a three-month duration, and effective pharmacotherapy should be continued for 12 months or longer depending on the severity and duration of symptoms and impairment.

Although a variety of psychosocial treatments have been employed, cognitive-behavioral therapy (CBT) approaches have shown the strongest empirical evidence for efficacy in both children and adults with PTSD, and should arguably be considered as a first-line approach either alone or in combination with other forms of treatment (American Academy of Child and Adolescent Psychiatry, 1998; Chard, 2005). Although most forms of CBT incorporate exposure techniques, it has not yet been established how intense or how explicit exposure needs to be to initiate a therapeutic response (Cohen, Berliner, & March, 2000). Reports of the treatment of PTSD with psychotherapy alone or in combination with medication (e.g. selective serotonin reuptake inhibitors, SSRI) showed that the combined treatment is more effective than psychotherapy alone (e.g. Bleich, Siegel, Garb, & Lerer, 1986; Brady et al., 2000; Tucker et al., 2001).

Hypnosis in the treatment of PTSD

Currently, there is no “gold standard” for assessing PTSD treatment outcomes (for medications or psychotherapies) in clinical trials of children and adolescents. There is, however, converging evidence that PTSD is associated with higher levels of hypnotizability (Bryant, Guthrie, Moulds, Nixon, & Felmingham, 2003). Hypnotic techniques for the treatment of posttraumatic conditions were often used by the clinical pioneers of the end of the 19th century and by military therapists treating soldiers during the 20th century’s conflicts (Bleich, Siegel, Garb, & Lerer, 1986). More recently, hypnosis has also been used with survivors of sexual assault, accidents, and other traumas, and with various groups, including children and ethnic minorities (Nash & Lynn, 1986; Spiegel & Cardeña, 1991; Spiegel & Spiegel, 1988; Spiegel, Detrick, & Frischholz, 1982; Stutman & Bliss, 1985). Nonetheless, very few studies exist that assess the efficacy of hypnosis on PTSD or the stability of hypnotizability levels following trauma (Bryant et al., 2003; Bryant et al., 2006; Cardeña, 2000; Gantt & Tinnin, 2007). This state of affairs is especially disappointing considering the number of PTSD individuals who have shown high hypnotizability in various studies, and the fact that hypnosis can be easily integrated into therapies that are commonly used with traumatized clients and possibly successfully assist with the modulation and integration of traumatic memories. Hypnotic techniques may indeed be efficacious for posttraumatic conditions, but controlled group or single-case studies need to be conducted before reaching that conclusion.

This paper is the first to report the outcome of a spiritual-hypnosis assisted therapy (SHAT) for the treatment of PTSD in children. It was hypothesized that children receiving SHAT would show statistically reduced PTSD symptoms as compared to the non-treatment control group.

Method

Design and Subjects

The study utilized a longitudinal, quasi-experimental (pre-post test), single-blind, randomized control design. Two bombs exploded in Kuta on 12 October 2002 at 23:05 and 23:15 respectively. They destroyed buildings within a one-kilometer radius, and resulted in 188 deaths and hundreds of additional victims who suffered burns and other injuries. A total
Spiritual-Hypnosis Therapy of PTSD

of 2,223 children live in Kuta and attend their four elementary schools in the area. The bomb blasts occurred when these children were in the majority at their homes situated one kilometer or less from the blast centers. According to our survey, all children heard the explosions which were audible within at least 50 kilometers around Kuta. The following days they heard stories of the disaster while some visited the blast sites.

Six weeks after the bombs, an initial screening interview with these children revealed that 514 exhibited symptoms of PTSD that were directly attributable to the bomb experience. Subsequently, of these, 226 (10.2% prevalence) were diagnosed with PTSD according to DSM-IV-TR criteria and were selected for this study (mean age = 9.83 years, range = 6 - 12 years; SD = 1.53 years; 52.7% were girls). All children were of the Bali Hindu faith.

However, we obtained permission based on our available resources to treat a total of only 48 of these children. Children were allowed to blindly select participation to one of two groups offered to them while not knowing which of the two groups they were choosing. Thus, participants were randomly assigned into one of the following groups: 48 children received group spiritual-hypnosis assisted therapy (SHAT; treatment group), while the remaining 178 children did not receive any therapy (and served as our non-treatment control group).

In order to make the group-therapy sessions manageable, the treatment group was further split into two subgroups (25 children in one and 23 in the other), based on the proximity to the schools they were attending. Both these subgroups received the same treatment, which was administered by one of the researchers in a single group-session. Parents and teachers of the participating children gave their permission for participation in the study. Finally, participants had no knowledge about the purpose or design of the study. Our null hypothesis was that children receiving SHAT will show no difference in PTSD symptoms as compared to the no-treatment control group. It follows that our alternative hypothesis is that children receiving SHAT will show statistically reduced PTSD symptoms as compared to the no-treatment group.

Procedure

The Balinese beliefs. The rationale for using the specific treatment technique was that hypnosis, with the additional spiritual component that is consistent with the culture of the Balinese people, would be an appropriate and effective method. Bali is a relatively small island in the Indonesian archipelago. Most of the 3.5 million inhabitants are Hindu (87% of the population in Bali; Badan Pusat Statistik, 2007). All aspects of life in the Balinese culture are associated with the spiritual world (Jensen & Suryani, 1992). According to Balinese Hinduism, human beings consist not only of mind and body, but also of spirit (atma). The spirit is the source of energy, the source of our personal awareness, a repository of knowledge and a kind of subtle intelligence within the individual. In Bali, to understand a person requires a holistic understanding of the mind, body, and spirit. These in turn are enmeshed and work together with the socio-cultural system, the environment, and they are all integrated with the Universal Spirit (Sang Hyang Widhi).

In Bali, two types of psychotherapists exist, viz. the Western-trained psychiatrists and the spiritual (traditional) healers, also known as Balians. There is a clear distinction between the perception, abilities, and function of these two identities (Suryani & Jensen, 1993). Balians speak of illness; psychiatrists speak of disorders. Balians speak of healing; psychiatrists speak of therapy. The psychiatrist tends to rely on "external manipulations," such as medication. The Balian may also use medicine, albeit traditional or herbal, but their aim is to "reset" the body systems so that they regulate themselves harmoniously. The
Lesmana, Suryani, Jensen, Tiliopoulos

doctor tends to treat disorder and symptoms at the time. The Balian regards the process as continuing by the client/patient for a long time. The client/patient is entrusted with the responsibility for his/her health. In the West, the psychiatrist sees the treatment goals achieved when the symptoms disappear. After the completion of a successful treatment both clients/patients and therapists assume a complete, or near complete, recovery has occurred. However, after treatment by a psychiatrist, Balinese patients tend to believe that their recovery is incomplete (Jensen & Suryani, 1992). A state of fogginess or apathy tends to persist until subsequent treatments occur by a traditional healer.

One of the current study’s researchers has developed a bio-psycho-socio-spiritual (thus holistic) approach to psychiatry out of her experience as both a psychiatrist and a Balian (Suryani & Wrycza, 1996; 2003). Her approach relates not only to helping patients, but also to preventing psychiatric problems within the community. Her community-based projects focus on educating people about how they can stay mentally healthy. Her programs teach people ways to understand the cycle of human life, from the womb until death, and to balance their spiritual and material needs. She and her team of psychiatrists work with large population cohorts across Bali, including teachers, students, women, and the elderly, as well as with groups in the business and the government sectors. She has been treating people with mental health problems using hypnotherapy, among other therapeutic approaches, for the past 13 years. Finally, she and her team were actively involved in the psychological rehabilitation of the victims of both the 2002 and the 2005 terrorist attacks in Bali.

Method

Spiritual-hypnosis assisted therapy (SHAT)

All the children within each of the two treatment subgroups were hypnotized together. It is well-documented that children are more easily suggestible and hypnotizable than adults (for example see Olness & Kohen, 1996). Furthermore, as both local researchers (Suryani & Jensen, 1993) and Western scholars in the field of clinical hypnosis (Spiegel & Spiegel, 2004, chapter 3) testify, the Balinese Hindus tend to meditate from an early age, as part of their prayer rituals, while a large number of them have experienced trance or mass hypnotic states through certain annual religious ceremonies (such as the Kuningan or the Ngrebong ceremonies).

The following is a description of the SHAT utilized in this study. It began with a meditation-trance induction (Suryani & Wrycza, 2003). Through this process, the participants were initially instructed to meditate with their eyes closed; after meditating for approximately five minutes, they were instructed to breathe deeply through their nose and slowly exhale through their mouth. These instructions were repeated five times. These deep breaths lasted for one minute. Subsequently, the participants’ breathing remained constant and deep, without any further guidance from the researcher, at approximately five breaths per minute. At that stage, the researcher monitored certain behavioral cues on the participants, such as arm rigidity and immobilization, eye catalepsy, and inability to communicate, all of which the authors’ accepted as indicators of a hypnotic state – which within the context of SHAT is referred to as a trance state.

When in trance participants were guided through suggestion to be sensitive of their own spirit and were advised to identify and reframe the meaning of traumatic memories that may have been at the root of a strong tendency to obscure their spirit. It was suggested they express emotions and to visualize the past. It was suggested to them that their spirit would lead them to choose the particular traumatic memory related to the bomb.
Spiritual-Hypnosis Therapy of PTSD

Participants were asked not to imagine or visualize the traumatic moment, but rather to let the process happen in a natural way. They were told that if they remembered or had flashbacks about the past memories, including uncomfortable feelings, anxiety, sadness, anger, frustrated feelings of aggression, disappointment, difficulty of knowing what to do, or any other bad feelings, they were experiencing the feeling of the traumatic event, and thus to allow the emotion to “come out” again (Suryani, 2000). Children were then directed to express undesirable feelings with crying, shouting, or by inhaling deeply and exhaling slowly. The purpose was for them to release all emotional burdens that had been stored in their memory. They were led to their culturally familiar concept that the power of God would help them gain strength to cope with their emotions.

As they re-experienced hidden emotions, they were advised to see the problem from the perspective of the moment. By means of suggestion, they were guided to see the environment around them, to see their family, their friends, and to visualize walking through the site where the bomb blast occurred. Further, they were guided to understand the situation, and accept the concept that the trauma they experienced was in the past. The final suggestion presented was that what happened in the traumatic experience would enable them to face new challenges in life without the burdens of the past trauma. All the above happened during the hypnotic state. The entire group-session of hypnosis lasted about 30 minutes.

After the session ended they were guided back to their usual state of consciousness. When they were no longer in trance and felt awake they were asked if they wished to select the option of an individual hypnotherapy or psychotherapy session in order to indirectly control for the possibility of a lack of hypnotic responsiveness. None of the children elected this option.

In our view, SHAT significantly differs from convention treatment approaches to PTSD through (a) the absence of systematic desensitization, (b) imagery is replaced with re-experiencing the present, (c) the presence of the regression process, (d) the role of unconscious, and (e) the elements of faith, as discussed earlier, in particular that of the spirit (atma), that play a central and constant role in the therapeutic discourse.

Material

Questionnaire data were collected. The questionnaires were given to both the treatment and the control groups at the same time, before the therapy session (T1), and again two years later (T2). Given the absence of a widely accepted, cross-culturally valid and applicable, standardized self-report assessment of PTSD, a questionnaire was devised, which was based on the DSM-IV-TR criteria for PTSD, and included the three symptoms of reexperience (flashbacks), hyperarousal, and avoidance. The total questionnaire consisted of 34 forced-choice questions that required responses on a five-point scale (1=Never, 2=Less than once a week, 3=Once a week, 4=More than once a week, 5=Almost every day), and two open-ended questions that asked about the triggers of the traumatic memories and nightmares the children had (questionnaire available on request). All questions were in Bahasa Indonesia. The forced-choice section of the questionnaire exhibited good internal consistency reliabilities (for T1, Cronbach’s alpha = .70; for T2, Cronbach’s alpha = .82). The questionnaires were administered by six trained psychiatry residents who also helped the children understand the PTSD symptoms and describe them in their own words.

Data Analysis

The following effects were assessed: 1) improvement of symptoms of PTSD between the treatment and the control group, both at the univariate and multivariate levels; 2) amount of PTSD symptoms (reexperience, hyperarousal, avoidance) between the two groups; and 3) types of triggers of PTSD symptoms. Data were analyzed using SPSS version 11.5.
Results

Pre-treatment statistics

Pre-treatment demographic descriptors are presented in Table 1. The sex-ratios between the control and experimental groups were not statistically different, $x^2(1, N=226) = 0.55, ns$. The only statistically significant result was in the total mean age difference between the two groups, $t(224) = 2.47, p < .05$, two-tails. Therefore, age was treated as a covariate in the subsequent multivariate model presented below.

Table 1: Pre-Treatment Descriptors

<table>
<thead>
<tr>
<th>Group</th>
<th>Boys</th>
<th>Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$ (%)</td>
<td>Age* (SD)</td>
<td>$n$ (%)</td>
</tr>
<tr>
<td>Treatment</td>
<td>25 (52.1%)</td>
<td>9.40 (1.35)</td>
<td>23 (47.9%)</td>
</tr>
<tr>
<td>Control</td>
<td>82 (46.1%)</td>
<td>10.04 (1.63)</td>
<td>96 (53.9%)</td>
</tr>
<tr>
<td>Total</td>
<td>146 (64.6%)</td>
<td>9.89 (1.59)</td>
<td>80 (35.4%)</td>
</tr>
</tbody>
</table>

*Age in years

Univariate results

Of the reported types of triggers of PTSD symptoms in both groups, the data indicated that watching television and hearing stories of the bomb blast had the strongest influence on the reappearance of core symptoms, $x^2(9, N=226) = 90.17, p < .001$.

Within each of the study-groups (control/treatment) all pairwise mean differences between $T1$ and $T2$ for each of the three PTSD symptoms (see Table 3) were statistically significant at the .05 alpha-level, even after applying the Bonferroni correction to account for the inflation of the family-wise error. Following the DSM-IV-TR diagnosis of PTSD, which prescribes that symptoms need to be experienced more than once a week, responses to the questionnaire were initially dichotomized above and below the third point of the assessment scale (see Material subsection for scale points). Thus, only responses on the two high scale-points (points 4 and 5) were assumed to be showing symptoms of PTSD. The assessment of improvement was done through the comparison of the above dichotomized responses between $T1$ and $T2$. Of the children who received SHAT in a single group-session, 77.1% showed improvement in PTSD symptoms, compared to 24.2% in the control group, $x^2(1, N=226) = 46.31, p < .0001$ (see Table 2).
Table 2: Two-year follow up results of improvement in PTSD symptoms.

<table>
<thead>
<tr>
<th>Groups</th>
<th>Not Improved</th>
<th>Number of Children</th>
<th>Improved</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td>11 (22.9%)</td>
<td>37 (77.1%)</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Control</td>
<td>135 (75.8%)</td>
<td>43 (24.2%)</td>
<td></td>
<td>178</td>
</tr>
<tr>
<td>Total</td>
<td>146 (64.6%)</td>
<td>80 (35.4%)</td>
<td></td>
<td>226</td>
</tr>
</tbody>
</table>

Multivariate results

The two groups were compared for amounts of symptoms of reexperience, hyperarousal, and avoidance (see Table 3). As Table 3 shows, all means were lower in the treatment group in both sampling times and they decreased even further in T2. In fact, at T1 the mean hyperarousal levels were statistically different between the two groups, $t(224) = 2.42$, $p < .05$, two-tails. To control for such baseline differences (and thus, indirectly address the effects of any selection by treatment biases present), all three symptom scores at T1 were respectively subtracted from those at T2 for both groups, and the subsequent multivariate analysis was run on the symptom score differences between the two sampling times.

Table 3: Mean (SD) of the amounts of symptoms of reexperience, hyperarousal and avoidance between the control and the treatment groups.

<table>
<thead>
<tr>
<th>PTSD Symptom</th>
<th>2002 (T1)</th>
<th>2004 (T2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Control</td>
<td>Treatment</td>
</tr>
<tr>
<td>Reexperience</td>
<td>3.39 (0.94)</td>
<td>3.22 (0.98)</td>
</tr>
<tr>
<td>Hyperarousal</td>
<td>2.73 (0.98)</td>
<td>2.34 (0.99)</td>
</tr>
<tr>
<td>Avoidance</td>
<td>3.54 (1.10)</td>
<td>3.30 (1.00)</td>
</tr>
</tbody>
</table>

Initially, a single MANCOVA was performed, in which group (control vs. treatment) served as the IV, age was used as a covariate, and the symptom score differences in the three PTSD symptoms were the DVs, using Type III sum of squares to account for the unequal group memberships (Cramer, 2003). However, age was found to have no statistically significant effects at any level in the model, and thus the analysis was rerun without the covariate present. Group had a statistically significant effect both at the multivariate level, Wilks’ Lambda $(3, 222) = .94$, $p < .005$, and at the three individual symptom score differences, with the treatment group consistently showings larger symptom-reduction levels than the control (see Table 4).
<table>
<thead>
<tr>
<th>PTSD Symptoms</th>
<th>Control</th>
<th>Treatment</th>
<th>$F(1, 224)^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reexperience</td>
<td>-0.99 (1.49)</td>
<td>-1.81 (1.16)</td>
<td>12.51$^b$</td>
</tr>
<tr>
<td>Hyperarousal</td>
<td>-0.47 (1.40)</td>
<td>-1.00 (1.04)</td>
<td>7.01$^c$</td>
</tr>
<tr>
<td>Avoidance</td>
<td>-1.37 (1.37)</td>
<td>-1.86 (1.06)</td>
<td>5.34$^d$</td>
</tr>
</tbody>
</table>

$^a$using Type III sum of squares; $^b$p < .01; $^c$p < .01; $^d$p < .05

**Discussion**

Our goal in this work was to significantly help the children relieve their symptoms in a brief and effective manner. We conducted this study to measure if that effect was occurring. We disproved the null hypothesis and confirmed the alternative. The results indicated that brief group SHAT is effective with children and it should be considered as a potential treatment of PTSD. This current effort did not conduct parallel treatment situations to compare SHAT with CBT, hypnosis sans the culturally relevant religious trappings, with EMDT, or with any other intervention. Indeed, the study would be stronger if we had done so. However, doing that would have shifted us away from our main focus of bringing relief to the children. Nevertheless, we can look at previously published findings about other interventions with PTSD and possibly draw conclusions that underscore ours.

None of the treatment methods reported in the literature used a single session or group therapy technique as did the current study. The effectiveness of other methods (psychotherapy with or without medication or CBT) is far less than that shown by the method used in this study. The group method used in this study is not only highly effective in improving PTSD, it also requires less time for treatment and, importantly, is much less expensive than other psychotherapeutic methods. In light of the success achieved by our use of SHAT to children suffering from PTSD, several issues need to be emphasized.

The single session was not followed up by any other psychiatric treatment. The high level of effectiveness shows the strong capacity of SHAT to affect a reframing of memory in the afflicted persons. This method can be carried out with individuals or groups, small as well as large, depending upon space available, and thus it would be particularly beneficial in the context of large disasters. The cost and the number of therapists needed are strikingly small. One of the researchers has utilized the spiritual-hypnotherapy method with groups numbering up to 350 adults. Analysis of effectiveness with these large groups is in process.

This method is performed in a brief period of time; about 10 minutes for an individual and about 30 minutes for a group although longer or follow-up sessions can still be arranged following assessment of the initial treatment’s effectiveness. Nevertheless, the success of this method is arguably highly dependent on the skill of the therapist and the patient’s trust of the therapist. Kinzie (2001) showed that the existence of a feeling of physical and emotional security, along with a feeling of trust by the afflicted person toward the therapist have roles in the success of treatment. The therapist’s ability to provide a sense of security and trust is
Spiritual-Hypnosis Therapy of PTSD

an important element in treatment techniques. It is important to note that the treatment method used in this study does not use any medication.

Finally, the use of the spirit concept, as presented in this study, is consistent with the Balinese Hindu culture. It is conceivable that a spiritual/therapeutic connection can be made with any group of patients, if consonant with their religious/spiritual beliefs. If so, the method used in this study would potentially have application in many cultures.

Future research needs to provide us with an understanding of the specific genetic or otherwise biological vulnerabilities that make certain individuals especially susceptible to the disorganizing effects of traumatic stress and recovery. Among the potential biological markers, the roles of the hippocampal volume and that of certain neurotransmitters in trauma need to be further explored. Furthermore, a better understanding of the importance of specific regions of the brain to memory and emotion may further inform intervention and therapies. More specifically, research on the mechanisms that affect memory storage reversibility, and that seem to work or at least interact with our specific hypnotherapy technique is needed, in order to acquire a better understanding of, primarily, the arguably unique therapeutic effects of the spiritual elements in SHAT. Additionally, future research may utilize a multisite randomized design, ideally with cross-cultural settings, to enable an assessment of the generalizability of the SHAT efficacy across sites, situations, and most importantly, cultures as well as meta-analytically identify any site by treatment interaction effects. Finally, assuming that SHAT is indeed a worthy approach in clinical hypnosis, future studies should assess its combined and comparative therapeutic effect with CBT, EMDR, and other forms of hypnotherapy (Alladin, 2008), to allow for its refinement and eclectic integration into mainstream interventions for PTSD.

References


Lesmana, Suryani, Jensen, Tiliopoulos


Spiritual-Hypnosis Therapy of PTSD


