Understanding Dissociation and Insight
in the Treatment of Shortness of Breath with Hypnosis: A Case Study

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Abstract

Training in hypnosis is particularly valuable for the physician seeking to better appreciate the interplay between mind and body. Through such experiences the physician can learn that presentation of symptoms often is affected by patients’ psychological states, and that symptoms sometimes serve as solutions for patients’ psychological dilemmas. The presented case study demonstrates how an 11-year-old’s complaint of shortness of breath becomes an opportunity for an appropriately trained physician to provide treatment by helping the patient to engage his inner resources. The case illustrates the strength of hypnosis for accessing resources outside of conscious awareness and use of dissociative language to both support and alter the patient’s defenses. We discuss the role of hypnosis when working psychodynamically with a patient, and whether and when insight is important or necessary for change of behavior.

Keywords: Children, denial, dissociation, dyspnea, enuresis, headache, hypnosis, insight, stuttering, vocal cord dysfunction.

The belief in a mind/body dichotomy has historically led to practice of body medicine without significant attention given to the power of the mind (Anbar, 2006). A good physician quickly learns the challenges and complexities of the interface between practicing “medicine” and caring for the whole person. The more a physician understands about the plasticity of the brain, the emotional mind and the biological body, the more likely he or she will be able to support changes in the patient’s management of symptoms and/or the presenting disease process (Doidge,
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Physicians are taught to identify diseases, illness, and injuries and to correctly treat them. However, traditional medical training generally provides meager preparation for learning to recognize and help patients utilize their internal cognitive resources for therapeutic benefit. Additional training is needed to augment physicians’ understanding of how to align themselves with their patients in the pursuit of full mind/body health.

Training in hypnosis is particularly valuable for the physician seeking to better appreciate the interplay between mind and body. Through such experiences the physician can learn that presentation of symptoms often is affected by patients’ psychological states and that symptoms sometimes serve as solutions for patients’ psychological dilemmas (Goleman & Gurin, 1993; Griffith & Griffith, 1994). Such an understanding allows physicians to avoid providing inadequate treatment arising from inattention to patients’ psychological needs and also sensitizes them to the importance of their suggestions made during assessment and treatment of their patients.

In the following case, a young child’s presentation in a pediatric pulmonologist’s office with a complaint of shortness of breath (dyspnea) becomes an opportunity for an appropriately trained physician to treat “the problem,” which is much greater than dyspnea, by engaging the youngster’s many inner resources. The case illustrates the strength of hypnosis for accessing resources outside of conscious awareness and the use of dissociative language both to support and alter dissociative defenses. Of interest is the approach the physician takes of offering the child an opportunity to gain insight into his problem. We have come to expect this approach from the psychiatrist or psychologist but seeing it used by the pulmonologist is a good reminder that treatment of the whole patient allows for a better practice of medicine.

The youngster shows some outward interest in the prospect of gaining insight. And, the case illustrates the wavering between readiness for conscious awareness and the fear of feeling uncomfortable emotions and the consequence of well-practiced avoidance behaviors. Avoidance behaviors often are the result of an attempt to manage overwhelming events and emotions (Pynoos, 1994) and a measure of the quality of early attachment experiences (James, 1989). This youngster had at least six potentially traumatic incidents in his history. As the case in this report represents information derived from a chart review, without identification of the patient, this report was exempt from and received waiver from review by the SUNY Upstate Medical University Institutional Review Board. The patient’s name and some of his biographical information was changed in order to protect his privacy.

Case Presentation

The patient was an 11-year-old referred for evaluation of his four year history of dyspnea in association with playing soccer. The patient was accompanied by his mother on his first visit. His dyspnea first occurred when he was seven years old and he developed sudden difficulty breathing while playing soccer, after which he collapsed on the field. As a result of this episode he was diagnosed as having asthma. The dyspnea with playing soccer (both during practice and competitions) persisted despite several asthma and allergy medications, as well as a trial of therapy for gastroesophageal reflux, which sometimes complicates the management of asthma (Cheung, et al., 2009).

At the time of referral, the patient reported that his dyspnea was associated with difficulty with inhalation, making a loud noise when he inhaled, a feeling of tightness and burning in the chest, racing heart, and occasional fear. He had no associated headaches, stomachaches, nausea, or parasthesia (tingling or numbing in the extremities). His breathing problem prevented him from keeping up with his friends.
During early childhood the patient developed coughing that would last for weeks in association with upper respiratory infections. Also, he had a history of recurrent bronchitis and pneumonia as a young child. However, in later childhood he did not develop any lower respiratory symptoms other than the dyspnea. The patient stuttered since two years of age. He had a delay in speech and received speech therapy when he was three years old. The patient explained that he tended to stutter when he was upset or excited. He underwent surgery for recurrent sinusitis when he was ten years old with the hope that this would reduce the frequency of his headaches, which occurred two to three times a month. However, following the surgery his headache frequency did not improve. The patient reported that his headaches often turned into “migraines” when he was upset. He said he suffered from nocturnal enuresis “a few times a week.”

The patient’s parents were never married nor lived together, but lived across the street from one another. The patient lived with his mother who had a boyfriend. The patient said he liked the boyfriend but that he did not want him to marry his mother for fear that this would disrupt his relationship with his father. The patient became tearful as he discussed his parents, and stated that he thought it was his responsibility to keep his family “together,” as it were. The patient had no siblings. His mother was 41 years old and diagnosed with a liposarcoma (a malignant tumor arising from fat cells) when the patient was ten years old. After her diagnosis was made the mother took the patient for counseling, during which both she and the patient cried because they felt badly about her health. The mother reported that the patient had talked a lot about his father during those sessions. The patient said he could not recall the counseling. The mother was receiving chemotherapy and was in remission at the time of the patient’s referral for his breathing problems. His father was 63-years-old, and had undergone an angioplasty a few years beforehand. The patient said he was worried about his mother’s health but not worried about his father. The physical examination and pulmonary function testing of the patient were normal.

Assessment

The patient and his mother were told that his dyspnea most likely was the result of vocal cord dysfunction, given his report of difficulty with inhalation and associated inspiratory noise and lack of improvement with therapy for asthma, allergies, and gastroesophageal reflux. Further, it was suggested that the patient was an outstanding candidate for instruction in self-hypnosis, which can help resolve vocal cord dysfunction, and also is helpful in the treatment and prevention of migraine headaches, enuresis, and possibly stuttering. The patient indicated he wanted to learn how to use hypnosis to help himself.

Hypnosis Intervention

The pediatric pulmonologist who offered hypnosis instruction was trained in hypnosis at three workshops sponsored by the Society for Developmental and Behavioral Pediatrics and the American Society of Clinical Hypnosis. Additionally, this physician consulted regularly with a Professor of Psychiatry, specializing in pediatrics and family counseling, who was faculty member of the Department of Psychiatry at the SUNY Upstate Medical University.

Session 1

As an introduction to hypnosis, the patient was shown how imagining that his hands were giant magnets could cause them to become attracted, “on their own.” Once his hands became “stuck” to each other, the patient reported he could not separate them as long
as he imagined the magnets remaining in place. The patient was easily able to allow one of his hands to fall as he imagined himself holding a bucketful of wet sand, while allowing his other hand to rise by imagining that in that hand he was holding strings to hundreds of helium balloons. The patient was coached to imagine with all of his senses as if he were in a safe, relaxing place, which he chose to be a forest. He was coached to progressively relax from head to toe. The patient picked a “relaxation sign” of touching his index finger to his thumb that would serve as a trigger of a relaxation response when he was not in hypnosis. After alerting the patient reported that his relaxation had improved from an “8” to a “1” on a “0-10” relaxation scale, wherein “0” represented the most relaxed he had ever been, and “10” represented the most tense he had ever been. By making his relaxation sign, the patient said he was able to improve his relaxation to “0”.

To help with his stuttering, it was suggested that since the patient tended to stutter when he became upset or excited, he could calm himself with his relaxation sign during such times, and that subsequently his stuttering would improve.

The patient rehearsed his hypnotic skills by imagining that he was playing a soccer game, which he said made him feel as if he had brought on an asthma attack. He then used his relaxation sign and said that his breathing returned to normal. Similarly, he brought on stuttering by imagining talking excitedly after a soccer game he had won and subsequently was able to resolve the stutter by using his relaxation sign.

The patient was instructed to practice his self-hypnosis techniques on a nightly basis for at least two weeks in order to become good with their use. Further, it was suggested that he might want to learn how to use hypnosis in order to gain insight into the stressors that may have led up to his dyspnea and other symptoms. The patient said he was interested in learning more about hypnosis and how it could help him, and requested a follow-up appointment in five days.

Session 2 – 5 days after session 1

Over the subsequent week, the patient played soccer twice without associated dyspnea. He reported he had used hypnosis induced relaxation multiple times during the games even though he did not feel as if he was going to develop breathing problems. His mother reported he had decreased stuttering, which she attributed to his improved affect and becoming more aware of his speech pattern.

The patient wanted to learn how to express what was stressing him without become upset. Therefore, he was taught how to utilize automatic word processing (AWP, Anbar, 2001; Anbar, 2008) during which he was instructed how to allow his “subconscious” to type responses to comments and questions from the author. “Subconscious” was defined as a part of the patient’s mind of which he was usually unaware. He was seated next to the author in front of a computer screen that was attached to two keyboards. He was instructed to go to his forest in hypnosis with his eyes closed. Once the patient indicated he was in hypnosis by nodding his head, he was instructed that when his subconscious is ready to type, his eyes will open by themselves, and his subconscious will be able to read the computer screen and to operate his hands. During this time, his job will be to remain in his forest. He was told that he would be allowed to read a copy of the typed interaction following the session, if he so wished.

In the following excerpt of the typing the patient explained one reason he is stressed. The transcript is verbatim. The authors (RA) typed statements are in italics.
Anbar, Linden

Explain why Matthew is upset...

Matthew is upset with his dad for many reasons. For example, he tries to make him perfect and really never gives him a chance to do something. Another reason his he can be mean to mom and me. He also can.... I can’t think of anything else.

You can’t think of anything else or you don’t want to say?

Both I guess.

OK, well if you want to say it later it will be fine... Explain to me why Matthew’s dad tries to make Matthew perfect?

He can’t do anything wrong but I don’t know why

Who can’t do anything wrong?

Me or he gets mad

Give me an example of a time when Matthew did something wrong and his father got mad, and Matthew thought it was not right.

At soccer practice he got hurt and his dad yelled at him to suck it up very meanly.

And that felt bad because - He didn’t have that right

Who didn’t have it right?

Dad

His Dad yelled at Matthew, but Matthew was hurt?

Yes

And how did it feel to Matthew to be yelled at under those circumstances?

It didn’t feel good

Did Matthew tell his dad that he was hurt?

His dad knew

But he thought Matthew should suck it up?

Yes

How do you wish his dad would have reacted?

Instead of mad he could have been a little more sympathetic

Is that within his nature to be more sympathetic?

No
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So if Matthew’s dad is like that, what could Matthew do differently so that he won’t feel badly under such circumstances?

Dunno

How do you wish Matthew would react?

Stand up to him instead of just agree with him.

So one option is to stand up to his dad... Can you think of other options?

Talk to him.

So a second option is to talk to him in private, when everyone is calm, to explain how you feel?

I guess

What’s a third option?

Dunno

How about working on the way that Matthew feels when his dad yells at him... In other words, if Matthew think his dad is being unfair you/he can help him feel OK with it, and not to get upset...

That’ll work

Following the automatic word processing, the patient denied remembering the content of the typing, and did not want to see its transcript.

Session 3 – 2 weeks after session 1

A week later the patient did not want to use hypnosis in order to develop insight further. He discussed at length his feelings about his mother including his concern about her suffering as a result of the cancer and her difficulties in paying her medical bills. The patient acknowledged he was worried that his mother’s cancer might recur and that if it did there would be nothing he could do for her. Also, he worried about who would care for him if she became sick again.

The patient said he believed in God and prayer, and therefore the author suggested to him that he could be helpful to his mother by praying for her. We discussed that even if the patient’s mother did not feel well enough to care for him that he could recall her love for him, and thus be comforted.

The patient wanted to work on his stuttering, and in the session discussed how he can encourage himself to speak more fluently each night as he practiced hypnosis. Also, the patient was encouraged to visualize a near-term future when he speaks fluently.

Session 4 – 6 weeks

The patient reported that he had suffered from dyspnea on only two occasions, and had no migraines over the month, although he reported two headaches. He said his stuttering had improved by 30%. His enuresis occurred only once a week. He said he had practiced hypnosis approximately twice weekly.

The patient was accompanied by his father to this session, and asked in front of his father whether he wanted to say anything to his father. He said he did not. Asked if
there was anything for which he was mad at his father. He said there was not. Asked him if he wanted the author to keep talking about this subject, and he said he did, even though he became tearful. He was given a number of examples of why an 11-year-old might be angry at his father, including that the father expects his child to be perfect, but the patient denied any of the mentioned scenarios applied to him. Once again, the patient was asked if he wanted the authors to keep talking about the subject, and he said he did. He was asked if he wanted help in figuring out why he was upset, and the patient said he did.

The father was excused from the room, and the patient was asked if he wanted to read what he had typed during session 2. He said he did. Together, we read approximately half of the transcript, and the patient appeared upset as we did so. He said he did not know if what was stated in the typing applied to him, and denied having typed what was in the transcript. I asked if this was too difficult to read, and he said it was. He explained it was too difficult to deal with the issues raised in the transcript. He was offered him an opportunity to forget what we had read, and he was interested. Therefore, it was suggested that he go into hypnosis, imagine going into his forest, surround the woods with a glass wall, and tell himself to forget what he had read. When he alerted the patient said he could not remember what he had read in the transcript. It was suggested that perhaps in the future in he would want to see again what he had written, when he is ready to deal with the issues discussed.

The patient’s father then was invited back into the session, and the patient asked to be taught how to use hypnosis to further improve his enuresis. We discussed the brain/bladder connection, and the patient realized that when he was asleep the full bladder was unable to awaken his sleeping brain. It was pointed out to the patient that part of his brain actually was awake at night because it kept him from falling out of bed, and also showed him dreams. It was suggested to him that while in hypnosis he could ask his bladder to talk with his “awake” brain when it feels he needs to relieve himself. The patient was encouraged to practice this technique on a nightly basis.

Sessions 5-7

The patient was seen three times on a monthly basis, during which time the frequency of his dyspnea, headache, stuttering, and enuresis diminished greatly. He then requested a follow-up appointment three months later at which time he reported minimal symptoms.

Session 8 – 33 weeks

The patient agreed to use ideomotor signaling (moving his fingers) in order to indicate whether his subconscious thought there was an issues we ought to discuss. The subconscious was not aware of any issues that were important for the patient to discuss with me. When asked if there was any psychological issue of which the patient should become aware, he alerted spontaneously and complained of dizziness. It was suggested that he return to hypnosis and then suggested that he would feel steady and good. When he realerted, he said he felt well.

The patient said that he wanted to return one final time in two months, and an appointment was so scheduled for him. He was told that the author could meet with him in the future at any time if he thought this would be helpful.

Final session – 42 weeks

The patient reported minimal symptoms at his last visit, even though he had stopped his asthma therapy. We discussed what the patient recalled from our work together over the
year. The patient remembered talking, typing and doing hypnosis. He denied recalling times that he was upset during the year during our interactions, including when we talked about his father. He said he appreciated that the therapy helped him verbalize his feelings and said he was happy to know that if he needed to he could return to work with me.

The patient was asked if he wanted to read what he had typed in session 2. He said he did. He read the transcript through while showing little emotion. He pointed out typographical errors in the transcript, and said he thought they were “funny.” He commented that he had forgotten most of the issues we had discussed. He was told that the last time he read the transcript he had become very upset, but he said he did not recall that. Asked if he had typed what was in the transcript, he said that he did. When asked what happened to the issues with his father, the patient said that his father had stopped picking on him during the year.

Discussion

There are several features of this case that merit discussion. First is the manner of work the physician is doing. Second is the role of hypnosis when working psychodynamically with a client. This includes the exploration of dissociation as a defense and mechanism for change. Third is the role of the client’s resources and direction in the hypnotic work. Finally, a discussion of the question of whether and when insight is important or necessary for change.

The Role of the Physician

In this case, the physician recognizes the potential psychological basis of his patient’s symptoms. Based on the physician’s experience, training and regular consultation with a psychiatrist, he undertakes hypnotic work with the patient, which includes instruction in achieving relaxation with self-hypnosis, and an offer to help the youngster verbalize his thoughts and feelings with the hypnotic technique of AWP. This approach fits well within the role of some non-psychiatric physicians whether working with or without hypnosis. For example, if a patient is non-adherent to prescribed therapies (which is a common issue), it is in the best interest of the patient if the physician can promote adherence. The physician can, with the patient’s agreement, help define why he or she believes he is non-adherent, and then ask the patient for solutions regarding the problem (Quittner, Modi, Lemanek, Levers-Landis, & Rapoff, 2008). The physician may give suggestions that the patient is free to embrace or reject. This case exemplified this process both during an ordinary office visit interview and within hypnotic work.

Physicians who feel they do not have sufficient expertise or time to provide patients with adequate behavioral counseling (with or without use of hypnosis) should refer patients who might benefit from such work to appropriate health care providers such as psychologists or social workers.

The physician is very respectful of the youngster’s use of denial in this case. There are many ways to understand the mechanism of this defense. Ego State Therapy (Watkins & Watkins, 1997) frames all defenses as useful for restoring and maintaining stability of the person during and after a trauma. While meant to be of service to the developing mind, restriction to or overuse of the same defenses can ultimately render one more rigid and hinder ongoing development. Within this framework, the physician establishes rapport with the youngster, a goal of resolving his symptoms, and works collaboratively with the conscious and subconscious aspects of his mind to develop ego-strength, curiosity for change and healthy self-hypnotic skills.

There are several postulates that guide the physician’s approach. These include the working assumption that some part of the patient, 1) knows what the matter is, 2) knows
whether it should be discussed, and 3) may have some ideas about resolving the issue (Anbar, 2007). The use of some part is intentional since it reflects the concept of ego state therapy as a metaphor for the complex human mind and manner in which defenses protect the mind and developing personality.

The role of the physician is to focus on the relief of symptoms within the domain of the physician's area of expertise. The non-psychiatric physician should not be in pursuit of psychodynamic change of personality, although that may occur as part of the therapy. This distinction is imperative in that it clearly defines the physician's intention and method of working with the patient.

The Role of Hypnosis

In this case the method of initial work primarily is hypnotic. First, the client is introduced to the notion that self-hypnosis can be useful for his symptoms. The youngster reports stress related to his dyspnea and using hypnotically facilitated relaxation techniques reduces both his stress and shortness of breath. Typical of work with children, hypnosis is introduced as the use of one's imagination. The child's sense of personal control is enhanced with the self-hypnotic training.

The notion that one can “learn how to use hypnosis to gain insight into the stressors” then is introduced. The introduction of such an approach presupposes that the child is developmentally ready to understand the concept of insight, as well as emotionally ready to utilize this approach. The approach implies to the youngster that there is something to be learned about how stressors relate to one’s behavior. It also conveys the physician’s view that it is part of his role to help the patient bring to conscious awareness what he tells the physician in hypnosis, as part of the process of learning to deal with the issue. It does not assume the youngster is under any obligation to do so, however, which is a strength of working hypnotically. It provides the youngster with the “room to wiggle;” because hypnotic work is dissociative (Anbar, 2008) the youngster can remember only what he is ready to remember from what he learns during hypnosis. We see the youngster become upset with the expression of emotions and then wanting a way to express himself without feeling upset. The physician offers AWP as a means to do so. This is a good example of the respect shown for the youngster’s defenses and the use of the dissociation from the conscious critical self to the subconscious inner helper (Linden, 2007).

There are many advantages to dissociation (Putnam, 1997). One needs distance in order to achieve mastery in some situations. Thus, to compartmentalize, have a discontinuity in experience, dissociate in order to maintain, gain and regain control or to have the body handle some of the worst responses through somatic means may serve the ego well in its preservation or survival. The changes in consciousness reported by those in hypnotic state include a narrowed focus of attention; dissociation or a numbing, out of body, “spacey” feeling; an altered sense of time; or altered sensory perceptions (Cardeña, 2000). Hypnosis as an altered state of consciousness is another way of describing the dissociative experience of hypnosis.

The Role of the Client

In this case, the youngster utilizes hypnosis and outlines the many areas he wishes to improve. These include not only the reduction of the dyspnea, but also of headaches, stuttering, enuresis, and his distress about his parents’ health and relational issues.

The client sets his agenda and then proceeds to use his newly developed ego-strength garnered during his success with the self-hypnosis skills for relaxation and stress reduction. What is significant in the goal setting is the role of the physician as a presence in the
the boy’s life. One might argue that there is both tacit permission to change and support to do so, without pressure, since it is the boy’s subconscious mind and not the physician who has set the agenda for change. In session 8 we see what happens when the subconscious says it is not aware of any issues to discuss, and the physician persists and asks if there are psychological issues he should be aware of. The youngster alerts and complains of dizziness. This kind of response indicates the physician has not respected the subconscious’ determination that the youngster is not ready for conscious awareness of the psychological issues. This report of dizziness is consistent with reports of conflicts among ego-states in ego state therapy (Watkins & Watkins, 1997). The physician restores stability and appropriately does not pursue ego-state work with the youngster.

The Role of Insight

This brings us to the final consideration that the boy seems to have made many changes without the conscious development of insight or awareness in spite of the physician’s belief that insight is important to change. It is noteworthy that vocal cord dysfunction was the main symptom for which treatment was begun. How interesting that this youngster for whom the defense of denial is paramount should exhibit a symptom that limits talking or speaking about something. The “choice” of the constriction of the air passages as a symptom fits with the youngster’s need to convey his conflicts about expressing himself, albeit through a somatic conveyance. This idea arises from the authors’ belief that the psyche is constructed in a way that yearns for growth and increased health.

We noted that this youngster had experienced many traumas during his lifetime. Traumas here are defined as events in which significant loss is experienced or the person is overwhelmed (McCann & Pearlman, 1990). The authors work from a framework in which if something is mentioned by the patient then it has significance. We learn that the patient has collapsed on the soccer field. He has childhood history of coughing that lasted for weeks, and a recurrent history of bronchitis and pneumonia. He underwent surgery for sinusitis. His mother has been diagnosed with a sarcoma. His father has undergone angioplasty and he has never had his mother and father in an intact living situation. In addition he complains of how his father has picked on him. Cumulatively, these issues may cause the youngster to feel overwhelmed and may further explain his “choice” of denial as a coping mechanism.

The youngster first demonstrates his forgetfulness when he tells the physician that he cannot recall his counseling sessions a year before his presentation for dyspnea. We watch the youngster develop less forgetfulness over a year’s time and become appreciative of learning to verbalize his feelings. If we can ask the purpose of the denial for this youngster. It can be conjectured that this youngster used distancing mechanisms to keep major affect, such as anxiety or depression, from being felt. He did so successfully until ready to begin to express his emotions in the safety of forgetting (provided by the dissociation of hypnosis).

By the time the youngster said that he no longer needed treatment he was able to see what he had typed in hypnosis, found it funny (perhaps ego-dystonic), and yet knew he had written it. This is an example of trance logic and/or different ego states that permit resolution of symptoms without full conscious awareness. The patient is unlikely to give up a coping mechanism that has served him so well, unless and until others are firmly in place. Thus, this case reinforces the valuable lesson that insight may not be necessary for change of behavior.


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