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## Hypnosis and Psychotherapy with HIV, ARC and AIDS Patients

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■ Between the time of having become infected by the human immunodeficiency virus (HIV) and dying from AIDS patients pass through different physical and psychological stages. A simplified distinction reveals three types of patients: Seropositive, AIDS-related complex (ARC), and AIDS patients. Each of these groups need different psychotherapeutic treatment and support. The necessary coping strategies of these patient groups differ from the usual population in need of psychotherapy. Hypnotherapy is useful at all stages. The therapeutic implications are supported by relevant findings in psychoneuroimmunology, AIDS research and coping research. Two patient protocols and one case description are included for illustrative purposes.

### 1. Medical and psychological stages in the course of HIV infections and AIDS

From the time of having become infected with HIV to the time of developing AIDS, HIV patients pass several medical and psychological stages. The medical field has attempted to classify disease development with different staging systems (e.g., CDC 1987; Redfield et al., 1986; WHO, 1991). Stage I, for the sake of simplicity, would include all those patients who are HIV positive or seropositive and are asymptomatic. Stage II characterizes ARC patients who are suffering from AIDS related symptoms which are not yet lifethreatening, whereas Stage III includes all those patients with progressive disease leading to death (for a differentiated description cf. Peter, 1994). The clinical course of infection can vary tremendously among patients. Munoz et al. (1988) estimate that some HIV patients are asymptomatic for more than 10 years. This can be verified by long-term survivors.

Von Forstein (1984) advocates a psychological staging based on the stages on death and dying by Kübler-Ross (1971):

1. Denial, paralyzing fear.

2. Denial of the diagnosis and attempts to maintain and hold on to existing life styles.

patients demonstrated significantly more depressive symptoms, anxiety as well as psychological distress than AIDS patients, since the developing and realization of HIV associated symptoms can be considered the most distressing factor during disease progression.

A similar trend was found in the German study by Franke (1990): ARC patients received the highest SCL-90 scores on depression, anxiety and distress in comparison to AIDS- and-HIV patients, whereas AIDS patients scored even lower than HIV patients (SCL-90-R-Questionnaire; Derogatis, 1986).

The psychological implications of such findings seem to be self-evident; they range from immediate crisis intervention to symptom control as well as support towards finding a meaning in life and terminal care.

## 2. What is adaptive coping?

Certain psychological coping strategies generally are regarded by the psychotherapeutic community as maladaptive. For example, defensive mechanisms like repression or denial, displacement, projection, rationalizing, intellectualizing, affect-isolation and many more are frequently considered counterproductive coping strategies when an individual is confronted with a threatening situation, since they can lead to maladaptive behavior. Traditionally oriented psychotherapy usually tries to motivate the patient to give up these defense mechanisms. Whether this is wise and to what extent it might be useful remains to be seen. Recent research findings, however, seem to suggest a reorientation in terms of such defense strategies when applied to serious illness or at least when dealing with HIV-or-AIDS patients.

HIV patients who just received their diagnosis often go into a state of trance (a variation of the diagnosis shock). Intellectually they have understood that they are seropositive, emotionally, however, they appear to be completely unaffected and frequently they simply try to „forget“ or deny the diagnosis. This type of affect-isolation or denial can, however, be viewed as a productive and adaptive emergency response. On the one hand such strategies help protect the individual from being flooded by panic and facilitatively prevent other possible forms of decompensation and on the other hand they tend to provide a time frame within which the patient can gradually come to terms with the traumatic situation. For example one of our patients (Reiser, Peter et al., 1993) had to be hospitalized in the psychiatric ward after receiving his diagnosis since he decompensated completely. Another one of our patients reported that he felt suicidal for about 12 weeks following diagnosis. Consequently these type of defense mechanisms when utilized as a temporary emergency response can be regarded as healthy and mature in that they provide a time frame within which the patient can develop more productive coping strategies. On the other hand

3. Attempts to postpone the course of the disease; changes in life style; approaching life with more awareness, active compliance in terms of the disease.
4. Acceptance of the illness and trying to actively master life as best as possible .

These psychological stages provide a good overview of the different phases HIV patients experience during the course of illness, even if the formulations are quite general. From the time of seropositive identification until the manifestation of AIDS the patient is confronted with a series of stressful factors (cf., Perrez, 1992):

1. When hearing the diagnosis the patient usually experiences a so-called „diagnosis shock“ which incurs unforeseeable reactions within the first eight weeks ranging from extreme fear, depression to suicide, or psychotic decompensation (Morin & Batchelor, 1984; Tross & Hirsch, 1988).
  2. In addition the patient is also confronted with many psychosocial problems (vocational and familial, „coming out“, etc.) which are quite distressing. However, if the patient is asymptomatic it is understandable that he/she continues with the way things were or tries to deny the diagnosis. At the same time the patient may start to watch out for somatic symptoms in a realistic or hypochondriacal manner.
  3. Sooner or later the patient will accept the fact that he/she is HIV positive at least then when ARC symptoms become manifest. At this point the patient generally changes his/her behavior towards health in that he/she becomes more conscious about his/her dietary behaviors, life style and attempts to lead a more healthy life. Good medical treatment becomes more and more important in order to delay or postpone the outbreak of the disease. The psychological toll is enormous as shown by several studies (see below).
  4. The acute manifestations of AIDS symptomatology again incur some psychological problems but as a rule they are less stressful than before. At this point the patient seems to have accepted the fact that he/she will eventually die of the disease if the patient has passed the „meaning of life“ crisis and is receiving medical and/or psychotherapeutic treatment (cf. patient protocol below).
- For each patient the psychological manifestation across the course of the disease are just as variable as the physical variations in the clinical course of the disease. Some studies, however, indicate that ARC patients suffer the most psychological distress following the shock of a seropositive diagnosis. According to Temoshok, Mandel et al. (1986) and Temoshok, Sweet et al. (1987) ARC patients tend to suffer more psychosocial distress than AIDS patients. The findings by Chuang et al. (1989) showed that HIV positive and ARC

such defense mechanisms can be minimized or completely discarded to the extent that the patient replaces them with other more appropriate coping strategies. Thus, a specific integration of defense-and-coping mechanisms should be interpreted as a sign of mental stability (Steffens & KŠchele, 1988; Weimer et al., 1989, 1991). The clinical progression of the disease and its corresponding symptoms will eventually force any HIV-or-AIDS patient to come to terms with his/her illness. The question remaining is which coping strategies can generally be considered adaptive, i.e., effective, in terms of maintaining quality of life by reducing feelings of anxiety, depression, and helplessness.

Studies on cancer patients demonstrate that active participation in life is a more effective coping strategy than a passive tolerating attitude combined with feelings of repression and social retreat (Heim, 1988). In terms of control attributions it seems to be of psychological benefit if the patients are convinced that they can influence their illness themselves or indirectly through the physician. Such patients appear to be less depressed, frightened and anxious than patients who think they have no control over their illness (Taylor et al., 1983; Taylor, 1984). Patients who attribute the cause of their illness to psychological problems also tend to be more depressed (Riehl-Emde et al., 1989). One interesting finding of the well-known Spiegel et al. study (1989, 1991) on breast cancer patients showed that survival time correlated with group session participation. Patients who had been assigned to group sessions but who did not participate had an average survival time of 25 months in comparison to the control group which had an average survival time of 18.9 months. Patients who participated in one to ten group sessions had an average survival time of 36 months and patients who participated in more than ten group sessions had an average survival time of 41 months. Based on these results, which however should be interpreted with caution, it seems that an active coming to terms with the illness has an effect on outcome, i.e., survival time.

Other studies on HIV-and-AIDS patients have also investigated the supposition espoused by Spiegel. One German/Swedish collaborative study on 42 seropositive homosexuals (Weimer et al., 1988) found two opposing coping patterns (Freiburger Coping Questionnaire; Muthny, 1989). One coping pattern comprised fighting strategies while the other pattern comprised denial and passive retreat strategies. Correlations of the two opposing coping patterns with criteria depression, resignation, *carpe diem* and zest for life demonstrated that passive retreat correlated significantly with depression and resignation, whereas fighting correlated significantly with *carpe diem* and zest for life. The authors interpreted their findings that an active coming to terms with the illness has a more positive effect on the mental attitude regarding the acceptance of the HIV diagnosis than the attitude of denial and passive retreat.

criterion of adaptation	coping strategy	
	fighting	passive retreat
depression	-.11	+.81 (p<.001)
resignation	-.14	+.49 (p<.01)
<i>carpe diem</i>	+.42 (p<.01)	-.12

Tab. 1: Coping strategies of 42 seropositive-and-ARC patients (Weimer et al., 1998)

Another study by the same authors (Weimer et al., 1991) on 54 HIV-positive homosexuals found the following coping patterns and attributional styles: Depressed patients showed a tendency towards avoidance, wishful thinking, social retreat, and dependency in comparison to non-depressives. In terms of attributions the authors found the following: Depressive patients thought that they had little influence on the course of the disease and believed that the likelihood of getting AIDS was very high. Depressives in comparison to non-depressives blamed themselves for getting the disease and consequently suffered from feelings of guilt. Moreover, the findings revealed a significant relation between the coping style „avoidance/wishful thinking/social retreat“ and the attribution „not to be able to influence the course of illness“. The authors interpreted their findings that the subjectively experienced threat of developing AIDS was reduced if the patients had a positive attitude about themselves.

depression	copingstyle	
	fighting spirit	avoidance
influence	-.38 (p<.01)	.26
risc of getting ill	.46 (p<.01)	-.36 (p<.05)

Tab. 2: Coping strategies of 54 seropositive-and-ARC patients (Weimer et al., 1991)

These findings have been corroborated by other studies on HIV-, ARC-and-AIDS patients: For example Perrez, Hÿsler et al. (1992) showed in a study on 77 HIV positive patients that poor attributions of controllability of daily stressors (passivity, avoidance behavior, self- and other directed discriminations, ruminations) correlate with greater emotional stress, low mental stability and health. Wolf, Balson et al. (1991) as well as Wolf, Dralle et al. (1991) showed (29 homosexual/bisexual men) that (1) active instrumental coping cor-

related with improved moods, more social support and less stress while (2) avoidance behavior correlated with affective disorders and less social support. Nabir et al. (1987) attained similar result in their study (50 homosexual/bisexual men). Findings demonstrated that (1) active instrumental coping correlated significantly with improved moods, improved self-respect, and improved social support, whereas (2) avoidance behavior correlated significantly with anxiety about health, existential problems, difficulties with friends, low self-respect as well as depressions. The authors, however, attributed these poorer emotional states to be caused by less effective coping behaviors and not so much by the lack of social support: „The result is that ‘poor copers’ who are in greatest need of support are least likely to receive it“ (p. 325). They emphasize further that avoidance coping is not the consequence of a poor state of health, since it did not correlate with daily activities, health state, symptoms or medical problems. Moreover, one interesting finding concerns active cognitive coping strategies in comparison to active instrumental coping in that „positive thinking“ alone can lead to an obsessive and ruminating attitude and thus becomes counterproductive.

That coping behavior not only correlates with mental and social states, but also with changes in the immunosystem, was demonstrated for example by Goodkin and colleagues (1992). They were able to show in their study on 62 seropositive homosexuals (stage II and III, CDC), that (1) an active coping style correlated positively with the cytotoxicity of the natural killer cells (NKCC). In addition, they also discovered a negative trend between NKCC and daily hassles. That is, the more stress a person experienced the less cytotoxic were the killer cells. Finally, they were able to demonstrate that social support acts as a buffer for daily hassles (cf., Spiegel, 1991, 1993). In a second study Goodkin et al (1992) investigated the question whether daily hassles could have an effect on the time interval between HIV infection and the outbreak AIDS. They found a significant correlation between life stress experienced in the previous year, passive coping style, and the total number of lymphocytes in 11 asymptomatic seropositive homosexuals. This means that the more stress a person experiences the more passive his coping style and the lower the total amount of his/her lymphocytes. This trend could also be corroborated for a CD4-cell subpopulation, i.e., those cells which are particularly affected by the virus and whose number is an important indicator of disease progression and prognosis.

Nevertheless, since these are all retrospective studies it remains unclear whether these particular coping strategies were dispositional and reactive variables that existed already before the illness. As long as there are no prospective studies, for example the continuation of the study by Goodkin, Fuchs et al., the previous mistakes which have dominated psychooncological research for so long should not be repeated, such as concluding ex post

facto that there is such a thing as a „cancer personality“.

Consequently, the previous findings should be interpreted with caution and one should not generalize them onto HIV-and-AIDS patients. For example, Leiberich and Olbrich (1990) found a state evasive-regressive coping behavior in HIV patients with a still intact immunosystem whereas patients with poor immune responses demonstrated an active coping behavior. The authors interpreted the results in that they assumed that the evasive-regressive behavior served as a grief and orientation response at the beginning of the illness and only after becoming aware of the threat posed by the illness were active coping strategies implemented. Our recent research findings (Reiser, Peter et al., 1993) indicate that length of illness and/or low number of helper cells correlate with changes in coping behavior: The lower the number of CD4-cells the more positive the attitude (BDI), and the greater the length of illness the less somatic complaints. It appears as if patients with objectively worse biochemical values grow beyond the point where they feel emotionally affected resulting in an improved physical state. This apparent paradox points in the direction of the experience of long-term survivors (CF. Solomon et al., 1987; Temoshok et al., 1987; Temoshok, 1991):

- a) Flexibility as a response to the stressor: Long-term survivors generally exhibit a rather low level of arousal (e.g., as measured by heart beats). They respond to the stressor with an increase in arousal but quickly return to their arousal baseline.
- b) Emotional hardness (Kobasa, 1972): Is the combination of these particular coping styles, (a) control, (b) commitment (taking responsibility), and (c) challenge (viewing the illness as a challenge).
- c) A basic mood of confidence, less dysphoria and depression, i.e., more fighting spirit, the ability to say no and express emotions.

### 3. Preliminary implications for clinical practice

When summarizing the adaptive coping strategies used by HIV-and-AIDS patients we can say the following:

- 1) The adaptivity of coping behavior is dependent on the stage of illness both psychologically and physically. Therefore, HIV-, ARC-and-AIDS patients should be treated as separate patient groups. What is adaptive coping for an AIDS patient, as for example dealing with his/her imminent death, can lead to depression and suicide in an HIV patient.
- 2) In the meantime a number of studies have verified correlations between social support (high/low), behavior (active/passive), cognition (active/avoiding/ruminative), and emotional states (confident/depressive), arousal level (flexible/inflexible), perceived pro-



blems (many/few), and immunostatus (good/poor). Consequently the general objectives of therapy are clearly demonstrated.

3) However, these correlative relations differ according to stage of illness: Each new stage implicates at first a psychological and physical destabilization, which has to be stabilized with corresponding adaptive coping behaviors. The selection of a specific coping style depends on the task at hand which generally is predetermined by the illness. This demands a lot of flexibility on part of the therapist as well as a patient-oriented attitude.

4) Thus it seems that an attitude of denial immediately following the diagnosis shock can be considered adaptive, whereas during the ARC-and-AIDS stage accepting, hopeful, and active control coping strategies represent adaptive behavior. During the terminal stage of AIDS different coping strategies come into play which according to my knowledge have not been empirically verified.

**4. Hypnosis and psychotherapie with HIV-and-AIDS patients**

*4.1 Previous research findings*

4.1.1 General topics

Based on a literary survey we conducted in 1993 the following areas of psychotherapy research and aids received the most attention: Generally psychotherapy for HIV-and-AIDS patients proved useful and helpful (e.g., Dunde, 1990; Lomax & Sandler, 1988; Scappaticcio, 1989; Schaffner, 1990). However, most of the studies dealt with the usefulness and problems of group therapy (e.g., Beckett & Rutan, 1990; Beckham, 1988; Bliemeister, 1990; Coleman & Harris, 1989; Gabriel, 1991; Getzel & Mahony, 1990; Levine et al., 1991; Spector & Conklin, 1987; Tunnel, 1991; Viney, 1991). Problems specific to the therapeutic relationship including projection and counterprojection as well as (conscious or unconscious) fears of becoming infected by the patient are another research topic. One subtopic is the ethical dilemma of the therapist (the so-called „Tarasoff-Dilemma“ who has to assume that the patient might infect other persons knowingly or unknowingly (e.g., Adler & Beckett, 1989; Brody, 1989; Kermani, 1989; Kleinman, 1991; Perlin, 1992; Totten et al., 1990) as well as the necessity of supervision (e.g., Battegay et al., 1991; Santorelli, 1989). Other studies deal with the anxiety, depression and guilt of the person having become infected with HIV (Bradley, 1991; Carballo-Diequez, 1989; Levine et al., 1991; Markowitz et al., 1992), and crisis intervention (e.g., Isaacs, 1985) as well as terminal care (e.g., Consoli, 1992; Gabriel, 1991).

4.1.2 Social support

Many HIV -and-AIDS patient studies mention the role of social support. Social support is

considered to function as a buffer when coping with serious illness. Folkmann and colleagues (1992) found an interesting negative correlation in their study on 398 nonmonogamous homosexual and bisexual men between high risk sexual behavior (unprotected anal intercourse) and the utilization of social support and religion: The less social and/or religious support and the greater the emotional control in terms of expressing affect, the greater the practice of high risk sexual behavior. Catania and colleagues (1992) were able to show in their three year study on 529 seropositive and seronegative homosexual men that (1) in times of need homosexuals look for more support among peers than family, whereas (2) those who were less afraid of dying received more social support from family and peers, and (3) at the time when close to death many homosexuals seek the closeness and support of their own families. This corroborates our own clinical experience and does not come as a surprise if one is aware of the fact that many HIV-and-AIDS patients try to hide not only their homosexuality but also their illness as long as possible, because they feel guilty and ashamed. The other side of the coin was demonstrated by Remplein-Keller and colleagues (1992) in a study on families, each having one infected family members. Findings revealed the protectionistic tendencies on part of the whole family as well as their poor utilization of social networks, presumably because of social fears, distrust and lack of family cohesion.

4.1.3 Studies utilizing hypnosis and imagery

Occasionally a few psychotherapeutic studies utilizing hypnosis and imagery as an additional or almost exclusive tool were presented at AIDS conferences. Auerbach's (1991) eight-week group program with ARC-and-AIDS patients using biofeedback, imagery and hypnosis was able to show that the participants in comparison to the control group demonstrated a significant reduction of HIV-associated physical symptoms such as fever, pain, nausea and a significant increase in activity and „hardiness“. Gochros (1989) used hypnosis in both individual-and-group therapy (seropositive homosexuals) in order to strengthen coping abilities and to reduce stress; his findings indicate a positive effect on anxiety, helplessness and social support. Kelly's (1989) eight-week group program based on a self-hypnosis and meditation training resulted in stress reduction, improvement of control and daily quality of life. Newton and Marx (1989) used hypnotic imagery a la Simonton on 4 men (10 individual sessions) and 22 men (10 group sessions) with the objective of mediating long-term survival abilities. Three of the men, who received individual therapy, showed a reduction in stress experiences, they worried less about their health and demonstrated increased activity. The fourth participant dropped out because he did not want to imagine aggressive behaviors. After one year the three men still utilized the learned techniques and

demonstrated in comparison to the drop-out less dysphoric states as well as stable T4/T8 quotients.

In our group study of 22 homosexuals (Reiser, Peter et al., 1993) the implementation of hypnotherapy was one of the essential components of psychotherapy. Following 3 therapy blocks of 3 days each across a time interval of approximately 4 months and a one-year follow-up the participants showed improved scores in the following areas: Basic mood, depression, negative attitude, and social support. Furthermore, the CD4 values remained relatively stable in comparison to the continually declining CD4 values of the untreated control group (cf., Figure 1).

#### 4.2 Clinical experience and advice

Based on previous research and our clinical experience we are of the opinion that we are basically dealing with three different groups of patients: HIV-, ARC-and-AIDS patients.<sup>2</sup> The hypnotherapeutic and psychotherapeutic treatment and management of HIV-, ARC-and-AIDS patients comprises, depending on the stage of illness and psychological constitution, different tasks and objectives.

Patients suffering from diagnosis shock are frequently suicidal and suffer from psychotic decompensation.<sup>3</sup> These individuals are in need of immediate psychological help in terms of acute crisis intervention. Other types of reactions range from affect isolation to the utilization of various defense mechanisms such as denial, avoidance, projection, intellectualizing including emotional outbreaks and sociopathic behaviors by knowingly infecting others.

patients suffering from diagnosis shock seldom go to a psychotherapist on their own, and if they do, they generally are confronted by a long waiting period. Therefore these patients should as a rule seek out psychological counseling centers. Here the psychological management/treatment is done in terms of crisis intervention whose objective is the stabilization of ego functions. Such intervention comprises the active support of existing defense and coping strategies, and in many cases also the factual explanation of the long symptomless course of the illness, as well as advice in terms of social support through therapeutic or self-help groups which have been founded in the last decade by different homosexual organizations and AIDS groups. At this stage one should under no circumstances work psychodynamically with these patients in order to reduce their defenses.

Hypnosis and imaginative techniques can be used as an adjuvant technique at this stage, especially to promote relaxation and stress reduction, and as an aid for affect isolation and to facilitate the selection and stabilization of appropriate coping strategies. Similar to other traumatic situations - at the right time - the suggestibility of the patient is increased and

this promotes a precise and direct hypnotic intervention.

Following the diagnosis shock stage, i.e., the asymptomatic HIV stage, it would be desirable that some patients receive psychotherapeutic support in order to find and practise appropriate coping strategies. However, many HIV-positives go back to their old life style and try to suppress their tension, anxiety and depression resulting possibly in increased social isolation, poor mental health, and in poorer immunological and/or medical states (Godkin et al., 1992). HIV-positives generally seek psychotherapeutic help shortly before the manifestation of ARC symptoms.

The psychotherapeutic objectives for this HIV stage is foremostly defined negatively, i.e., reduction of anxiety and depression as well as the reduction of social isolation. Expressed positively it would be as follows:

1. That the patient informs his most important significant others about his illness and tries to enlarge his social contacts.
2. That the patient changes current behavioral habits in favor of stress reduction and starts living a more „meaningful“ and productive life.
3. That the patient takes better care of his health (e.g., better nutrition, more exercise).
4. That the patient informs himself about his illness as best as possible in order to work together with the physicians and most of all tries to gain active attributive control.
5. That the patient increases his somatic and mental awareness in order to understand and express his needs and emotional states.
- 6) And finally that the patient develops a fighting attitude instead of retreating into a state of passive suffering.

Existing coping and defense mechanisms should be tested whether they are suitable to achieve the desired objective. Consequently, also in this stage or phase affect isolation or intellectualization should not be changed or prevented. At this stage group therapy might be more advantageous than individual therapy because of its social buffer effect with the exception of those patients who, because of massive psychopathological symptoms, are in need of psychotherapeutic or psychiatric treatment. To what extent and how hypnosis should be implemented depends on the clinical evaluation of the individual case (the same goes for all other stages) and contraindications for hypnosis should be carefully adhered to.

Imagery promoting healing should be tailored individually, also if a more aggressive attitude towards fighting the illness (Kobasa, 1972) might be indicative for a longer survival. Moreover, imagery should be understood more in terms of the word *ad-gredi*: „to approach the subject matter instead of avoiding it. Not only Newton and Marx (1991) had

to realize that the simplified killer scenario is not suitable for everyone in addition to the fact that one cannot assume that aggressive imagery has a direct influence on such complex illness processes as HIV, AIDS or cancer. Especially in terms of an unchangeable prognosis it might be more advantageous to work with symbolic images such as „the internal guide and healer“ or „the wise old man / wise old woman“ (cf., anonymous protocol 2, see below).

An important place is taken up once again by hypnosis when ARC patients are expressing typical symptoms of their disease stage and hypnosis is implemented to reduce symptomatology. This concerns most of all hypnotic pain management, nausea control, sleep disorders. Hypnotherapy should also be used primarily to teach the patient how to deal with the new stressors and to reduce anxiety and depression. Good medical care is a prerequisite at this stage. Belonging to the realm of active medical cooperation on part of the patient in addition to adequate knowledge about disease and progression is adequate observation and judgement of bodily states and moods as well as the not always easy differentiation between „hypochoondriacal“ and real symptoms. As helpful as individual hypnotic techniques might be, like for example ideomotoric signaling or asking the internal healer/guide, they will never replace careful medical diagnosis and treatment, all they can do is support it. In some cases relatively infrequent individualized psychotherapeutic sessions can be quite useful.

Furthermore, it makes more sense at this stage to work problem and behaviorally oriented, i.e., to focus is on the present instead of on the past usually done with psychodynamically oriented procedures. Also no pressure should be exerted on the patient like „If you don't work hard enough on yourself / if you don't imagine aggressively enough“, etc. At this point it is most important to mobilize and reinforce the patient's resources so that the patient can change his way of life, live a more productive life and accepts the illness as his illness.

By the time the patient has progressed to the AIDS stage he should have established a good therapeutic, i.e., hypnotic rapport with his therapist. Hypnosis has proved to be effective for many different symptoms but not all. In some cases the patients can achieve dissociative states such as leaving their body or reaching mystical states which help them alleviate the symptoms. However, at this stage, contact must be established to the internal guide or the unconscious in order to provide them with not always easily maintained equilibrium of body and soul.

## 5. Clinical impressions

The following reports are protocols of three patients going through the HIV-, ARC-and-

AIDS phases. The first and last protocol were written by the patients themselves, the author of the first protocol gave permission to use his name, whereas the anonymity of the second protocol is guaranteed by the author Burkhard Peter.<sup>4</sup>

The first protocol was written by Thomas Sedlmayer (44 years old) in the spring of 1992, about one year after becoming infected and receiving his diagnosis and three months after having participated in group therapy (Reiser et al., 1993). He is still asymptomatic at this time and does not take any medication..

The second protocol (anonymous 1) was written by the author. At the begin of therapy the patient was 59 years old with a symptomatology of leukoplakia, dermatitis of the face and night sweats. He believes that he became infected 1982 and was diagnosed 1984.

The third protocol was written by the patient (anonymous 2). At the beginning of therapy (1990) he was 42 years old and became infected in June 1985 and diagnosed December 1985. His symptoms were nausea, flatulence, infection of the mucous membrane of the mouth, perianal infection and exhaustion. 1991 he had his first PCP and at the beginning of 1992 he had become almost blind due to CMV symptomatology and was could not come to us for treatment any more. He died in the summer of 1993. He wrote his report at the beginning of 1992.<sup>5</sup> Table 5 shows the blood chemistry of the three patients.

### 5.1 Experiences of an HIV positive patient

On April 26th, 1991, at 7.00 P.M. I was told that I was HIV positive. Five weeks earlier I had contact with a homosexual. Two days later he told me that he was seropositive. For thirty long days I lived between fear and hope of having or not having been infected. I was driven by an extreme inner unrest, self-despair dominated by disorientation and many sleepless nights. My days were filled with bouts of fury and crying, feelings that I had never experienced before in my life.

After I had received the positive test results I became suicidal for about twelve weeks. At the same time I also helped my partner to prepare for his exams in August. On the one hand I did not want to help him, on the other hand I was unable to tell him that I was „positive“ since I did not want him to fail his exams. Furthermore, because of my disorientation I was unsure whether I had infected him already and if I had then it would be all my fault. I was unable to kill myself since I felt responsible for him. Moreover, I would be the one responsible for causing his death in addition to all the suffering that would lie ahead of us, not to think of the shame I would cause our families. The thought that everyone would be pointing their fingers at us was driving me crazy.

For me those first twelve weeks were pure hell, since I was torn between killing myself and not killing myself. Feelings of complete helplessness, depression and mental agony,

the likes of which I had never known before, were tearing me apart. I was convinced that everything was senseless, I lacked the will to live and was dominated by the fear of future suffering. Therefore I got myself a four-fold lethal dose of Paracetamol suppositories. If it turned out that my partner was not positive then I could end my unbearable situation. My longing to end my life during this time was multiplied by my fear of confiding in someone. The whole situation changed after my partner had passed his exams and I was able to tell him everything. Surely you can imagine the relief I felt being able to break the silence. It was like being reborn, euphoria despite my guilt feelings. I was overjoyed when his test results turned out negative.

In this context I would also like to talk about our sexuality. My partner developed the classical phobia of getting AIDS. Despite his refusal to practise safer sex I felt that our friendship had become deeper, even though we no longer had any sexual intercourse. It was not easy for me at first to continue our relationship on an asexual basis but it turned out to be a lot more satisfying both physically and emotionally than I had expected.

Since I lived near Munich, I was lucky to be able to choose between two self-support groups. It was there that I first learned to differentiate correctly between HIV positive and AIDS, despite my medical training. Slowly it became clear to me that I did not have AIDS, but that I was 'merely' HIV positive. This was supported by the first seminar „Psychotherapy and AIDS“ which I attended from October 2 - 4, 1992 and that had been organized by one of the self-support groups. It was also at the seminars that I first learned to distinguish between acquaintances, friends and the afflicted.

I would like to say something about the message brought across to us by the seminars as well as to the consequences it had for me.

During this seminar my therapist managed very quickly to bring out what troubled me most of all; how to tell my parents the truth about myself. My parents had noticed an enormous change in me during the last few months and they were unable to understand me. My therapist managed to help me find the courage to tell my parents the truth before the second seminar started in November. Their reaction was totally different from what I had expected. At first my mother asked who was responsible and my father was only worried whether I had told my partner. My parents were shocked but encouraged me also not to give up. Their behavior was so different from what I had expected. Their understanding and empathy gave me the courage to go on.

The second seminar concentrated on financial problems and worries. My task was to solve them by the time the third seminar would start. Encouraged by the success I had experienced in the first seminar I now worked with self-hypnosis using it to summon my courage in order to solve these problems. My brothers and sisters strongly opposed my

financial plans; however, I had not informed them about my diagnosis. Only by threatening them to take legal action was I able to get the money belonging to me.

This step had two important consequences: I broke off the relationship to my older achievement-oriented brother completely. It had been bad before and ending it did not hurt me very much. My relationship to my identical twin brother, which so far I had thought of as being optimal, also ended spontaneously. This was emotionally very hard for me but I have to live with that. The other change was more pleasant: From now on I will have a monthly income and my financial worries will be gone for many years. The third seminar took place in December and its main objective was planning the future. The self-hypnosis exercises were broadened and deepened.

To sum up the therapy I would like to mention some of the changes that I observed in myself. I did not have the time to review the three videos given to me at the end of the seminar every day. Therefore I recorded the music onto tapes and listen to them when I get up in the morning, when taking a shower, when having breakfast, on my way to school, and in the evening before going to sleep in order to reduce and release my anxiety. I am not saying that I only listen to this music but this helps me relax and cheers me up and as background music it puts me into a state which feels comfortable, and stimulates my creativity.

For example, I have become more patient with myself and other people. I am slowly coming out of my self-imposed isolation and am looking forward to company. I can also accept more from others once again. Outside changes hardly affect me. I concentrate more on my problems and I still tend to bury my anger, although I know that this is not good for me and I have to learn to deal with my anger differently. I have become more competitive at school and less fearful since I realize that others are satisfied with my work. I have become more self-trusting. Furthermore, I have learned to express my great need to be loved without feeling ashamed and to search for more intimate friendships. I can handle money once more in a responsible manner, I don't play hide and seek any more, but tell the truth and have found out that popularity is not that important after all.

I have been able to reduce my compulsion for order and consequently I can enjoy taking it easy. I avoid disputes with others. Having gained more self-confidence, I feel less guilty towards myself and am no longer troubled by my inferiority complex. When my imagination flows freely I might appear obstinate and difficult. My former „helper syndrome“ may suffer, but at the same time this helps me worry less about others and allows me to give first priority to my fight for life.

I have learned to concentrate on things in front of me and am able to stick to the point. I show more interest and am less self-conscious about being a homosexual and more relax-



ed when dealing with heterosexuals.

At the moment I am taking vitamins and minerals for my health and as a mood lifter I listen to music but take no mood lifting drugs.

I want to end with a statement and an interpretation by Max Frisch who said: „A crisis is a productive state. Just take away the taste of catastrophe.“ Fear of the future is anything but a problem solver. It holds back from crisis or stares at it in paralysis instead of saying: Finally! Crisis is either the highest or the lowest point, in any way it is the end of a negative development. Better an end with a shock than a shock without an end. A crisis always contains the possibility for a productive new beginning. Death as well as healing, separation as well as reconciliation; despair as well as self-finding and maturing. Crisis is always the end of the shock - in one way or another. Catastrophes may be unavoidable - but crises demand decisions!

### 5.2 Psychotherapeutic experiences with an ARC patient (Anonymous 1)

At this time the patient is 62 years old, became infected 1982 and was diagnosed 1984. He came to me for psychotherapy, November 1991, because of back pain, a sleeping disorder, night sweats and other symptoms and it was not clear whether those were typical signs of ARC or psychological distress. He tried to hide his severe depressive state from me and himself and suffered from severe internal as well as external tensions. His back pain could be interpreted in this context as well as being caused by a crushed lumbar vertebra. With additional physical therapy and Feldenkrais therapy the back pain could be controlled and disappeared for a certain period of time. The severe depression was expressed by him, that he felt that for the last three years he had been living within glass walls separated from the rest of society. He had isolated himself more and more and only concentrated on what else could still happen to him. Previously he loved to travel but now he just liked to stay in his apartment. He and his partner - also infected - live together and have a stable relationship. Already back in 1984 he had good knowledge about the biochemical processes of HIV and AIDS and their respective medical treatment. He had not thought about the psychological effects of the illness. But since he had watched his friend achieve good results with auto-suggestive techniques he was willing to try them. He wanted to learn to deepen his experience with autogenic training and apply these strategies to stressful situations.

Since at that time he seemed closed to suggestions, hypnotic techniques were not indicated. Consequently the first six months of therapy consisted of talks in which I attempted to demonstrate to him psychophysiological correlations. His depressive states became less during the hours of therapy together with his back pain and sleeping disorder and the

other symptomatology. They only became worse periodically and only then when he experienced actual mental or somatic problems. At this time it became possible to use imagery but not hypnosis. It became easier for him to establish contact with his body and to become more aware of its states and needs. His bodily and mental state improved throughout 1992 and at the end of 1992 he founded an AIDS organisation which to this day is extremely successful. However, I only saw him a few times during 1992. In May 1993 he asked me for an emergency session since he had been diagnosed with malignant lymphoma. He decided, after prior reservation, to undergo chemotherapy. In the first two sessions the pros and cons of chemotherapy were discussed as well as the question whether this would be the end. My objective was to motivate him to think of the toxic agent (chemotherapy) as a helpful agent and to have him talk to his body as if it were a small child soothing it by explaining that at first the application of the toxic agent would be a shock but that the poison was aimed at the lymphoma. The evening before he started chemotherapy I visited him in the hospital. There for the first time the patient was able to demonstrate true hypnotic phenomena like arm levitation and visual hallucination. I suggested that he should concentrate his total energy on supporting chemotherapy in order to heal his lymphoma. During this suggestive state the patient levitated his arm and reported at a later time that he saw the word heal appear on the opposite wall through his half-closed eyelids and that the letters were getting larger and larger. Quite a bit later he informed me that he saw the same letters on the wall the next morning too. In fact the lymphoma disappeared completely after the second chemotherapy treatment and has not reappeared. After this experience he developed an extraordinary sensitivity for his body which enabled him to perceive symptoms of disease progression very early and was able to help his physicians both diagnostically and therapeutically. He is receiving excellent medical care and is actively involved in the whole process. One could say he is the complete opposite of a passive receptive patient.

By the end of 1993 he saw me once more and told me that for the past six months he had been worried about something that was happening to him and maybe he was getting too old. Every afternoon when he took a rest and laid down to read the newspaper, the paper would slowly fall on his lap, his eyes would close and he would just lie there in a calm paralysis awake and asleep at the same time.. He would hear everything that was going on but without feeling or thinking. He wasn't napping or sleeping but it was such a pleasant state that he had to force himself to get up each time after about two hours. I assured him that this had nothing to do with age but that he should view this experience as a genuine autohypnotic episode (cf., Meares, 1984).

### 5.3 The trance experience of an HIV infected patient (Anonymous 2; died 1993)

To begin with, I should perhaps mention a few things: I became acquainted with autogenic training 15 years ago and ever since then have been fascinated by the possibilities of influencing mental and physical states in trance. For the last 6 years I have known that I am infected with HIV. Quite early I thought about influencing the course of the infection via trance work, but it took quite a long time before I found a therapist who came up to my expectations.

For just under a year I have been going to Munich every two or three months to work intensively for two or three days with my therapist and then afterwards, at home, I try to develop and extend what I have learned. This is like slowly groping my way forwards. Some things have crystallized clearly in the course of this year, others change time and again.

To begin with my body posture: here the most comfortable position for me has become clear. From autogenic training I was already acquainted with lying and sitting with and without arm and backrests; and I already knew of a few yoga positions. But whereas perhaps the one was too passive for me - sometimes I just simply go to sleep when lying down - the other was then too strenuous. Therefore I tried out various positions, whatever I just happened to feel like, and so I discovered what is obviously best for me: sitting cross-legged like a tailor with my back very upright and leaning against a wall.

Sometimes, according to mood, I stand on my head in the yoga fashion. That, too, is a position in which I feel good all round. It is good to turn everything topsy-turvy from time to time. Though I must admit that it is hardly possible for me to work with trance in my own way then. Be that as it may - it seems to me essential to find out what is best for oneself and to keep searching till one finds out „Yes, now it's right“. And this is true not only for the position of the body, but also for space, time etc. Once I have taken up my position, there are - to put it rather simply - three main forms of trance that may occur.

First, I just simply sit there and let myself fall, sink down. I let go of everything that is occupying me. I empty myself and then just fully enjoy the state of rest, the peace within me that develops then. Sometimes it just keeps on like this. I sit there like that for a quarter, a half or a whole hour and try nothing else but becoming empty and quiet inside all over again and again. This is the most passive form of trance. I use it particularly when I am completely exhausted internally.

The second form is somewhat more active: I use it when I am in the toils of (ensnared by) something emotional. Fear of illness, dying or death or the pains of love, for example. Here again I sit cross-legged with eyes closed. There in front of me I imagine an old man who has probably been sitting there for centuries. For some reason it is a Buddhist monk

in a bright orange habit; but on occasion he has had the features of an ancient Indian (a character in a novel by Thornton Wilder) or of my therapist. In any case it is „a wise old man“ (in the case of my therapist, a fairly young one). In front of him I can display all my grief and sorrow; fears, desperation, longings. He just sits there - calm and composed, with complete understanding. He nods occasionally and seems to say „Yes, I know, I understand“, or - with unshakable confidence - „Everything will turn out well“.

When I can, as it were, have a good cry on his shoulder, afterwards I feel relieved at the very least; often the mood of this old wise man spreads across to me: I become calmer and I can look at myself and my situation from a comfortable distance and with a certain serenity and composure. Sometimes it stops here. But it is also quite well possible to progress from this second form of trance to a third one, which is - at least for me - the most strenuous. Here I now make direct attempts to summon and activate the healing powers within my body.

For this I still sit in the same cross-legged position and it is good if I am internally as empty as possible. Thus my attention is not distracted by anything and I can completely devote it to what is happening within my body. Here my autogenic training experience is of advantage. I recognize the feelings of weight and warmth that can appear in trance and I know that my pulse and breathing can change.

Now I simply pay attention to whether body sensations of this sort take place and, if this is the case, I imagine that these sensations are an expression of the healing processes inside my body, and I try to make as vivid a picture of these processes as possible. For instance, it often happens that I get a heavy feeling in the elbow area, quite a pleasant sensation. Then I imagine that something of „gravity, grave importance, of heavy import“ is happening there. This seems sensible also because there are red marrow and lymph nodules in the elbow area, and these are important places for the production and functioning of the T-lymphocytes, those cells that are infected by the HI-Virus. I then actively associate an occasionally occurring feeling of warmth or tingling to the image of energy and the idea of healing power that streams through the place where I have the sensation. The feeling of warmth and heaviness and the tingling let themselves be directed very easily into any part of the body where energy or „healing power“ is desired. Another frequent sensation is that of the heartbeat or pulse. Here, too, the idea of an energy that is actually felt presents itself once more. And here, too, this energy can be conducted well into those parts of the body where it is desired. In the case of the heartbeat, there is the additional, generally calming effect of the regular rhythm, and for me this is combined with the idea of advancing or progressing further and trusting my own body.

To me, though, what is more important than the accompanying images is the experiential

cing of these body sensations as intensely as possible. I myself have found that the intensity of these sensations and, concurrently, the entire trance diminishes the more attention and energy I require for the accompanying images. Of course, this may be different for other people.

Perhaps why I find both the following sensations the most delightful and the most intense is because, in their case, I have given up imagining anything further. Unfortunately, these are also the rarest of the phenomena described here: One is the vision of light (usually blue) or colour. The other is the feeling of vibration throughout the whole body. In both cases I think something like „That's it“, nothing more, and otherwise completely give myself up to experiencing these phenomena, which can then become even more intense and last surprisingly long. - It's a pity that I cannot describe these processes adequately. Every attempt seems too dry, sounds rather commonplace and does not do justice to the overwhelming feelings I have sometimes. As already mentioned, during this third form of trance I find it relatively difficult to imagine visually (have visual images). This may be a personal failing of mine, perhaps my strength lies more on the kinesthetic side. I think that the particular sensory channel where the strongest impressions are obtained probably does not play an important role. Certainly less developed channels can be rendered more serviceable as far as this can be done easily. But when this becomes an effort, I feel this disturbs the trance. At any rate, for visual images I am usually dependent on ideas from my therapist. And sometimes I can incorporate these in my trances very well and sometimes simply cannot do this at all.

What also makes visualization more difficult is the fact that it is not really known what actually destroys the T-cells. Is it the virus itself or some super-antibody or something else? This naturally makes it correspondingly more difficult to imagine a target for the mobilized defence forces. When I have been completely confused and at a loss, I have sometimes helped myself with a sequence from a film that impressed me very much; in „Witness“ Harrison Ford plays a detective who is shot while escaping. The wound becomes infected, he has a high temperature and becomes delirious, and his life is obviously in peril. He cannot be taken into medical care because then his pursuers could track him down. And the Amish people, with whom he has gone into hiding, lead a very simple life, reject modern medical treatments and use only a few herbs for healing. So there is nothing left to do for the woman who is nursing Harrison Ford than to wait and watch. And so she keeps watch for three days and three nights with such a presence that in the end one believes that Harrison Ford has survived only because she has watched by him. (Of course, in the meantime she has fallen in love with him and he will love her - that may have helped.) So I imagine that I am sitting at my own side and watching over myself with the same intensity, patience and perse-

verance as that woman. And if Harrison Ford got well again like that, why shouldn't I, too? Get well again? Do I think that I can get well again by means of these trance exercises? I should like to close by saying something about what I expect of this trance work and what I feel I have achieved through (gained from)it. Being healthy in the sense of being free from the virus is impossible once an HIV infection has occurred. The virus has integrated itself with the genetic material of the infected cells and is transmitted at every cell division. It is, however, possible to keep healthy (in the sense of being free of symptoms) with the virus for a long period. It is not yet known how many finally become ill. The fact is that 10 years after infection, half of the people suffer from Aids, thirty to forty percent are less seriously ill, the rest are symptom-free. No one knows whether all infected persons become ill after 20 or 30 years have elapsed, but there is an increasing number of those who say that this is to be expected on the basis of mathematical models. What at least is clear is that one can stay healthy for a long time. And my hope is that I shall stay as healthy as possible as long as possible, thanks to these trances.

I also hope that the trances help me with dealing with the fact that I am HIV-positive. The confrontation with this begins right at the very moment when one is told of one's HIV condition and concerns not only illness, dying and death but also the fact that everything seems to be infected: relationships, home-life, work. Specific problems that need to be mastered may crop up all over the place; and I began with the idea that my trance work could also help me with all of this continual confrontation and processing.

Have my expectations been fulfilled? In January 1991 the laboratory test results (T4-Lymphocyte count) had deteriorated so much that AZT medication was recommended. Subjectively, I suffered mainly from a continuous feeling of nausea and I always had some sort of small skin trouble. After commencement of the AZT medication, both symptoms became somewhat better. In March I began with the trances; since then I have been practising for half an hour up to an hour almost every day. Since August 1991 the feeling of nausea has distinctly decreased and is often completely gone. A check-up in the same month showed a slight increase in the T4 count for the first time in a year. (I am no longer acquainted with the later laboratory results, because I do not want to know them any more. Since about November I have had the impression that the skin troubles are improving, though in December I also began with a new treatment for them. Two or three times I have had the feeling I have also managed to nip a cold or a herpes outbreak in the bud.

On the whole, I can say that I now feel better physically than I did about a year ago. Admittedly, an HIV infection typically runs an extremely fluctuating course. And the improvement could also be attributed to the AZT. Despite this, I still tend to attribute it to the trances at least partly. The temporal correlation is really good, and one would expect



an improvement particularly in the first few months in the case of AZT treatment, but then a relatively early recurrence of a general deterioration.

Nothing more can be said about the physical side, but I am satisfied with that. I am also satisfied with regard to my coping with the disease. I think in the course of time I have done well in managing to confront the possibility of illness, dying and death, and, as is so nicely expressed, accepting this possibility - without at the same time having the feeling I am giving myself up. I have less fear and can cope better with this fear. And I do actually have the impression that this only became possible via the trances.

I obviously still have my times of absolute crisis. Panic attacks when some symptoms occur. Anxiety states at night. But also problems that are not (directly) related to this infection, but are specially accentuated on account of my HIV state: tensions with living partners, difficulties at work, unhappy love affairs. Whereas I was almost completely desperate a year ago, I have the impression that I can now bear many things very much better, thanks to the trances.

So, in conclusion, I can say with conviction: the work with trance states helps me considerably in living with the HIV infection.

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## Notes:

- 1 A court decision of 1976 based on the famous case „Tarasoff versus Regents of the University of California“ (not an AIDS case) states that a therapist is responsible for the victim if he did not warn the same of possible harm his patient could cause him - despite his obligation of professional secrecy and discretion.
- 2 Infected hemophilic patients, addicts and women probable make up subgroups. Because of little clinical experience I have excluded these groups on purpose.
- 3 Drug addicts seem to be less affected by this syndrome since they have other coping strategies available.
- 4 All three patients gave permission for the publication of their blood chemistries.
- 5 This patient also gave permission to use his name. Since I was unable to ask him once again as I did, T. Sedlmayer and I decided to anonymize his protocol.

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