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Experiences and Perspectives of Healthcare Professionals With Hypnotherapy for Adult Childhood Sexual Abuse Survivors

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This is to certify that the doctoral dissertation by

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Abstract

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MA, Walden University, 2021

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Dissertation Submitted in Partial Fulfillment

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Abstract

Childhood sexual abuse (CSA) has been defined as one of the most prevalent forms of childhood trauma. Current treatment approaches for adult survivors of CSA often fail to provide timely or sufficient relief, indicating a pressing need for more diverse and innovative therapeutic approaches to achieve optimal recovery. Hypnosis is one treatment method available and has been proven to provide reliable and timely recovery for other complex traumas. The purpose of this study was to gain knowledge on healthcare professionals expressed experiences and treatment of adult CSA survivors, while also exploring their efficacy and usage of clinical hypnotherapy as a treatment approach. Social cognitive theory served as the theoretical foundation for this study. The study was guided by two research questions: the shared experiences of licensed healthcare professionals treating adult survivors of CSA, and the lived experiences and perspectives of licensed healthcare professionals with clinical hypnotherapy in treating adult survivors of CSA. This research study employed a generic qualitative design. One-to-one semi-structured video interviews occurred with a sample of six licensed healthcare professionals. Data analysis employed a five-phase cycle. The findings suggest that many healthcare professionals treating adult CSA survivors lack efficacy on the usage of clinical hypnotherapy. As evidenced by this study, further research and practice are necessary to determine whether clinical hypnotherapy should be more frequently utilized as a treatment approach for adult survivors of CSA. Increased education and exposure to clinical hypnotherapy for healthcare professionals can improve survivors' recovery experience, thereby contributing to positive social change.

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Dedication

My first dedication goes to my son Dreydon, without you I would not have pushed so hard and made it this far. Every time I thought of giving up, I saw your face and knew that giving up was not an option. Everything I have always done in the last 14 years I have done with you in mind. I would also like to make a dedication to my wife LaShena. LaShena, you have been the best support system over the last 7 years, and I thank God for you being here. To my baby boy Knyn, you have been the greatest addition to my life and have provided me with the motivation I needed to complete this stage of my accomplishments. Lastly, but certainty not least I would like to thank my mother Jarrell for believing in me. I hope I have made you all very proud.

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Chapter 1: Introduction to the Study

Introduction

Childhood sexual abuse (CSA) and its effects have been studied, and it is described as the most prevalent form of abuse in childhood. Several adverse relational effects of CSA have been examined, such as promiscuity, trust issues, sexual aversion, sexual tension, and PTSD (Newsom & Myers-Bowman, 2017). Newsom and Myers (2017) defined CSA as physical, sexual contact with an individual under 18, with the perpetrator belonging to any age group. This form of abuse typically consists of forced sexual behavior on a child and sexual activity commonly occurring between a child and someone significantly older than them. Valentine and Pantalone (2013) described CSA as contact or interaction between an adult and child when the child is used for sexual stimulation of an adult, or another person and a sexual act committed by a minor when the person is at least five years older than the victim. According to Newsom and Myers-Bowman, survivors well into adulthood carry adverse effects of CSA. There are situations and behaviors that adult survivors face, and they are not always fully aware of why those behaviors exist or the origin of the behavior. Ginzburg and colleagues utilized attribution theory to explain an event efficiently; individuals needed to explain the event based on the role they played (Newsom & Myers-Bowman, 2017). Newsom and Myers-Bowman stated that if the event was unfavorable, it was much more critical for the individual to paint the picture of events through the roles they played in them. Many survivors of CSA blame themselves for the abuse and feel shame and guilt. Communication with their abuser is often internalized, and survivors become very

overwhelmed. Some CSA survivors develop maladaptive behaviors that have a negative impact on their lives mentally, emotionally, and at times physically. Among those adverse effects, survivors struggle with verbalizing how the abuse made them feel emotionally, and the ability to be openly expressive about emotions remains a challenging task throughout life (Newsom & Myers-Bowman, 2017). Individuals who have been sexually abused in childhood face barriers in building relationships and attachments, as they may have developed a distorted view of the sexual self. This distorted view created by some survivors makes it difficult to develop healthy intimate relationships because sexual acts have been associated with fear, concerns of dominance, and submission rather than mutuality. There are a multitude of studies completed that show sexually abused women are at a heightened risk of sexual difficulties, ranging from hypersexuality to avoiding the act altogether (MacIntosh et al., 2016; McDevitt-Murphy et al., 2017; Newsom & Myers-Bowman, 2017).

There are a variety of treatment options available for treating survivors of CSA. According to Newsom and Myers-Bowman (2017), some people believe that after an extended amount of time, the effects of CSA disappear; however, even when the memory of CSA is repressed, it can affect the person's behavior and relationships. Mc Devitt-Murphy et al. (2017) explained that most trauma survivors require professional assistance and guidance to effectively work through and cope with the memories of the trauma. Traditional therapy techniques are known to be time-consuming, causing survivors to struggle with completing treatment because they do not see results quickly. Survivors often begin self-medicating with illegal and prescription drugs and alcohol because it

provides them with quick relief, though it is temporary, which in some cases leads to addiction (McDevitt-Murphy et al., 2017). One popular treatment tool is prolonged exposure therapy, in which the clinician educates the survivor about trauma and leads the survivor to relive the event emotionally. However, this treatment intervention is time-consuming and can make survivors feel worse than before treatment started (Wilen et al., 2017). Hypnosis is another treatment tool that typically works faster and allows the client to be relaxed or sleep-like during treatment. This approach is also more passive, making the recovery process more mentally and emotionally comfortable for the survivor (Legault & Laurence, 2007).

Background

MacIntosh et al. (2016) stated that CSA is linked to unfavorable mental health conditions. It remains a leading issue in survivors establishing and maintaining healthy relationships and attachments. For the survivors who can form healthy relationships and attachments, they often struggle to retain them. Over the years, clinicians have utilized many treatment options for survivors; however, more effective treatment options should be considered for optimal recovery and coping. Adverse effects from CSA not only affect the survivor's relationship with others but can also affect their relationship with themselves (MacIntosh et al., 2016). Poon (2007) reported that 48-85% of CSA survivors have PTSD over a lifetime and that these survivors experience issues related to how they perceive themselves. Some CSA survivors show a prevalence of distorted body image, unsureness of their sense of self, and the belief that they are damaged or helpless (Poon, 2007).

According to Poon (2009), over the years, hypnosis has effectively assisted survivors of other complex traumas in their recovery process. For the most effective treatment, clinicians proposed that whatever treatment option is used, it should include a strategically staged transtheoretical and multidimensional approach. By utilizing hypnosis, clinicians saw more positive outcomes and reduced trauma-related symptoms (Poon, 2009). Lesmana et al. (2009) completed a study on children who survived a traumatic event and were diagnosed with PTSD. The study consisted of a treatment group (who received hypnotherapy) and a controlled group (no hypnotherapy treatment). The researchers found that the children in the treatment group showed a 77.1% improvement in the negative symptoms they were experiencing due to their complex trauma, as opposed to only a 24% improvement from the control group (Lesmana et al., 2009). Rotaru and Rusu (2016) completed a study that was considered a meta-analysis as it conducted four experiments that studied the efficacy of hypnotherapy for complex trauma survivors with PTSD symptoms. Researchers found that hypnotherapy alleviated long-term and short-term symptoms when comparing the control and experimental groups. Posttest results showed that PTSD symptoms were reduced by more than one standard deviation (Rotaru & Rusu, 2016).

By understanding how clinicians treating adult CSA survivors express the effects of this treatment option, there is a possibility that hypnosis can become more widely utilized for CSA recovery, thus helping more survivors move past the barriers (if barriers are present) that this abuse has placed on their lives. Even though research shows that hypnosis aids in complex trauma recovery, no specific study has examined whether

hypnosis has successfully provided positive outcomes for CSA survivors who receive this form of treatment (Lesmana et al., 2009). Thus, before establishing if clinical hypnosis is a valuable treatment option for adult CSA survivors, the shared experiences, and perspectives of healthcare professionals regarding hypnosis to treat adult CSA survivors must be examined and understood thoroughly. Gaining a thorough understanding of clinicians' experiences and perspectives with hypnosis to treat adult CSA survivors, will provide insight to the scholarly and mental health community. If survivors had a treatment option that provided quicker recovery, they could become happier, more productive, and understand their trauma-related symptoms, if present at all.

Problem Statement

According to Lassri et al. (2017), CSA survivors have sought therapy utilizing multiple approaches over time; however, research shows that they still struggle with issues because of the abuse. There are often issues related to trust and emotional communication that make intimate relationships nearly impossible to sustain for some survivors (Lassri et al., 2017). According to MacIntosh et al. (2016), establishing trust and security has been difficult for CSA survivors. Research suggests that if CSA survivors can enter secure romantic relationships, they report very high levels of dissatisfaction (MacIntosh et al., 2016). Effectively managing conflict, closeness, and sexual function are said to be difficult for CSA survivors even while utilizing multiple therapy approaches (Lassri et al., 2017). There has been a substantial amount of scholarly research from authors such as MacIntosh et al. (2016) and Jong et al. (2015) that have a focal point on understanding why survivors engage in promiscuous behavior and struggle

with maintaining healthy attachments, even with some survivors receiving treatment. Clinical hypnotherapy is underutilized as a therapy approach, as most healthcare providers are not comfortable with this approach to treatment; however, studies show that hypnotherapy has assisted in providing a mentally healthier lifestyle for survivors of complex traumas, which CSA falls under (Sigurdarodottir et al., 2016).

Though CSA is a common traumatic experience, the practice of hypnosis has not been widespread in modern psychotherapy, thus causing there to be an inadequate amount of information on how clinical hypnotherapy supports CSA survivors' recovery process. Previous researchers, such as Sigurdarodottir et al. (2016), have explored utilizing clinical hypnotherapy for other types of issues like PTSD and smoking cessation; however, there is little research on hypnotherapy used with CSA survivors. Since there is minimal research that states healthcare professionals utilize hypnotherapy for CSA survivors, I sought to understand the shared experiences of these therapists regarding working with the survivor. In recent years, studies have validated the effectiveness of utilizing hypnosis as a treatment option for trauma recovery; however, it remains underutilized by clinicians (Sigurdarodottir et al., 2016). The problem is lack of information on how clinical hypnotherapy supports CSA survivors' recovery, thus supporting the need to explore and understand the experiences and perspectives treating adult survivors from the clinician’s point of view.

Purpose of the Study

The purpose of this qualitative study with a generic research design was to discover the experiences and perspectives of healthcare professionals with hypnotherapy

for adult CSA survivors. Hypnosis has already been proven to be a successful treatment method for other traumatic experiences and mental health disorders such as PTSD. This study explored how licensed healthcare professionals describe their experiences and perspectives in treating adult CSA survivors by becoming more knowledgeable on their treatment approaches. This study reviewed data composed of these shared experiences and perspectives to better understand the utilization of different treatment approaches, including hypnotherapy, and why those treatment approaches are utilized to treat adult CSA survivors. This study also examined data derived from the shared experiences of these clinicians on their perception of whether clinical hypnotherapy is a valuable treatment option for successful recovery of CSA or if this treatment option is helpful.

Research Questions

This study answered the following research questions:

RQ: What are the shared experiences of licensed healthcare professionals treating adult survivors of CSA?

Sub RQ: What are the lived experiences and perspectives of licensed healthcare professionals with clinical hypnotherapy to treat adult survivors of CSA?

Framework

Kirsch (2003, as cited by Lynn et al., 2007) defined hypnosis from a social-cognitive theoretical perspective as a situation in which individuals respond to imaginative suggestions rather than a formal hypnotic induction has been used. The different changes in feelings, sensations, actions, and thoughts are perceived to be out of the normal capacity of how a person typically presents, thus implying that something

extraordinary happens during hypnosis (Spiegel, 1998, as cited by Lynn et al., 2007). According to LaMorte (2022), the social cognitive theory (SCT) developed in 1986, beginning as a social learning theory in the 1960s, and was created by Albert Bandura. According to Lynn et al. (2007), in 1986, N. Spanos was one of the first theorists to emphasize social cognitive theories or perspectives to be goal-directed in hypnotic responding. Spanos believed that while under hypnosis, the hypnotic behaviors exhibited were meaningful as they led the individual and clinician to understand the issue better (Lynn et al., 2007). Spanos founded socio-cognitive theory and believed that an individual's attitude, attributions, self-perception, and beliefs were effortless and shaped the hypnotic phenomena. The client's self-perception and understanding of needs will likely continuously change to allow them space to realize attainable goals. According to Lynn et al., responses during hypnosis aid individuals in regulating their behaviors and better understanding their intentions and needs, thus fostering a favorable outcome by utilizing social cognitive theories. The unfavorable effects of CSA have been studied and identified using a multitude of terms. They are associated with multiple mental health deficits, such as depression, anxiety, PTSD, and eating disorders (Newsom & Myers-Bowman, 2017). Though many researchers have studied and found that many therapeutic approaches aid in CSA survivors' recovery, there has also been a high number of studies that show the effects of those commonly utilized approaches being low, thus slowing down the recovery process.

According to Lynn et al. (2007), socio-cognitive theory of hypnosis has a structure that incorporates several aspects, such as placing clients in different states of

trance, understanding the function of how the mind works, and believing that clients can develop their solutions from resources they already present with. The practice of hypnotherapy holds the same beliefs (de Sazer et al., 2012). In comparison, according to Lynn et al., from a social-cognitive theoretical perspective, hypnosis can be defined as a response to imaginative suggestions; rather the word "hypnosis" was used or not. Socio-cognitive theory and hypnotherapy can provide successful treatment options for trauma survivor clients. One approach that falls under social cognitive theories is solution-focused brief therapy (SFBT). Though the likeness of the social cognitive approach SFBT and hypnotherapy appear to be the same, it seems evident they are different in that hypnosis can alter perception and facilitate awareness by bringing awareness to the unconscious. At the same time, SFBT does not stimulate the unconscious but assists the client in moving from problems to solutions (Gingerich & Peterson, 2012). According to Lynn et al., hypnosis activates special abilities, produces a trance, and interferes with a person's sense of agency. Clinical hypnotherapies focus not only on a person's mental capacity or deficits but on the person as a whole; mind, body, and spirit (Lesmana et al., 2009). According to Gingerich and Peterson (2012), clinical hypnotherapy also focuses on all aspects of an individual to guide them into a state of comfort while working toward solutions. While exploring the experiences of licensed healthcare professionals' efficacy and perception of hypnosis, social-cognitive theory of hypnosis (SCTH) should also be explored to operate concurrently with the act of hypnosis to assess for and apply to situations discussed with survivors during sessions. According to Robertson (2021), the use of cognitive behavior theories is far more effective when implementing hypnotherapy

as well. The goal of clinicians that utilize socio-cognitive theory approaches with trauma survivors is to get the individual to behave like a hypnotized person, wherein the behavior is understood by the clinician and the client (Robertson, 2021). According to Seligman and Reichenberg (2014), another goal of using SCT is to help the client build strength and establish self-regulation capacity. Sadler and Woody (2006) completed a study that compared disassociation and SCT wherein similar positions were found; however, SCT rejected the idea of dissociation. Dissociation theory argues that an individual's experiences of hypnosis are effortless but are being blocked from their consciousness. SCT agrees that an individual's experience of hypnosis is effortless; however, the hypnosis is possible due to the participant's willingness and motivation to interpret hypnotic suggestions (Sadler & Woody, 2006). According to Xu and Cardena (2008), cognitive behavioral approaches such as SCTH typically use relaxation techniques as it can be difficult for some survivors of complex traumas to revisit trauma memories. Hypnosis, too, is an approach that can be useful in enhancing relaxation. However, it has several other techniques that relax the participant and connect with the client to discuss trauma without possibly being retraumatized (Xu & Cardena, 2008). Though the researcher plans to learn about the clinician's experiences in treating CSA survivors, connecting with the survivor's expression of knowledge through the therapist's perception is crucial. Socio-cognitive theory does not connect directly to the clinician's experiences; however, it has a solid connection to the survivors the clinicians treat and their trauma-related issues due to CSA, which can assist the clinicians in providing better treatment options.

Socio-cognitive theory (rooted in social cognitive theories) was developed in 1986 by N. Spanos and was said to be a non-state theory. According to Spanos et al. (1980), non-state theories view subjects as willing participants in the treatment process and observe the suggested effects of hypnosis as an enactment rather than a happening. According to Lynn and Sherman (2000), socio-cognitive theory was created to provide insight into how individuals regulate their behavior through reinforcement and control. With the establishment of reinforcement and control, the individual will achieve goal-directed behaviors that can be maintained throughout their lives. Socio-cognitive theories are used to explain hypnotic phenomena in terms of typical social and cognitive psychological processes such as motivation, imagery, and motivation (Lynn & Sherman, 2000). Utilizing attentive exploration and the idea that participants expect to be hypnotized, this suggestibility therapy approach allows the clinician to gain more insight into the client (Lynn & Sherman, 2000).

According to Spanos (1986; as cited by Lynn & Sherman, 2000), social cognitive theorists believe responding to suggestions such as hypnosis is strategic. Spanos also hypothesized that individuals tend to define their conspicuous response to hypnotic suggestion as involuntary when immersed in a pattern of imaginings termed goal-directed fantasy (GDF; Lynn & Sherman, 2000). Lynn and Sherman (2000) defined GDFs as imagined situations that would be expected to lead to the involuntary movements of the motor response caused by the suggestion. According to Jensen et al. (2015), socio-cognitive theory highlights the clients' abilities, attitudes, expectancies, beliefs, attributions, and motivations about the hypnotic context. Since the individual believes

they are not in control of their verbal or physical responses, this approach aids the individual in navigating through their traumatic experiences with little to no adverse effects, such as being retraumatized (Jensen et al., 2015). Clinicians who utilize socio-cognitive theory as a treatment option for traumatized clients believe that the individual's social behavior in their hypnotic state is not altered from their behavior in their conscious state (Jensen et al., 2015). Clinicians who utilize SCT often use cognitive behavioral approaches such as SFBT to get clients to be optimistic by asking questions and encouraging them to think of their goals with positive outcomes in mind (Ratner et al., 2012). In activating these resources, the clinician can assist the client in the progression toward a more positive future. However, this therapeutic approach is still not widely used in 21st-century healthcare (BoVee-Akyurek et al.,2020).

Nature of the Study

For this generic qualitative study, the researcher explored licensed healthcare professionals' experiences regarding the understanding, viewpoint, and utilization of hypnotherapy to treat CSA survivors. Generic qualitative studies focus on people's experiences, perceptions, and perspectives, and how they attribute and interpret meanings to what has been experienced (Merriam, 2009). Merriam (2009) stated that generic qualitative research designs allow the individual to make sense of their experiences and the meanings they attribute to them. This research design is most appropriate because it provides the framework to examine the experiences and perspectives of healthcare professionals that treat or have treated adult CSA survivors, as well as assesses for their use, or lack thereof with hypnotherapy. I used inclusion purposeful sampling and selected

healthcare professionals with experience treating adult CSA survivors. I collected data utilizing video-and-audio recorded, semi-structured, in-depth, one-to-one interviews with licensed healthcare professionals in large urban areas. I developed overarching themes that were not generalizable but provided observations for future studies. Data analysis was conducted via an automated transcription tool available through Zoom online video meeting application. It includes interview responses, notes I took on the verbal and nonverbal responses from participants, and journaling I completed throughout the study.

Definitions of Terms

Attachment bonds: Attachment bond is wordless communication formed by emotional connections between two individuals, typically established in infancy (Schwartz, 2015).

Brainwaves: Brainwaves are the communication between neurons within our brains that are the root of all our emotions, thoughts, and behaviors (Brainworks, n.d.).

Cognitive behavioral therapy (CBT): CBT is a type of psychotherapy that aids people in overcoming mental disorders by modifying dysfunctional behaviors and irrational thoughts (APA, 2021).

CSA (childhood sexual abuse): CSA has been defined as psychical sexual contact with an individual under 18, with the perpetrator belonging to any age group (Newsom & Meyers-Bowman, 2017).

Clinical hypnosis: Clinical hypnotherapy is an approach used by licensed and trained clinicians for treating a psychological or physical problem and involves a set of

skills that facilitate a natural, altered state of consciousness referred to as trance (Rohern, 2022).

Clinical hypnotherapist: A clinical hypnotherapist is a psychotherapist who utilizes hypnosis as a treatment option for patients. Clinical hypnotherapists use hypnosis to unconsciously change the patient's thought process by introducing new thoughts, new responses, and often behavioral changes into the subconscious mind (American Institute of Healthcare Professionals, n.d.).

Distorted view of sexual self: The distorted view of sexual self refers to a view of self by CSA survivors developed due to fear and concerns associated with fear of sexual acts and concerns of dominance and submission rather than mutuality due to trauma (Newsom & Myers-Bowman, 2017).

Electroencephalography (EEG): An EEG is a test that detects and measures the electrical activity in your brain (Butt et al., 2019).

Emotional dysregulation: Emotional dysregulation is a poor ability to manage typical emotional responses (Cotiga & Stulz-Koller, 2021).

False memory: A false memory involves the belief that it is possible to create memories in the brain that never occurred but rather placed by utilizing therapeutic techniques such as hypnotherapy (Legault & Laurence, 2007).

Goal-directed fantasy: Goal-directed fantasied are imagined situations which, if they were to occur, would be expected to lead to the involuntary occurrences of the motor response called for by the suggestion (Lynn & Sherman, 2000).

Healthcare professional: A healthcare professional is an individual who is trained and licensed to provide healthcare services to patients. They encompass a wide range of roles including doctors, nurses, pharmacists, psychotherapist, and social workers (U. S. Bureau of Labor Statistics. Occupational Outlook Handbook).

Interpersonal struggle: An interpersonal struggle is any struggle or conflict that involves two or more individuals (Sullivan et al., 2020).

Non-state theories: Non-state theories view subjects (or persons) as active "doers" and observe the suggested effect as an enactment rather than a happening (Spanos et al., 1980).

Posttraumatic stress disorder (PTSD): PTSD is a mental disorder that appears after an intense experience or witnessing of violence, which results in a variety of symptoms, including depression and the inability of an individual to control their emotions (APA, 2013).

Problem talk: Problem talk involves holding the belief that there are no positive aspects in one's life and only focusing on adverse outcomes that have occurred or believing that only negative outcomes will occur in the future (Coulter, 2014).

Self-efficacy: Self-efficacy refers to an individual's confidence in their ability to exert control over their own motivation, behavior, and social environment (Benight & Bandura, 2004).

Socio-cognitive theory (SCT): Socio-cognitive theory posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior (LaMorte, 2022).

Solution-focused brief therapy (SFBT): SFBT is a solution-focused theoretical approach utilized to aid in the progression toward problem-solving while also utilizing attentive observation skills (BoVee-Akyurek et al., 2020).

Solution talk: Solution talk involves holding the belief that at least one good thing is occurring in one's life at the current moment and focusing only on the positive aspects of said occurrences (Coulter, 2014).

Assumptions

Several different assumptions or presumed factors cannot be proven to be accurate. The first assumption is that adult survivors of CSA have recovered from the abuse if they are living what appears to be happy and successful lives. Another assumption is that clinical hypnotherapy places pseudo-memories in the minds of survivors being treated is one of the most common assumptions in similar studies. Finally, there is the assumption that the only cause of CSA survivors having less than average interest in establishing romantically intimate relationships is previous sexual trauma. Medical conditions and medication side effects should also be considered as a cause for low sexual interest.

Scope and Delimitations

The study was based on shared experiences of licensed healthcare professionals who treat adult CSA survivors. The healthcare professional must hold an unrestricted professional healthcare license (counselor/therapist, social worker, MD, NP, nurses, etc.) to ensure they have a healthy amount of experience in this focal area to provide pertinent data. The age, race, and sexual orientation of the clinician are not important factors in the

study, as I wanted to ensure there are no unconscious biases in participant selection. Aside from the in-depth interviews and journaling I completed, the material utilized in the study was found on Google Scholar and the Walden University Library.

Limitations, Barriers, and Challenges

As a traditional clinician, one challenge for other clinicians will be viewing therapy from a non-traditional approach. A limitation that may be faced is confirmation bias toward the benefits of clinical hypnotherapy. Confirmation bias is when the researcher forms a belief about the study's outcome and utilizes the participant's information to confirm that belief (Sarniak, 2015). I used journaling and member checking to limit this bias by constantly reevaluating expressed notions from the participants and ensuring that any preexisting assumptions are challenged and documented accordingly. I began by journaling the personal thoughts regarding the study outcome, followed by notating common assumptions that are noticed during the interview process. I needed to focus on being mindful of both respondent and researcher biases not to taint the study.

Other challenges may include poor awareness of the participants being overwhelmed or experiencing burnout due to their caseload constantly increasing, thus causing responses not to be reliable. According to Bailey et al. (2021), the demand for mental health services has exceeded the number of available clinicians, causing actively working clinicians to take on an influx of new clients. This influx of clients has not necessarily benefited clinicians or clients as burnout is highly likely to occur, and client's risk not benefiting from services (Bailey et al., 2021). Burnout from higher caseloads

may pose a challenge because clinicians are susceptible to depression and may not have the time or mental capacity to entertain extra activities (Vocisano et al., 2004). I allowed participants to complete interviews based on their availability to combat this challenge. Another challenge could be access to participants. I combated this challenge by utilizing a data saturation grid, reaching out to multiple venues that employ clinicians, and utilizing the snowball effect.

Significance

This study will provide additional personal and professional opportunities for growth for clinicians and CSA survivors. The study will aid survivors by providing an additional useful therapeutic recovery option that has not been widely utilized or show survivors that this option is not favorable for timely and effective recovery. According to Gravitz (1991), hypnosis has been practiced seldom throughout history. However, only recently has it been associated with mental discomfort and diseases. Hypnotherapy has been utilized over the last decade for psychological treatments, thus being a form of recovery therapy that is likely to provide positive social change, as it can aid survivors in increasing emotional stability (Laveture et al., 2002).

Summary

Multiple treatment options for survivors of CSA have been available and continue to be developed over time. Research shows that some modern treatment approaches assist survivors. However, there remains a large population of survivors who have not received treatment that has successfully treated their issues due to CSA. The more modern approaches for treatment have been accepted as modern medical terms**,** and technologies

can physiologically understand them. With that thought in mind, fewer medical approaches, such as hypnosis, have not been widely utilized, even when it may be the ideal approach for treating a client. Clinicians once more utilized hypnosis, but modern medical approaches superseded it over time. This study intended to explore the experiences and beliefs of clinicians (healthcare professionals) who treat adult CSA survivors, while also exploring their efficacy and perception of the use of hypnotherapy as a possible treatment approach. I used data collected to understand better if hypnotherapy appears more favorable or less favorable among clinicians treating adult CSA survivors. By closely examining the experiences expressed by healthcare professionals in treating survivors, the data can show if clinicians believe hypnotherapy should play a more dominant role in coping and recovery for survivors.

Chapter 2 will provide a more thorough representation of the origin and usage of hypnosis. Chapter 2 will also provide a clearer image of the available research and experiences of hypnosis as a treatment option for complex traumas, specifically CSA.

Chapter 2: Literature Review

Introduction

This literature review demonstrates the need for further research exploring the utilization of clinical hypnotherapy for adult survivors of CSA. Furthermore, this review aims to provide insight into if CSA influences how adults form emotional and intimate attachments throughout a life span. CSA survivors have sought therapy utilizing a multitude of approaches. However, research shows they still struggle with issues because of the abuse. There are often issues related to trust and emotional communication that make intimate relationships nearly impossible to sustain for some survivors (Lassri et al., 2017). According to MacIntosh et al. (2016), establishing trust and security has been difficult for CSA survivors. Research suggests that if CSA survivors can enter secure romantic relationships, they report high levels of dissatisfaction (MacIntosh et al., 2016).

Effectively managing conflict, closeness, and sexual function are said to be difficult for CSA survivors even while utilizing multiple therapy approaches (Lassri et al., 2017). There has been a substantial amount of scholarly research from authors such as MacIntosh et al. (2016) and Jong et al. (2015) that have a focal point on understanding why survivors engage in promiscuous behavior and struggle with maintaining healthy attachments, even with some survivors receiving treatment. Clinical hypnotherapy is an approach that is underutilized as a treatment option for CSA survivors, as most healthcare providers are not comfortable with this approach to treatment. Studies show that hypnotherapy has assisted in providing a mentally healthier lifestyle for survivors of childhood abuse and neglect (Sigurdarodottir et al., 2016). There is minimal research that

states hypnotherapy is utilized by healthcare professionals for CSA survivors, thus establishing that there is a need for understanding the experiences of these clinicians regarding treating survivors. The data gathered from the shared experiences will be used to determine if hypnotherapy should or should not be utilized more for CSA survivors in recovery. This literature review aims to gather an understanding of the use of hypnotherapy based on clinicians' experiences over time. This literature review will also allow the researcher to become more knowledgeable on the effects of CSA on individuals across a lifespan, thus establishing the need for more treatment options. For further insight, the study will explore hypnotherapy as perceived by clinicians who treat CSA survivors.

Based on clinicians' expressions of experiences and perceptions treating CSA survivors using hypnotherapy, there will also be insight gained by other clinicians who have poor efficacy or no usage of this approach. Most importantly, this research study will provide insight to clinicians and survivors on whether clinical hypnotherapy should be more commonly utilized to support CSA recovery. There has been extensive research on CSA survivors in academia for several years; however, no specific research studies multiple factors related to CSA, such as attachment, emotions, and intimate relationship attachments. Recently, there has been research that aims to understand what factors, if any, lead to the behaviors of adults who were sexually traumatized as children.

Adults who have now, or in the past, experienced intimate (sexual) interactions often tend to have negative sexual outcomes and satisfaction in monogamist relationships if they are CSA survivors (Vaillancourt-Morel et al., 2016b). Negative relational and

sexual outcomes typically relate to the severity of the abuse based on outside factors such as how often the abuse happened, the relationship with the aggressor, and how intrusive the act perpetrated was (Vaillancourt-Morel et al., 2016a). Survivors of CSA struggle for years after the abuse, often leading into adulthood; however, CSA survivors are not a homogeneous group, and some survivors have no adversity in life after the abuse. No extensive research examines the relationship between CSA and forming healthy emotional attachments outside of intimacy. Attachment systems are a form of emotional, psychological, and social support. One of the goals in treating CSA survivors is to have the survivor explore attachment issues and emotional dysregulation (if present) and guide them in working through it (Nelson et al., 2019).

Literature Search Strategy

There was a plethora of academic research engines that assisted in the completion of this literature review primarily the last three years. A significant amount of literature was accessed through Walden University's online library, although other search engines were utilized. Through the Walden Library, I accessed APA PsycInfo, APA PsycArticles, APA PsychBooks, Education Sources, Health & Psychosocial, LGBTQ+ Source, Primary Search, Social Work Abstracts, SAGE Journals, Academic Search Complete, CINAHL Plus with Full Text, Cochrane Database of Systematic Reviews, Cochrane Methodology register, and ScienceDirect. Google Scholar was also utilized for the literature that was accessed. To ensure the most accurate results for this literature review, the following words and phrases were searched either in conjunction with other phrases or independently: *sexual compulsive behavior, attachment, emotions, hypo sexuality,*

hypersexuality, recall or memory, retention, and CSA, childhood sexual abuse, sexual abuse as a child, childhood trauma, childhood sexual trauma, CSA survivors, sexual trauma in adults, clinical hypnotherapy, hypnotherapy, hypnotherapists, holistic therapy approaches, social cognitive theories, hypnotherapy theories of cognitive development, healthcare professionals and CSA, healthcare professionals and hypnotherapy, licensed clinicians, licensed healthcare professionals and treatment for CSA, social cognitive theories of hypnosis, and *socio-cognitive theory.* After the completion of my search, there was an innumerable amount of research that has investigated the struggles adults face because of CSA; however, there was an inadequate amount of scholarly literature that examined the utilization of clinical hypnotherapy being a utilized treatment options for CSA survivors. As a result, we do not have substantial information on how clinical hypnotherapy supports CSA survivors' recovery. Previous researchers have explored utilizing clinical hypnotherapy for other types of issues like PTSD and smoking cessation; however, there is little research on hypnotherapy being used with CSA survivors and how clinicians perceive their experiences in utilizing this approach for recovery treatment.

Theoretical Foundation

SCT: An Overview

The SCT served as the theoretical foundation for the present research. As outlined in Chapter 1, the SCT was founded by Albert Bandura in the 1960s; however, the SCT of hypnosis was coined in the late 1980s by N. Spanos (Spanos et al., 1980). According to Lynn and O'Hagen (2009), socio-cognitive theory states that cues from an individual's

social environment in the present moment cause the person's cognition to carry out the behaviors they show while under hypnosis purposefully. According to Coulter (2014), berg and colleagues noticed that clients only attended one session of traditional talk therapy before giving up on finding substantial treatment options. Socio-cognitive theory holds the understanding that there are individual differences in responding to suggestions (Lynn & O'Hagen, 2009). According to Lynn and O'Hagen, this approach benefits clinicians who utilize it as it allows the space for understanding that individuals may respond differently based on suggestibility. SCT view individuals as having a very active role in the treatment process due to their known or unknown motivational tendencies to resolve problems.

According to LaMorte (2022), SCT aims to explain how people regulate their behaviors through reinforcement to achieve goal-directed behaviors that can be maintained over time. Self-efficacy is an essential construct of social cognitive therapy as it refers to a person's confidence to achieve a goal or successfully perform a behavior (LaMorte, 2022).

SCT: Research Examples

According to Benight and Bandura (2004), individuals who attempt to incorporate their experiences of trauma into existing beliefs about the world, others, or themselves are harmful to the therapeutic process. Trying to make the connection between trauma and current thoughts about oneself will cause the individual to establish unhelpful and confusing understandings of their experiences and perceptions of self-control (Benight & Bandura, 2004). For instance, if someone believes that only unattractive women are

raped, being raped confirms that one is unattractive, not that an unjust violation occurred to them. Clinicians who utilize cognitive theories encourage patients to reevaluate and shift their thinking patterns so that they can identify patterns of unhelpful thoughts. Getting the client to have a more positive mindset helps in their recovery journey as they begin to see experiences in a different light (Benight & Bandura, 2004).

Bannink (2008) stated the following questions to get the client to move from a victim position to that of a survivor:

- What helped in the past, even if only marginally?
- How do I succeed in getting from one moment to the next?
- Could it be worse than it is? Why is it not worse?

As these questions are thoroughly assessed and answered by the client, the idea is that they now can see that there is hope for recovery and a life of substance. The questions then become more focused on what the client can do in the present moment that will continue them on the road to recalling experiences and recovering effectively from the results of those experiences (Coulter, 2014). Bannink then posed the following questions to the client:

- What will be the first sign that trauma has less impact on your life?
- How much of your time is trauma in control of your life? How much time are you in control? What are you doing differently at these times?
- What will (close supportive family member) see that will tell them you are continuing to progress towards a more satisfying life?

- Imagine that in 10 or 15 years, when things are improving, you look back on today; what will have helped you improve things?

The socio-cognitive theory is a strength-based psychotherapy approach that focuses on people's beliefs in their efficacy to control their functioning and to exercise that control over events that affect their lives (Benight & Bandura, 2004). Benight and Bandura (2004) stated that self-efficacy regulates human functioning through cognitive, motivational, affective, and decisional processes. Clinicians that utilize socio-cognitive therapy aim to minimize the impact trauma has caused the survivor by helping the survivor increase or build a better sense of self-efficacy. Coping self-efficacy is essential in the therapeutic process as it plays a crucial role in stress reactions and the quality of dealing with threatening situations such as CSA (Benight & Bandura, 2004). Clinical hypnotherapy and socio-cognitive theory can be utilized in conjunction with one another to treat complex trauma survivors, in that the survivor is motivated to work through traumatic experiences rather conscious or unconscious. Persons attend hypnotherapy sessions to work through events and experiences that cause discomfort, showing their motivation to establish a better sense of self-efficacy (Benight & Bandura, 2004). Clinicians who utilize SCT approaches focus on the client's understanding and establishing self-efficacy to the point of seeing that negative experiences they lived through are not a result of who they are but rather an unnecessary or unwarranted act (Benight & Bandura, 2004). Yapko (1998) believed that clients reach individuation when they have developed stability in their awareness of thoughts, acceptance, and representation of themselves—socio-cognitive theory and an individual's self-efficacy

development support this belief. Socio-cognitive theory, when combined with solution-focused hypnotherapy, can be beneficial to the client because after discussing an understanding of how self-efficacy, attitudes about hypnosis, and expectancies of the individual aid in the healing process, the treatment session will be followed by encouraging a hypnotic level of trance. This relaxed trance state then allows the client's brain to explore the understanding, motivation, and ideas discussed during the first half of the session, leading to favorable benefits in the recovery process (Solution-Focused Hypnotherapy, n.d.)

According to Sadler and Woody (2006), socio-cognitive theory does not require cognitive functioning as people act and respond based on how they believe they should while under hypnosis. If one thinks one must answer all questions truthfully for positive results while under hypnosis, this individual will unconsciously respond. According to this theoretical approach, the client becomes their problem-solver, which provides more willingness and understanding of change, self-perception, and self-control, making this approach appropriate for the study (Lynn et al., 2007). Cognitive behavioral theories, such as the socio-cognitive theory of hypnosis, utilize dialogue that has a purpose while providing a realistic perspective of life reflections. According to Gonzalez (2017), significant evidence shows that CSA links to mental health issues in adulthood. Children and adolescents who have experienced CSA have been said to present with trauma-related symptoms that usually lead to PTSD (Gonzales, 2017). Clinicians who utilize this therapeutic approach agree that clients already have the solution to their issue; however, they need assistance in coming to that realization.

According to Lynn et al. (2007), in utilizing socio-cognitive theory as the basis for hypnotherapy treatment, the clinicians' task is to help the client establish a strong perceived and coping self-efficacy so that their responses under hypnosis will require no effort and allow them to separate themselves from the traumatic experiences being explored. By using this approach, the clinician believes the problem could be resolved. The cause of the problem is presumed to be concealed in the individual's psyche and typically is related to some form of childhood trauma (Visser, 2013). Sexual childhood trauma has always been one of the most prevalent types of trauma that often require extensive therapeutic treatment, as it is often repressed in the memory of survivors. Psychotherapists found that the clinician must access the unconscious mind to get the most helpful information to help clients heal from trauma, as it allows for the most transparency. These psychotherapists utilized techniques that tapped into parts of the unconscious, however, not disturbing the client further (Visser, 2013).

SCT: Application to Study

Hypnosis has been identified over the centuries as useful in treating individuals naturally and holistically. Clinicians have utilized hypnosis to aid clients in healing from traumatic life experiences. For centuries hypnotic treatments have been around, specifically from the ancient Hindus who were said to have included aspects of magic, an English surgeon (James Braid) who invented the word hypnosis and found a way to connect it to medicine, and a philosophy of change that identified our actions lead toward change was then discovered by Zen Buddhism (BoVee-Akyurek et al., 2020). The goal of Zen was described by Haley (1993) as "to be enlightened and for the 'student' to have

inner wisdom and specific attributes that allowed them to be present at the moment, while also being open to enlightenment." Zen was identified as experimental learning in which the direction and facilitation of the therapist stimulated the client's (or student's) behavior. Hypnotherapy aims to arouse the client's perceptual and physiological processes while enabling their behaviors (BoVee-Akyurek et al., 2020).

Often, CSA survivors repress the memories of the abuse, which causes a multitude of inconsistencies and causatum in their lives over a life span. While clinicians have widely utilized clinical hypnotherapy to work through PTSD symptoms with clients who have survived a plethora of traumatic incidents, there is not much literature that provides insight into this therapeutic approach not only being used for CSA survivors but also finding that it is an effective treatment approach. To better assist CSA survivors in more appropriate and valuable treatment approaches for recovery, this study aims to determine if the use of clinical hypnotherapy is an effective treatment option for CSA survivors and if it should be used more widely by clinicians as a recovery option based on shared experiences of participants in the study.

Literature Review Related to Key Concepts

Childhood Sexual Abuse (CSA)

Clinical hypnotherapists are certified in performing hypnosis techniques on their patients by placing them in a trance, also called deep relaxation. While in this trance, the hypnotherapist attempts to provide the patient peace and tranquility by accessing their subconscious and assisting them in working through different traumas, bad habits, and fears (Role of the Certified Clinical Hypnotherapist, n.d.). To become a clinical

hypnotherapist, you must first already hold, at minimum, a master's degree and be licensed in medical, mental health, or another healthcare professional. The certification process requires the clinician to complete training workshops, at least two years (sometimes five years) of practical experience in their practice, and supervision hours by an already certified hypnotherapist (Role of the Certified Clinical Hypnotherapist, n.d.). These clinicians utilize non-medicated approaches, which makes it more favorable for patients who follow a more holistic lifestyle or who have not found traditional therapeutic approaches to provide relief.

CSA has been identified as the most prevalent form of childhood abuse and adversity, according to Gonzalez (2017). CSA has also been identified as having low percentages of survivors reporting the abuse due to the perpetrator usually being a close member of the family system. According to Gonzalez, there is a normal process of psychological adjustment for survivors after the occurrence of CSA; however, for some individuals, there are effects that remain due to the emotional turmoil the abuse inflicts. Studies have identified CSA as a traumatic event that causes a high percentage of youth to develop mental health disorders such as anxiety, eating disorders, substance abuse disorders, and personality disorders. These children and adolescents are often diagnosed with PTSD and, as a result, struggle in many areas of life over their lifespan, leading to and continuing into adulthood (Gonzales, 2017).

According to Rosmalen et al. (2016), John Bowlby found that adults who now have problematic behaviors and struggles with secure dependency had lived through experiences of emotional or physical deprivation, separation or were placed in neglectful

situations in childhood. Researchers also found that adults face limitations while trying to establish healthy attachment bonds if there were traumatic experiences in the past (Schwartz, 2015).

The attachments we form as children accompany us throughout our lifespan and can considerably affect how we create attachments in adulthood. To understand how we respond to forming attachments and develop in adulthood, we must consider childhood experiences and better understand how those experiences may have shaped our thought processes (Rosmalen et al., 2016). It is important to note that even during traumatic experiences, we do not have a conscious recalculation of the affect attachments we form and our behaviors throughout life. Often, adults exhibit behaviors and are unsure where they stem from; however, some adults are aware of traumatic experiences but struggle to make connections. Theorist William Blatz believed that reasonable adjustment in childhood is likely the best predictor for happiness in adulthood (Rosmalen et al., 2016). Blatz believed that children needed to feel they could rely on their caregiver to grow up mentally healthy and that children who experienced trauma likely had mental deficits later in life. In many cases, when CSA survivors can establish intimate relationships, they have difficulties with closeness, lower levels of communication, poor conflict management, higher levels of domestic violence, and more frequent infidelity than non-survivors (Macintosh et al., 2016).

A child can prevent emotional dysregulation if they are able to establish at least one secure emotional attachment. Emotional dysregulation is a poor ability to manage typical emotional responses (Cotiga & Stulz-Koller, 2021). Sullivan et al. (2020)

completed a study on CSA survivors that examined the relationship between attachment style, therapeutic bond, distress, and interpersonal struggles. Sullivan et al. (2020) assert that adults who were sexually traumatized as children have behaviors that contribute to a multitude of problems later in life. CSA survivors suffer from social, emotional, cognitive, behavioral, and biological issues over a life span, making it difficult to establish healthy attachments and work through the trauma brought about by the abuse. Most survivors enter adulthood with repressed memories of being sexually abused and are not consciously aware of how the abuse continues to affect their lives in the present time. Other adverse long-term consequences may be that the client struggles with relationships, emotional and sexual victimization, thoughts of self-harm, and inappropriate emotional responses (Sullivan et al., 2020).

In the absence of a warm and loving environment, children who receive poor parenting pass through the stage of early adolescence with subpar social skills (Miner et al., 2010). According to Miner et al. (2010), these children become unable to separate sexuality and aggression and struggle with having negative attitudes toward authoritative figures. Sexual aggression becomes a means of providing higher self-esteem to the aggressor (usually men). Sexually aggressive individuals have claimed that they believe their behavior stems from interactions in their childhood with parents and close relatives or friends of the family. On the opposite side of the spectrum, others describe their poor childhood experiences as a reason they are easy targets of sexual aggression from perpetrators (Miner et al., 2010).

Children and adults who have committed sexual crimes have been shown to have high rates of being sexually and physically abused compared to children and adults who have not been sexually abused (Grady et al., 2018). Experiencing a traumatic event (sexual, emotional, or physical) while still in the early stages of brain development leads to challenges in relationship development and emotions. According to Grady et al. (2018), a significant number of researchers have found a link between childhood trauma and offending behaviors. Neurological imbalances could cause childhood trauma survivors difficulties many years after the traumatic event and for a lifetime in some individuals. CSA survivors often present with sexual dysfunctions, which creates barriers to establishing healthy emotional and sexual relationships. Sexual dysfunctions include but are not limited to, erectile disorder, female organism disorder, female sexual interest/arousal disorder, and hypoactive sexual desire disorder (Gewirtz-Meydan & Ofir-Lavee, 2021). Pulverman et al. (2018, as cited by Gewirtz-Meydan & Ofir-Lavee, 2021) report that 25-59% of women who are not CSA survivors report having sexual dysfunction; however, it is 63-94% of women who self-disclosed they are CSA survivors. It is also reported that men who are CSA survivors are far more likely to present with sexual dysfunction than those who did not have this experience.

CSA survivors often struggle with establishing clear sexual boundaries. As previously stated, adults often form their response to intimate relationships based on childhood attachment systems. Adults who were sexually traumatized as children often struggle with sexual dissatisfaction, sexual withdrawal, and hypersexual behaviors due to insecure attachments in childhood (Gewirtz-Meydan & Ofir-Lavee; Miner et al., 2010).

CSA survivors may also struggle with interpersonal relationships that cause them to develop insecure attachments. According to Grady et al. (2018), attachment disorders are often overlooked or ignored in adults, as most adults who have experienced attachment disorder behaviors believe it is a normal response. Common signs of attachment disorder include lack of affection, poor impulse control, self-destructive behavior, and intentionally hurting others.

Theorist John Bowlby describes three different attachment styles and their related experiences. According to Grady et al. (2018), the anxious-ambivalent/resistant attachment style shows in children whose caregivers provide inconsistent care and are often unpredictable, causing the child to feel emotional and physical abandonment. Attachment avoidance is often present in adulthood if no healthy attachments are formed in early childhood. Attachment avoidance reflects how maintaining behavioral and emotional distance is a way of protecting oneself. Adults who present with attachment anxiety have the opposite thought process, as they fear their significant other not being emotionally available and abandoning them. When considering adult survivors of CSA, their experiences with intimate relationships are based on one of these attachment bond types. Survivors perceive anxious and avoidant behaviors as a way of protecting themselves; however, it ultimately destroys the relationship due to stressors placed on their partners (Gewirt-Meydan & Ofir-Lavee, 2021).

This same notion applies to relationships that are not intimate. While attempting to build healthy relationships with friends and family, CSA survivors still struggle with these relationships due to thoughts of being mistreated or abandoned. Negative responses

and understanding of accepting and maintaining these relationships often become self-defeating, specifically during early childhood trauma. According to Gewirt-Meydan and Ofir-Lavee (2021), attachment trauma is common in CSA survivors as they have had a disruption in healthy attachment formation with a caregiver. Emotional detachment begins when a healthy bond is not created and maintained and makes securing healthy relationships as adults difficult. It is common for CSA survivors to have either avoidant or anxious attachments or both forms of attachment styles (Gewirt-Meydan & Ofir-Lavee, 2021). Anxious attachment often manifests intense desires for intimacy and displaced aggression.

In contrast, avoidant attachment manifests disengagement from the relationship, resulting in a failed attempt to contain a healthy attachment (Ainsworth et al., 1978, as cited in Sullivan et al., 2020). The severity of the trauma is often dependent on how the trauma will affect the individual over a life span. Understanding the lived experience of trauma survivors, when and how long the trauma occurred, and the type of trauma is vital to be cognizant of.

CSA survivors often establish poor attachments in relationships they deem essential; however, when the connection is compromised due to the survivor's incapacity to understand their interpersonal problems, it causes even more distrust and anxious behaviors (Sullivan et al., 2020). CSA survivors limit their emotional support in a relationship before the other person can prove they are emotionally available. This behavior is due to emotional distress and perceived insecure attachments by the survivor. Sullivan et al. (2020) completed a study that examined the role of CSA survivors'

attachment style, therapeutic bond, distress, and interpersonal problems. Sullivan et al. investigated whether attachment style and therapeutic bond mediated the association between the type of early treatment received due to emotional distress and treatment received later for interpersonal problems. Two groups were examined, CSA survivors and adults who did not experience CSA. Using components of attachment theory, researchers found that CSA survivors showed an association between emotional relationship bonding and interpersonal problems. Researchers also discovered that CSA survivors fail to acknowledge their role in unhealthy attachments throughout their life span because they are unaware of the issue (Sullivan et al., 2020). Attachment concepts learned in childhood are reconstructed in adult romantic relationships (Hazan & Shaver, 1978, as cited in Miner et al., 2010). How survivors internalize their trauma and the level to which clinicians have attempted to help them recover varies. The researcher hopes that by examining the experiences and perspectives of clinicians who treat CSA survivors, the data will show what interventions they believe work best for optimal recovery.

Clinical Hypnosis

Hypnosis was slowly accepted in medicine. The Catholic Church became the first group that indicated acceptance in 1847. Following the Catholic Church's acceptance, many other religions began studying the effects of hypnosis and utilizing it in their religious practices. Hypnosis was often used in childbirth during this period. According to Holdevici (2019), in the simplest terms, hypnosis can be described as representing a state of consciousness that has been modified and produced by repeated stimuli. Hypnosis has also been defined as a state of mind that has been induced unnaturally and

is a state characterized by increased suggestibility (Holdevici, 2019). Hammond (1998) described hypnosis as "a procedure during which changes are suggested in sensations, perceptions, thoughts, feelings, or behavior." Hypnosis involves intently focusing on one thing while ignoring the distraction of outside stimuli. Over the last 200 years, researchers have struggled in attempting to determine if the nature of hypnosis is a social psychology-related phenomenon or if it is simply a heightened state of consciousness based on advanced body/mind or neuropsychological talents. There are a multitude of studies that suggest and support both theories, including how their effects should be measured. Over the last few decades, it has been determined that the most clinically significant aspect of hypnosis is understanding that the patient holds all the power as opposed to the clinician (Wickramasekera II, 2015).

Clinicians who utilize hypnosis expect to lead the patient to recognize and use their unconscious potential, which is a 360 approach to typical therapeutic techniques. Most standard therapeutic techniques use a method where the clinician guides the session and essentially utilizes an authoritarian therapeutic approach. In comparison to modern therapeutic techniques, which hold the belief that anything can be accomplished voluntarily and consciously, the technique of clinical hypnosis has the notion that, at times, voluntary efforts to work through trauma can taint the healing process drastically (Wickramasekera II, 2015). Haskins (2001) defined hypnosis as a relaxing state that allows the subconscious to remain active and receptive to ideas and suggestions. However, it is typically considered a "sleep" state of mind. The subconscious and conscious mind share the same beliefs in a hypnotic state. In the most profound state of

hypnosis, a patient can utilize more selective thinking and have a less critical judgment of the issues being addressed (Haskins, 2001).

There are three styles of clinical hypnosis, each involving different techniques and levels of trance: directive trance, Ericksonian trance, and permissive trance. In a directive trance, the clinician gives commands to the patient to send them into an altered state of consciousness. This trance method is straightforward in working with the client. A clinician who utilizes this level of trance would likely say something like, “You will not keep eating when you’re full” or “You will not smoke.” With directive trances, the clinician can suppress the clients’ current issues or symptoms of past traumas by giving direct orders. This hypnotic trance is often utilized in comprehensive therapies as it considers the underlying problem (Churchill, 2015). A few other reasons a clinician would utilize directive trance would be to develop ideomotor responses from the client and to address a variant of motivators. The motivators could consist of; lifestyle issues, choosing better eating habits, challenges in everyday life, building confidence, developing a good attention span, clear focus while working, healthy relationships, accepting yourself, creating and accepting healthy energy, and appreciating yourself and those who contribute to your life (Churchill, 2015). The goal is to tap into a client’s highest potential to achieve the fulfillment of the purpose or objective that has been established.

These objectives are considered direct suggestions that run counter to the Ericksonian level of trance in that it believes that the hypnosis process involves a person's latent availability. This level of hypnotic trance involves more possibilities of change

than telling the client what will happen while they are in a trance. The Ericksonian trance allows the client to play a very active role in the work they complete with the clinician (Holdevici, 2019). This approach is very indirect and accommodating, allowing the client to accept suggestions at their own pace and with their level of understanding. For example, an Ericksonian hypnotist might say, “If and when you are comfortable doing so, tell me about your childhood.” In classical hypnosis, the clinician would likely say, “Now, you are going to tell me about your childhood.” If a client is resistant to authoritative or straightforward approaches, this approach would be most successful. The third type of hypnotic trance is permissive trance, in which the clinician makes suggestions; however, they are worded in a way that emphasizes the client's thought processes (Hodevici, 2019). Essentially, permissive trance is a more cultivated approach than ordinary authoritarian hypnosis. This level of trance provides the client with the perception of choices making the process a bit slower than classic approaches.

Cognitive hypnotherapy is another commonly utilized treatment approach for treating CSA. Cognitive hypnotherapy is a branch of cognitive therapy widely known as cognitive behavioral therapy (CBT). Fine (2012) defined cognitive behavioral issues as unwanted negative behaviors that affect everyday life in an undesirable manner. Considering the basic principles of CBT, the addition of hypnosis changes it to cognitive behavioral hypnotherapy and adds the focus on the way someone acts and thinks in certain situations. Cognitive behavioral hypnotherapy also focuses on how behavioral and emotional problems can be resolved in an unconscious state (Fine, 2012). According to

Robertson (2020), two theorists were responsible for developing the hypnotic addition to CBT: Theodore Sarbin and Theodore X. Barber.

Three main stages compose the process of hypnotherapy. Light trance is considered the first stage of hypnotherapy, during which the patient feels a heightened state of relaxation. In contrast, they become lethetic and feel "heavy" as their breathing becomes significantly slower. During this stage, the clients become more aware of their altered state of consciousness. The Cataleptic state (or medium trance) is considered the next stage. In this trance stage, the patient can accept complex suggestions from the therapist. The patient experiences a certain degree of time distortion characterized by a loss of consciousness as the patient loses track of time. At times during this trance stage, the patient has complete body catalepsy. The patient's body is taken over and utilized as a medium to act and speak (Goldberg, 2005).

The last stage of hypnotherapy is a somnambulistic trance, in which the patient will have no memory of what is done during the session unless the clinician asks them to do so. The client can be responsive to posthypnotic suggestions and even open their eyes while not affecting their trance stage. A deep or somnambulistic trance can be compared to sleepwalking or a comatose state, as a loss of awareness of the present moment is at the forefront. Deep trance can lead to hypermnesia, which involves the patient remembering things they were unaware they would remember. Deep trance is the last state reached during a hypnotic trance wherein the conscious mind is quietened. It has been noted that the client may remember everything they hear while in this unconscious

state of mind. Less than 10% of the population is estimated to reach this stage of trance (Goldberg, 2005).

Understanding the principles of hypnotherapy allows you to have an even more in-depth understanding of the therapeutic approach. According to Goldberg (2005), electrical charges in the brain are classified into four different activity levels to understand the principles better. These electrical charges are called brain waves. Brainwaves inform us about how our emotions, thoughts, and feelings communicate with the neurons in our brains (Brainworks, 2019). According to Brainworks (2019), these waves have best been described as continuous levels of consciousness, ranging from slow, loud, and functional to fast, subtle, and complex.

The first level is called *beta,* in which the client is aware of all aspects. The client has full consciousness and is involved in deep concentration. *Beta* brainwaves are divided into three bands: *beta*1, *beta*2, and *beta*3. *Beta* is present when one is most alert or focused on making an important decision. The second level, called *alpha,* is associated with the subconscious mind. *Alpha* allows the brain to enter a resting state and aids in learning, calmness, and overall mental coordination. This brainwave is usually present during light meditation and prayers (Brainworks, 2019.). *Theta*, the third level, is a part of the unconscious mind and requires the client to sleep lightly. This level typically occurs in a deep meditation-like state of mind. The waves are produced while the client is relaxed but still very alert, best described as thoughts we experience while falling asleep. One can experience nightmares in *theta* waves as it's where we keep things we attempt to withdraw from. The last level is *delta*, wherein the electrical brain waves require the

client to sleep deeply. According to Brainworks (2019), *delta* brain waves have a low frequency; however, they are still deeply penetrating, causing the suspension of external awareness ultimately. While in this level of consciousness, the most healing aspect of an individual is stimulated.

Brainwaves have a drastic impact on learning because the frequency at which the brain is in when trying to absorb new information is a significant determinant of if the new information will be retried, retained, or even understood. Larson (2019) described another brainwave, *gamma*, the fastest brainwave produced. Gamma brainwaves are present when you are alert and actively focused on retaining new information, such as processing the information, learning, and based on the situation, problem-solving while learning and processing. Though brainwaves are not able to be visually seen, they do have the ability to be studied through a test called EEG. EEG measures the activity in your brain at any given time (Larson, 2019).

In treating CSA survivors, understanding their brainwave frequency can aid in determining the severity of traumatization and deciding what level of trance is best for the survivor (Alper et al., 2013). Alper et al. (2013) completed a study that studied the EEG activity of a group of CSA survivors who also utilized crack cocaine and a group of individuals who used crack cocaine but did not experience CSA trauma. The results found that those with a history of CSA showed greater EEG power in the *theta* band; however, there were no significant differences in the *delta*, *beta*, *alpha*, or *gamma* frequency powers (Alper et al., 2013). Another study found that trauma survivors with PTSD showed a large amount of right parietal asymmetry in alpha band power based on

EEG results noting it as the most significant indication of PTSD symptoms. These symptoms were linked to overemphasized physiological stimulation that impairs environmental distractors (Butt et al., 2019). The findings showed that EEG measurements of brainwave activity in trauma survivors could determine if the trauma (or aftereffects of trauma such as PTSD) contributes to everyday issues such as concentrating, learning, and being aware of threatening distractors.

CSA and Clinical Hypnotherapist

Legault and Laurence (2007) completed a study with clinicians to understand their beliefs, thoughts, and techniques associated with the memory recovery of CSA survivors. The researchers were also interested in the number of CSA cases they came across as they believed the more cases of CSA present, the more the beliefs about memory recovery differed. CSA survivors who could recall the experiences of abuse were minimal, as therapists reported that only 4.3 % of survivors could recover their memory (Legault & Laurence, 2007). Some clinicians questioned the validity of recovered memories, believing that memories recovered during a therapeutic session were not always obtained in the most ethical way possible. Determining if the patient recalled repressed memories or if there was an induction of false memories remained very controversial for many clinicians. It was believed that practices such as hypnosis planted false memories of events in the patient's memory based on laboratory studies, and the researchers shared this belief (Legault & Laurence, 2007).

There remains an ongoing debate between different clinicians as to the issues of memory recall. Psychotherapists who typically utilized hypnosis had more concerns for

the number of patients they could get to recall traumatic experiences, as opposed to focusing on believing that the stability of these recovered memories was necessary for the healing process. Other clinicians, such as social workers, believed that practices like hypnosis provided too much suggestibility to the patient leaving too much room for error and false memory induction. There was also a sententious number of clinicians who believed that no matter the time frame of a traumatic event, a memory can be recovered in some section of the brain (Legault & Laurence, 2007). A substantial amount of psychotherapists remained practicing hypnosis and related techniques such as guided imagery. Psychotherapists that used this technique believed memories are not significantly affected by outside factors, such as things that have occurred years after the CSA and personal fantasies held by the patient. This belief has caused clinicians to become impudent in memory recovery.

Clinical hypnotherapists' education includes that it is impossible to create memories that never existed or for those memories to be distorted to the extent of false memory induction. Yapko (1994) completed a survey of therapists to gain insight into their views of memory recovery and found that over 50% of therapists believe that utilizing hypnosis allowed clients to recall CSA events and any traumatic event as far back as birth. Though there has not been any reliable research that supports memory permanence, some clinicians still support the notion that there is an imprint in our memory of every event we have encountered over a lifetime and that those events can be recovered utilizing hypnosis (Legault & Laurence, 2007). A separate study by Poole et al. (1995) found that 71% of clinicians used at least one memory recovery technique,

including hypnosis, and there was a significant correlation between the utilization of memory recovery techniques and success in memory recovery. Several studies followed this, one of which showed that at least 70% of clinicians reported being able to aid clients in memory recovery utilizing hypnosis or closely related techniques (Poole et al., 1995).

Some trauma researchers believe abuse-focused therapy should only address memories clients have a recollection of before beginning treatment. Other clinicians believe that memories of CSA should only be recovered if psychological distress is present in the current timespan (Fredrickson, 1992, as cited by Polusny & Follette, 1996). The question remains that without memory recovery techniques, is it possible for clients to be in psychological distress and not realize that it is due to repressed CSA memories? Some psychologists believe that when concealed memory techniques such as hypnotherapy are utilized, it indirectly causes clients to develop pseudo memories of CSA. Clinicians that believe their clients present with above-average memory repression can subconsciously suggest the belief that CSA has occurred (Lofus et al., 1994; as cited by Polusny & Follette, 1996). In simpler terms, it would be easy for a client who believes that memory repression is highly prevalent also to believe that even though they do not recall the abuse, it may have happened.

According to Polusnay and Follette (1996), some critics believe that some psychotherapeutic communities have adopted the belief that adults can exhibit symptoms that indicate CSA. The development of a symptom checklist has aided in the process of diagnosing and assessing for possible warning signs of repressed memories. Wakefield and Underwager (1992 as cited by Polusny & Follette, 1996) conducted a study that

surveyed parents who were accused of sexually abusing their children and found that in cases of adult CSA survivors remembering the abuse, there were usually young female therapists that assisted in the remembrance of events. The "repressed memory movement" (researchers once coined that) became viewed as an explicitly feminist agenda and psychoanalytic concept of repression (Polusny & Follette, 1996).

Researchers conducted a study that examined if theoretical orientation and gender played any role in clinicians' beliefs and practices related to CSA. It was found that there were no significant differences in memory recovery techniques, the number of clients who remembered CSA occurring, and how important recognizing the abuse was to the clinician (Poole et al., 1995, as cited by Polusny & Follette, 1996). Feldman-Summers and Pope (1994) completed a study showing that 40% of respondents did not remember abuse occurring when asked about CSA. Researchers of the study found that clinicians who have a history of CSA had a high prevalence of symptoms that were trauma related; however, this did not affect the clinician's ability or willingness to provide services to other CSA survivors they took on as clients.

The study conducted by Polusny and Follette (1996) surveyed clinicians who practiced repressed memory techniques such as hypnotherapy and found most participants could continuously recall CSA incidents. Another percentage of the participants reported they somewhat recalled incidents. Only 3 % of women and 5 % of men reported no recall of CSA before entering therapy and participating in hypnotherapy or a related technique (Polusny & Follette, 1996). The clinicians who participated in this study also reported that they all encountered clients who endured some form of CSA;

however, most of the clients expressed they could recall incidents that occurred, taking the need for repressed memory interventions out of the treatment plan. The few clinicians in the study with CSA survivors who could not recall incidents before therapy reported using clinical hypnotherapy as useful in recovering memories (Polusny and Follette, 1996).

Summary and Conclusions

CSA has been recognized as having a substantial role in adults developing long-term social, emotional, and psychiatric problems. As a result, CSA survivors have psychotherapeutic needs more significant than most traditional therapeutic interventions can aid (Elkjaer et al., 2013). Unfortunately, children face such disadvantages and hardship during critical developmental years especially considering the continued limitations it causes over a lifetime. Adult survivors of CSA face daily struggles in their day-to-day life due to unresolved traumas from childhood. These adults have a much higher risk of developing unhealthy behaviors because of the abuse. The abuse affects survivors, and women survivors' children are at a higher risk for sexual and physical abuse. Due to these long-lasting effects, it remains pivotal for survivors to be provided with treatment options that ease the difficulties and distress they face, and it is just as essential to ensure they are provided treatment plans that are utilized to promote lasting symptomatic remission (Elkjaer et al., 2013).

Hypnosis is a tool that has been available for many years, though it has not been utilized as much as more traditional treatment options. Over the years, researchers and clinicians began to see the benefits of hypnosis in treating patients with PTSD, anxiety,

sexual dysfunction, and depression. Issues such as these are noticed in survivors of CSA, which means hypnosis could be an effective treatment option with positive results for clinical hypnotherapists and their clients. However, there currently exists insufficient research linking hypnotherapy for CSA survivors as a prominent treatment option, as expressed by clinicians. By understanding the experiences and perspectives that licensed healthcare professionals have with treating CSA survivors and analyzing data to determine the effectiveness of this treatment option, the conclusion can be made on if clinical hypnotherapy should be utilized more as an effective recovery option for CSA survivors. Per the lack of currently available literature, it has been established that there is an obvious need for a better understanding of clinical hypnosis and its effects on CSA recovery. This study intends to gain this knowledge by understanding the shared experiences on the effectiveness or ineffectiveness of this therapeutic approach by interviewing licensed healthcare professionals who treat CSA survivors.

Chapter 3 will provide a more detailed description of the methods utilized for this study. This chapter will provide insight into the purpose of the research study, the qualitative data tools used for data analysis, and a detailed breakdown of the sampling criteria. I explored licensed healthcare professionals self-disclosed experiences and perceptions of if they believe clinical hypnotherapy is a valuable treatment option for survivors in reaching optimum recovery. The study is based on an existing theoretical treatment model, namely socio-cognitive theory, which is a cognitive behavioral perspective that explains how people regulate their behaviors through control and

reinforcement to achieve goal-directed behavior, utilizing it in conjunction with clinical hypnosis as the basis for treatment types surrounding this model (LaMorte, 2022).

Chapter 3: Research Methods

Introduction

As discussed in Chapter 1, the purpose of this generic qualitative research study is to discover the experiences and perspectives of healthcare professionals with hypnotherapy for adult CSA survivors. This study produced qualitative data that was derived by utilizing criterion purposeful sampling. To fit the criteria for participation in the study, I recruited licensed healthcare professionals who have experience in the described area of expertise. CSA has been deemed the most prevalent form of childhood trauma by many researchers. For decades, clinicians have treated (or attempted to treat) patients who have experienced this abuse. While there is a multitude of therapeutic approaches that have been utilized over time to aid in recovery from CSA trauma, there is still a need for alternative approaches that may render more favorable results in a shorter time frame than traditional methods.

Hypnosis has been proven to be a successful treatment option for treating individuals who have lived through traumatic experiences over a life span. Hypnosis has also been known to be a successful treatment option for trauma-related mental health disorders such as anxiety, PTSD, and depression. This study aims to understand how clinicians who treat or have treated adult CSA survivors describe their experiences and beliefs toward treating this population of survivors. This study also came to understand the efficacy and experiences these clinicians shared on the use of hypnotherapy as a treatment approach. Understanding the shared experiences of licensed clinicians provided insight to the researcher, scholarly community, and individual survivors on the

effectiveness or ineffectiveness of using hypnotherapy as a therapeutic approach to aid CSA recovery.

Even with the multitude of other complex traumas experienced in childhood and throughout life, there remains room for growth, specifically when treating CSA survivors. In this chapter, I have justified utilizing a basic qualitative research design and described the methodology used in the study. Chapter 3 also includes and describes the selection process for the participants, a description of the participants, recruiting procedures, data collection instruments, and the plan used for analyzing data while also providing a breakdown of the structure of interview questions. Providing reasoning behind the questions asked to participants paints a clearer picture of what I hoped to learn about the experiences of the clinicians. For clarity, I explain the rationale for the qualitative data instruments that were utilized and explain the development of the interview protocol. Finally, this chapter addresses trustworthiness, the possible threats to validity and reliability, ethical considerations, and how I was able to those risks.

Research Design and Rationale

I sought to answer the following research questions in this study:

RQ: What are the shared experiences of licensed healthcare professionals treating adult survivors of CSA?

Sub RQ: What are the lived experiences and perspectives of licensed healthcare professionals with clinical hypnotherapy to treat adult survivors of CSA?

The answer to these research questions is clarified by participants providing detailed insight into their shared experiences and allowing the researcher and other

stakeholders to become more knowledgeable on why and how licensed healthcare professionals perceive this treatment approach. This research study is based on a basic qualitative design, including data collection from interviews with six participants (licensed clinicians or healthcare professionals) regarding their professional experiences treating adult CSA survivors. Merriam and Tisdell (2016) defined qualitative research as philosophical approaches and orientations. There are alternative qualitative research designs; however, they were not deemed appropriate for this study after review. Narrative research, ethnography, grounded theory, phenomenology, case study, and historical study are alternative qualitative research designs (Merriam & Tisdell, 2016).

I considered utilizing phenomenology as my qualitative research design. This research design involves placing all focus on how an individual understands a phenomenon based on their experiences of it. Phenomenology inquiry provides a strong sense of understanding what it is like to have experienced a particular phenomenon (Patton, 2002). I rejected this approach and instead elected to gather information about the beliefs and perspectives of hypnotherapists as it relates to utilizing hypnotherapy to treat CSA survivors. This research only includes interviews of previous experiences of clinicians treating CSA survivors, not uncovering, and interpreting the inner essence of the phenomenon. I eliminated narrative inquiry as a research design because it would require the participants to provide a detailed narrative from start to finish about their overall experience of treating clients with a multitude of presenting problems (Merriam & Tisdell, 2016). A narrative research design did not fit my study because the study is

concerned with specific aspects and a particular approach to treatment, not in-depth expressions of overall experiences in providing treatment.

After considering alternative qualitative approaches such as the ones described above, I ultimately decided that a basic qualitative research design would serve as the most appropriate design for the intended study. Basic qualitative research design was chosen for several reasons. First, this design allows the researcher to understand the perspectives of licensed clinicians by collecting firsthand data and conducting in-depth one-to-one interviews. Secondly, this design enables the researcher to identify recurring patterns in participant responses by conducting an in-depth analysis (Cantu & Gomba, 2018). Additionally, this research design allows the researcher to understand the rationale behind the participants' beliefs. I hoped that by utilizing a methodology based on a basic qualitative design, that understanding, and clarity would be gained from the experiences of licensed healthcare professionals in treating adult CSA survivors. This study aimed to make an original contribution toward addressing a gap in psychotherapy practice by structuring it in a way that built upon previous studies.

Role of the Researcher

The role of the researcher was shaped through the process of designing and planning the research study while also ensuring the methods that were utilized were conducive to data collection. Researchers understanding their role in a qualitative study is crucial as it can weigh heavily on the study's outcome. For this qualitative study, I engaged in reflexivity to examine my position within the research. Practicing reflexivity also allowed the researcher to be cognizant of how their prior experiences, perceptions,

assumptions, and beliefs would influence the research process. Reflexivity also enables the researcher to be aware of how they may, in turn, be affected by the study (Merriam & Tisdell, 2016). I was able to discern biases, ethical issues, relationships with participants, and the overall role played in the study. I was also able to use reflexivity to help understand expressed experiences by ensuring that preconceived thoughts and notions about the data were included in the data collection process, such as utilizing qualitative journaling, member checking, and interviews. Merriam and Tisdell (2016) attested that the researcher is the primary instrument in a qualitative study as the researcher directly affects and impacts the study.

As the interviewer, my role in the study was to ensure that the semi-structured interview questions were aligned with the research purpose, gap, problem, and aim towards answering the research questions. Before the start of each interview, the participants were provided with informed consent that included their rights as a participant, why the interview questions were derived, and that all interviews would be video, and audio recorded for later transcribing purposes. Though I am also a mental health clinician, there were no past or current relationships with the participants chosen for the study. Before beginning the study, all clinicians were unknown to the researcher and only selected based on matching the inclusion criteria established using purposive sampling.

One tool I utilized to reduce bias was member checking. Member checking allows the participants to review the interview findings and increase the study's credibility. Member checking enables the researcher and participants to ensure that perceptions,

experiences, and views expressed during the interview are captured appropriately (Ravitch & Carl, 2016). I utilized journaling to indicate when an opinion arises in thoughts related to the participant's responses. I journaled thoughts on study outcomes and participant responses prior to conducting interviews, during interviews, and once the study was completed, utilizing self-reflection throughout the entire research study. I only had contact with participants as it relates to the study and ensured that any non-study-related interactions remained non-existent until the completion of the study in an effort not to taint the results. Finally, I participated in debriefing sessions with other professionals on the thoughts, themes developed, and perspectives of the participants. Debriefing allowed me to reflect on actions or unconsciously biased thoughts that may have affected judgment and critical thinking abilities (Ravitch & Carl, 2016).

Methodology

In this section, I explain and outline the research design and the plan for research methods that was used to conduct the study. I also provide in-depth rationales for how participants were selected, the recruitment process, participation, and how data collection occurred. Following the explanation of the methods before the study is conducted, I conclude this section with disclosures regarding the plan for data analysis, trustworthiness, and ethical problems and procedures. The study consisted of purposefully selected participants, licensed healthcare professionals, to learn about their experiences and perceptions with treating adult CSA survivors using different treatment approaches including the use of hypnotherapy. Semi-structured interviews allowed me to probe for more detailed explanations of experiences as needed.

Participant Selection

Participants for the study consisted of licensed healthcare professionals who treat adult CSA survivors. Using purposeful criterion sampling appeared appropriate as it allows the researcher to choose only participants who meet the criteria established for the study (Merriam & Tisdell, 2016). Aside from treating adult CSA survivors, participants also had to meet the following inclusion criteria: They needed to hold an unrestricted professional healthcare license. Participant selection was limited to clinicians who treat or have treated adult CSA survivors. Including clinicians who currently treat or have treated adult CSA survivors allowed patterns and themes to emerge from the data that aided the researcher in gaining insight into their experiences and perceptions on hypnosis and other treatment approaches.

I attempted to utilize the Walden University participant pool by posting a recruitment flyer that outlined the study's intent; however, no participants were gained from this approach. I searched and utilized Facebook social media platforms for professional social groups that included members who are licensed healthcare professionals. Posting the recruitment flyer in specific groups that targeted the intended participant audience was helpful as it allowed me to have a participant pool that held at least one of the specific inclusion criteria for participation in the study. After receiving several inquiries to participate from the clinicians who fit the inclusion criteria for the study, I contacted the potential participants via email and included the requirements for participating in the study, along with discussing the informed consent form. To be considered for the study, the participants had to be licensed healthcare professionals who

hold current unrestricted professional licenses, and now or in the past treat adult CSA survivors. A current unrestricted professional license was essential for the study because I wanted to ensure that the participating clinicians had enough experience to provide sufficient data for the research questions to be answered appropriately and accurately. Before the final selection of the participants, I verified their clinical licenses were in good standing by searching their state's website for clinical licensure verification.

After receiving email responses from potential participants who confirmed their interest and completed the informed consent by stating "I consent," I conducted interviews until data saturation was reached. I utilized a small sample size, $N=6$, as this study was qualitative and saturation was reached by this point. A qualitative study aims to obtain a deeply enriched understanding of the research topic; therefore, a small sample size and in-depth interviews was appropriate, especially since the participants were homogeneous (Boddy, 2016). After selecting the participants who fit the criteria for the study, I sent out another email and scheduled a date and time to conduct the interview. Though it was stated in the informed consent, at that time, I reminded participants that they could withdraw from the study at any time by calling and saying, "I would like to withdraw from the study" or email that they would like to withdraw. If any participants withdrew, other potential participants that fit the inclusion criteria were contacted. A new participant then replaced the clinician who withdrew from the study. Any data already received from the participant who withdrew will be carefully discarded and not used in the study. To discard, I will delete any audio footage and shred any written

documentation 5 years after the study. In the next section, I explain and discuss how the study was conducted and the instrumentation used.

Instrumentation

The researcher is the primary instrument for collecting data in the study and can utilize a multitude of means to gather pertinent data for the study (Ravitch & Carl, 2016). I created and utilized an interview protocol to assist with accuracy and allow for rich data collection (Siedieck, 2022). A researcher's interview protocol is a tool of inquiry; the researcher asks participants particular questions related to the aim of the study, including engaging in conversation about the research topic (Patton, 2015, as cited in Castillo-Montoya, 2016). During the interview process, it is important for the researcher to avoid doing all the talking to not unintentionally express personal thoughts or beliefs, possibly tainting the study results. The interviews were conducted using a semi-structured script to capture the shared experiences and to understand the healthcare professionals' perspectives. I utilized Zoom for audio and video recording for all interviews. Semi-structured interviews were sufficient for data collection for several reasons. Using this interview method allowed me to gather the detailed information needed to answer the research questions while also providing the flexibility for the participants to respond according to any new ideas or thoughts related to the study (Ravitch & Carl, 2016). Semi-structured interviews also allow additional open-ended questions to be asked that assist the researcher in gaining a better understanding of shared experiences if needed and enables the researcher to probe for new information that the researcher may not have been knowledgeable of before starting the study (Ghelich-Khani, Kazemi, Fereidooni-

Moghadam, & Alavi, 2021). Interviews that utilize open-ended questions help reduce bias while avoiding unresponsiveness during the interview process (O'Keefee et al., 2016).

Other data collection methods the researcher used are journaling, member checking, and note-taking. Using semi-structured in-depth interviews as the primary data collection sources paired with the other data collection methods named above, I had a higher chance of reducing threats to validity. Member checking and prolonged engagement in achieving saturation in qualitative research establish the credibility of studies (Abdalla et al., 2018). I used member checking throughout the study to address research reliability and validity. In utilizing observation, I recorded the participant's emotional reactions during the interview to gain a deeper understanding during the data analysis process (Ghelich-Khani et al., 2021). Working with the participants using member checking was another way to prevent bias and added validity to the data collection process (Thomas, 2017). If I misunderstood or was biased against anything the participants expressed, member checking allowed the participants to confirm the findings or make changes to ensure the participant's perspectives were captured correctly (Ghelich-Khani et al., 2021).

Procedures for Recruitment, Participation, and Data Collection

When selecting participants for a study, it is the researchers' job to understand the research goals and questions. In selecting participants, I utilized purposeful sampling. According to Ravitch and Carl (2016), participant selection can be strategic and intentional in qualitative research. The following subsections outline and describe how

the researcher recruited participants, worked with the participants, and how data collection and data analysis was conducted for the study. All the next steps and actions are aimed at efficiently and adequately answering the research questions, thus addressing the gap in research.

Recruitment and Participation

To recruit participants, I included licensed healthcare professionals. The clinicians or healthcare professionals chosen as participants had to fit the inclusion criteria: providing treatment to adult CSA survivors and hold an unrestricted professional healthcare license. Other identifying characteristics of participants, such as sex, race, age, and gender identification, were not important in the selection process. I wanted to eliminate as much potential bias as possible in the study, thus not making personal identifying information a part of the inclusion criteria. Once I selected the participants that were to be a part of the study, the remaining potential participants who also fit the inclusion criteria received an email thanking them and informing them that they were not selected at the current time to participate; however, if more participants were needed, they would be contacted again. If I had not gotten back enough responses to the initial invitation to participate, I had planned to send a follow-up email to garner further interest. The chosen participants for the study received an email thanking them for offering to participate and being informed that they were selected to participate. At this time, I arranged the initial meetings with each participant via phone to ensure that no further clarification was needed on the purpose of the study, or the information stated in the

informed consent. During the initial call, I scheduled the interviews, telling participants that interviews would be conducted via Zoom.

Data Collection Procedures

Interview data for the study was collected using an interview protocol I developed specifically for this study to aid me in conducting proper professional interviews. The data collection process had multiple steps that I believed would provide value to the study's outcome. The steps included: (1) reconfirming the participants have access and capacity to utilize Zoom; (2) conducting the semi-structured interviews; and (3) using Zoom to transcribe the interviews. I also utilized any notes taken during the interview as a part of the data collection and ensured that the information was transcribed or added to the study's data as applicable. I asked the participants when scheduling to reserve at least one hour for the interview, as it was expected to range from 60-90 minutes for completion. I informed each participant that they were only expected to complete one interview.

Assuming each participant was actively working, I allowed the participants to provide a time frame during the day or evening to complete the interview to help prevent interruptions during the interview process and to avoid disrupting the clinician's professional responsibilities. When a date and time frame were selected, the researcher emailed the participant a calendar invite as a reminder for the scheduled interview. The reminder email was sent 2 days before the interview restating the date and time. The next step of the data collection process included conducting semi-structured interviews with the participants. The participants did not receive any incentives for participation. During

the interview, I took notes of verbal and nonverbal reactions that stood out and video/audio record each interview to ensure accuracy and understanding of shared experiences and perspectives.

The informed consent provided to the participants in the invitation email was reviewed and discussed to ensure a complete understanding of their rights as a participant and to remind them that since their participation was voluntary, they could withdraw at any time. I also informed the participants of the confidential nature of the study and that at any time during the interview, they could ask questions if an example of what was being asked was needed to understand the interview questions better. I informed the participants at that time that their names would not be utilized in the study, but instead, they would be assigned a number. For example, Healthcare Professional 1 would be identified as HCP1, Healthcare Professional 2 would be identified as HCP2, and so forth. Only the participant's assigned number were used when I transcribed the interview data. No names were used for data analysis either. All electronic data were stored on a password-protected online application. The data will be retained for no more than 5 years and appropriately destroyed after. I ensured the participants knew that at any time during the study, they could decide they no longer wanted to participate and would like their responses removed from the data collected. To do so, the participants were encouraged to email me or verbalize via phone that they no longer wished to participate in the study.

Once the interviews were completed, I transcribed the recorded video and audio footage. When saving the footage to password-protected sources, I kept up with the interview responses by the numbers assigned to each participant. Any tangible notes or

data collected was stored in a secure lock box in my home. Once the 5-year mark is reached, data and documentation from the participant's interview responses will be deleted and appropriately shredded.

Data Analysis Plan

The purpose of data analysis is to use the data collected during the data collection phase of the study and assess how that data is relevant to the purpose of the study and the research questions (Bengtsson, 2016). The analysis plan includes constructing categories from the data collected, including all data collection sources. Following the construction of categories, I identified and placed these categories into themes. Establishing overachieving themes and coding them helped to facilitate understanding and interpretation of the participant's experiences and perceptions of the research problems. Additionally, while analyzing the data, I used a constant comparative analysis to find and compare differences, identify patterns, and identify any discrepant case evidence (Bengtsson, 2016). Coding requires several steps to disseminate data effectively in qualitative research. Coding allows the researcher to organize and analyze data (Bengtsson, 2016). I used a five-phase cycle that analyzed data for the study: (a) compiling, (b) disassembling, (c) reassembling, (d) interpreting, and (e) concluding (Yin, 2016).

Compiling the Data

According to Yin (2016), once the researcher collects all the data from the interviews, the data should be placed in an order that will be useful for analysis. Once all interviews were completed, I formally organized all information gained. The data

acquired from the interview that was organized included any transcriptions, any notes, and any journaling I conducted before and during the interview. I also made notes of any terms consistent across interviews, placing them on an Excel sheet to be easily discernable. I reflected while reviewing data and looked at how similar terms were being used by each participant (Yin, 2016). I hoped that this system of making connections between interviewees, organizing data, and compiling data would aid in understanding the data later in the study's results section.

Disassembling the Data

Disassembling is the second phase of the five-phase system. This phase requires the researcher to take the organized data from phase one and break it into smaller components to assign labels or codes (Yin, 2016). Once assigned, I completed the process as often as necessary until themes and categories became apparent. I used Excel to create a spreadsheet to document themes found and placed them in the correct category.

Reassembling the Data

The third phase of the five-phase system is reassembling. In this phase, I reassembled the disassembled data from phase two and searched for more patterns (Yin, 2016). In this phase, I placed themes into clusters using the same spreadsheet created in the disassembling phase. As patterns and themes emerged, this phase went back and forth with the disassembling phase. While in the reassembling stage, I began to make inferences about the data collected. Making these inferences about data could have led to possible bias; however, I watched for negative cases, look for similarities and

dissimilarities in the data, and used critical thinking to make sense of personal interpretations (Yin, 2016).

Interpreting the Data

Yin's (2016) fourth stage of the data analysis process is where the researcher discusses the findings from the data by using the reassembled data in the previous phase. The data were interpreted by focusing on the research questions and how patterns and themes emerged. I explain this process to ensure the data is as reliable as possible. To further ensure the data are being interpreted comprehensively, I considered several things: (1) are the data complete; (2) were the data fairly and without conscious bias; (3) empirical accuracy; (4) is how data were interpreted adding to literature as opposed to restating what has already been established, and (5) how will other researchers view and critique my interpretations (Yin, 2016). The data at this point was reviewed again for possible reorganization and reassessed to ensure that during the 5-phase analysis process, no significant changes occurred that would cause the data to be now inaccurate.

Concluding the Data

The final stage of Yin's (2016) 5-phase data analysis process is concluding the data. During this phase, the themes and patterns I established in the previous stage were utilized to draw conclusions and determine inferences from the research. How the data analysis was concluded could range from generalizing, insisting more research is needed, stating new theories, or challenging conventional stereotypes (Yin, 2016). The conclusion of the study explains the study's findings.

Issues of Trustworthiness

Lincoln and Guba (1985) defined trustworthiness as the extent to which one can have confidence in the study's findings. Concepts of trustworthiness include credibility, transferability, dependability, and confirmability (Ravitch & Carl, 2016).

Credibility

Credibility is established when the researcher accurately perceives and represents the research in a way that reflects the reality based on participant views. To achieve credibility, I utilized persistent observations, collecting data that identified and assessed factors that allowed the researcher to separate typical from atypical, and member checking, engaging with the participants to ensure that the data recorded was perceived accurately and correctly interpreted (Lincoln & Guba, 1985).

Transferability

Transferability refers to how applicable the study findings are and the degree to which the findings can be transferred to other situations (Lincoln & Guba, 1985). The researcher clearly explains the details of the study so that it can potentially be recreated for similar studies (Holloway, 1997). Detailed descriptions of the procedures, the context of the study, and the participants (aside from identifying information) is documented by the researcher (Lincoln & Guba, 1985). I also used reflexive journaling, such as documenting personal thoughts throughout the study, to assess for transferability (Ravitch & Carl, 2016).

Dependability

Ravitch and Carl (2016) defined dependability as stable data, thus producing consistent research. The researcher used audit trials to help ensure dependability in the study. To establish dependability, I reviewed reflexive notes from the journaling done throughout the data collection stage and provided the participants with the study's findings and interpretations gathered after interviewing to allow the opportunity to confirm or challenge the findings (Ravitch & Carl, 2016).

Confirmability

In qualitative research, confirmability represents the source of information for the study, which in this case is the researcher. Confirmability means that the researcher has acknowledged personal biases, and the study data can be confirmed by others who were not a part of the study (Ravitch & Carl, 2016). To ensure the confirmability of the study, I continually assessed the stance held about the study throughout the entire research process. Paying close attention to subjectiveness also ensures confirmability throughout the study. Utilizing personal notes and describing my thinking process allowed for transparency while reflecting on possible biases based on cultural and socio-economical statuses (Ravitch & Carl, 2016).

Ethical Procedures

There are many ethical factors to consider when conducting a qualitative research study. Ethics, as it pertains to research, involves taking the necessary steps to protect the research participants. Confidentiality and informed consent are two of the most common privacy methods included in minimizing harm to participants. Ravitch and Carl (2016)

defined confidentiality as a term that refers to omitting information that can be utilized to identify participants. Informed consents outline the reason, nature, and rights of the participant for a research study.

Before beginning the interviews, the participants received informed consents regarding the study and was able to review and ask questions at their leisure. Confidentiality was addressed in the informed consent. On the scheduled day of the interview, I reviewed the bounds of confidentiality again to ensure the participants thoroughly understood what would remain confidential and what must be disclosed. There are no ethical concerns regarding the recruitment of participants. I communicated to the participants that their participation in the study is voluntary and could be withdrawn at any time. Another way that I ensured the recruitment process was fair and ethical was to inform the participants that identifying information would not be disclosed in the study, as it is not intended to cause harm to them or their professional careers.

I completed the National Institute of Health human subjects' protection online training course to ensure awareness of ethical procedures when working with participants. I planned for ethical issues that could arise when creating the interview protocol; thus, practices were implemented throughout the study to ensure ethical procedures are followed. It was important to me that the participants remained confident that their personal information would be protected professionally and ethically. I constantly reassured the participants of the confidentiality agreement in place, and that objectiveness would remain present throughout the interview process. Participants were reminded that their data would be stored in password-protected locations.

Summary

This chapter describes the research methods I utilized in this study. I explained the methodology I used in conducting my research on the experiences and perceptions of licensed healthcare professionals treating adult CSA survivors. I provided detailed descriptions and rationales of how I choose my participants, research design, role as the researcher, instrumentation, data collection, and how I analyzed data. I also addressed trustworthiness by discussing the criteria: credibility, transferability, dependability, and confirmability. I discussed the issue of personal bias and what steps were taken to address it had it occurred. Finally, I described the ethical concerns, practices, and processes that were addressed and employed throughout the study.

In Chapter 4, I provide an extensive summary of the study. I further discuss the setting, participants' demographics, data collection, and data analysis. I also provide evidence of trustworthiness and explain the study's results. The impact on social change is explored to make possible suggestions for further research that may be needed.

Chapter 4: Results

Introduction

CSA and its effects have been studied extensively over the years and has also been named the most prevalent form of abuse in children. Adult survivors of CSA enter adulthood with many lasting adverse effects due to the abuse (Myers-Bowman, 2017). Some survivors adopt maladaptive behaviors that have negative impacts on their lives in many aspects. Many different treatment approaches by healthcare professionals have been utilized to treat these survivors; however, there still appears to be a lack of timely recovery. Hypnosis has been known to be effective in the treatment of other complex traumas, such as PTSD, by not only providing relief to the survivor but also providing a quicker road to recovery. There is a gap in current research as to understanding how hypnotherapy is viewed from a clinical standpoint by licensed healthcare professionals treating adult CSA survivors.

This study aimed to gain knowledge on the experiences of licensed healthcare professionals who treat or have treated adult CSA survivors. This study also aimed to gain insight into the lived experiences and perceptions of licensed healthcare professionals using clinician hypnotherapy to treat adult survivors of CSA to aid in determining if it is a valuable treatment approach. Chapter 4 discusses data collection, data handling, demographic information, the processes in which participants' identities were protected, interview questions, how data was analyzed, themes, findings, researcher biases, and summary. Chapter 5 will provide a more in-depth discussion of the study results.

Setting

I collected data for this study from March 2024 through April 2024. Though the researcher is also a clinician (licensed healthcare professional), the chosen participants were unknown to the researcher before the study. Initially, the researcher had difficulty obtaining participants due to participants' lack of follow-through with responses to the initial posting of the study, followed by poor responses to the informed consent needed before scheduling interviews. After multiple outreaches for participants in social media healthcare groups, the researcher was able to begin gaining participants. Due to low responses to the study posting, the researcher utilized the snowball method, which consisted of reaching out to the confirmed participants and asking them to share the study details with other licensed healthcare professionals. Initially, the researcher sought to recruit at least 15 participants to ensure enough data would be collected; however, the research was unable to secure more than ten participants, and the sixth interview reached saturation.

Demographics

To be included in the study, participants had to hold unrestricted professional healthcare licenses in their state and treat or have treated adult CSA survivors. The researcher used purposeful sampling. According to Ravitch and Carl (2016), participant selection should be intentional in qualitative research. Participant selection was limited to clinicians (or healthcare professionals) who have treated or currently treat adult CSA survivors with the intent of allowing patterns and themes to emerge from the data that was rendered by providing insight on the topic of valuable treatment approaches.

Identifying characteristics of participants, such as sex, race, age, gender identification, and sexual orientation, were not important in the selection process. This approach to participant selection was conducted in such a way so that the researcher could eliminate as much potential bias as possible and unintentionally taint the results of the study.

Table 1

Participant Profiles

Participant identification	Healthcare profession	Professional licensure	Years of treating adult CSA survivors	Previous use of hypnotherapy
HCP1	Licensed professional counselor (LPC)	LPC, LCDC (licensed chemical dependency counselor), LMFT (licensed family & marriage counselor)	33 years	None
HCP2	Registered nurse (RN)	RN	20 years	None
HCP3	Licensed clinical social worker	LCSW	15 years	None
HCP4	Licensed professional counselor	LPC	25 years	None
HCP5	Licensed professional counselor	LPC	10 years	None
HCP6	Licensed professional counselor	LPC	20 years	None

Data Collection

Six licensed healthcare professionals from large metropolitan areas participated in this study. The participants interviewed consisted of licensed nurses, social workers, and therapists who have treated or are currently treating adult CSA survivors. Participants provided treatment to adult CSA survivors ages 18 and up. Participants were required to have unrestricted professional healthcare licenses and treat or have previously treated adult survivors of CSA. Aside from the semi-structured interviews, the researcher utilized member checking, visual observation, and journaling as data collection methods. All participants completed an informed consent (Appendix) before each interview. The informed consent provided insight to participants that no self-identifying information would be used in the study.

The researcher utilized a coding system to ensure that all identifying information about participants would not be included in the study. Each participant was given a number that started with HCP (healthcare professional). For example, Participant 1 is identified in the study as HCP1, Participant 2 as HCP2, and so forth. Once each informed consent was reviewed and the researcher received an email stating “I consent,” the participants were assigned their number and code based on the order in which they responded, and their interview was scheduled. Once assignments were made to identify participants, the researcher documented this information on an Excel file that included the participant identifier, their informed consent had been reviewed and responded to, and the time and date of their scheduled interview. This Excel file was placed in a password-protected location on the researcher's computer hard drive.

None of the participants were provided a copy of the interview questions before the interview. The researcher wanted the most raw and authentic responses during interviewing, thus deciding to reveal the interview questions when they were being asked. When scheduling, the researcher informed all interviewees that interviews would be conducted via Zoom and be video and audio recorded for later transcribing. The researcher proceeded to video and audio tape face-to-face interviews and utilized the same video messaging platform, Zoom, to transcribe each interview. Interviews were completed over 2 months.

Data Analysis

The data analysis process began with establishing an interview protocol to assist with accuracy and allow for rich data collection. This protocol aided in transcribing the video-audio-recorded participant interviews and my observation notes taken while conducting the interviews. The researcher also used member checking, as this approach, paired with prolonged engagement in achieving saturation in qualitative research, establishes the credibility of studies (Abdalla et al., 2018). Member checking also provided another avenue to prevent personal biases and add validity to the data collection process (Thomas, 2017).

The interviews were completed via the Zoom video messenger application; thus, Zoom's transcription tool was purchased and utilized for transcribing. The data collection process had multiple steps that provided validity and value to the study's outcome. The steps include (1) reconfirming the participants have access and capacity to utilize Zoom,

(2) conducting the semi-structured interviews, and (3) using Zoom to transcribe the interviews.

To get the most understanding of the participants' experiences and perceptions of the research problem, establishing overachieving themes and coding those themes were important. Coding requires several steps to disseminate data effectively. Thus, I utilized a five-phase cycle that analyzed data for the study. The phases included (a) compiling, (b) disassembling, (c) reassembling, (d) interpreting, and (e) concluding (Yin, 2016).

The data analysis plan included constructing categories from the data collected, including all data collection sources. I labeled and coded the data to ensure the participants' simplicity, confidentiality, and privacy. After transcribing the data, I carefully read, organized, and prepared them for data analysis. I was sure to carefully consider each statement's relevance and meaning related to the participants' experiences, perspectives, and treatment of adult CSA survivors. After coding and paring the data into themes, I described and interpreted each with verbatim excerpts from each participant. I developed and entered statements I found significant in a data table and clustered those statements into emerging themes across participants.

Consistent Themes

The theoretical framework was the social-cognitive theoretical perspective. Kirsch (2003, as cited by Lynn et al., 2007) defined hypnosis from a social-cognitive theoretical perspective as a situation in which individuals respond to imaginative suggestions whether a formal hypnotic induction was used. In 1986, N. Spanos was one of the first theorists to emphasize social cognitive theories or perspectives to be goal-

directed in hypnotic responding (Lynn et al., 2007). One goal-directed approach that falls under social cognitive theories is SFBT. SFBT and hypnotherapy share many characteristics, but there are evident differences in that hypnosis can alter perception and facilitate awareness by bringing awareness to the unconscious. SFBT does not stimulate the unconscious, but it does assist the client in moving from problems to solutions (Gingerich & Peterson, 2012).

The goal of any therapeutic treatment approach is to provide aid to the client that will help them through their issues as timely as possible to reduce any mental and emotional discomfort. According to Robertson (2021), cognitive behavior theories are far more effective when implementing hypnotherapy or guided imagery techniques. Clinicians who use socio-cognitive approaches aim to get the individual to behave like a hypnotized person, wherein the behavior is understood by the clinician and the client (Robertson, 2021). This study's findings indicated practice and research recommendations.

Five themes emerged from the analysis of the participants' significant statements related to their treatment approaches, the efficacy of the use of clinical hypnotherapy, and their experiences with behaviors expressed by adult CSA clients they have worked with. The themes were as follows: (a) common treatment approaches, (b) hypersexual behaviors, (c) attachment issues, (d) lack of knowledge on the use of clinical hypnotherapy, and (e) fear. Each meaningful theme includes significant statements grouped to present the participants' expressed experiences, perceptions, and understanding of their adult CSA clients and their lived experience as a survivor of

treatment. This section presents the themes from data analysis and supporting narrative excerpts from semi-structured one-to-one interviews. When providing insight into narrative excerpts, note that each participant will be addressed as HCP, followed by the order in which their interview was completed. For example, Healthcare Professional Interview 1 will be noted as HPC1. There are also excerpts from the literature review to illuminate participants' statements.

Treatment Approaches

When asked to describe experiences and observations in treating adult CSA survivors, HCP1 said, “I noticed a shift over the years in how trauma is treated. I have been a licensed professional counselor for over 30 years, and CBT has proven very effective. However, different things at that time still needed to be developed and somewhat perfected.” HCP1 also provided insight into her perception of the outcome of treatment approaches that she has utilized, which includes CBT. According to HCP1, she has never utilized clinical hypnotherapy, but she believes that it could be a valuable treatment approach. HCP1 said, “Though CBT seemed effective, I could tell there were still clients who were not reaching their full potential with this approach. CBT was much more effective for anxiety and depression in the general sense." When asked about her efficacy of the use of clinical hypnotherapy for adult CSA survivors, and she stated, “I had started to become familiar with the use us hypnotherapy by other clinicians, but never had the opportunity to utilize it." She went on to explain that different treatment approaches like DBT (dialectical behavioral therapy) and EMDR (eye movement desensitization and reprocess) can come into play and prove very effective in working

with CSA survivors. HCP1 reported that she became satisfied with the outcomes of using CBT, DBT, and EMDR, but after a few years, there was still a multitude of clients struggling to process and work through their trauma. HCP1 said, "I wish that clinical hypnotherapy was more widely utilized and had more research so that perhaps I could have offered this approach to treatment for my clients who were still not making a great amount of progress with other treatment approaches."

Several other participants had a very similar response when asked the same questions. When asked about her experience in treating adult CSA survivors, HCP3 stated, "There have been a few treatment approaches that I have found to be effective for most CSA survivors, such as DBT and EMDR, but I also noticed that while it worked for a nice chuck of clients, there were others who did not appear to be progressing in treatment with these approaches. It always worried me that clients who required more intense treatment for recovery would have to try and adapt to the more widely utilized treatment approaches being used in healthcare." HCP3 also touched on having reviewed literature surrounding the use of clinical hypnotherapy for complex traumas but not finding much on its benefits in working with CSA survivors. She went on to say that in the last 3-4 years, she has considered becoming more familiar with and possibly utilizing clinical hypnotherapy to treat her clients, but due to lack of research, she has not moved forward with the thought.

HCP4 described her experiences with treating adult CSA survivors as difficult. She expressed that she has only been in practice for 5 years and had not been fully prepared for the array of differences in how CSA survivors respond to the trauma. HCP4

said, "When I started, I had not planned to work exclusively with trauma clients. I had not done much research on the true need for clinicians who were willing to work with survivors of childhood traumas, but I found it to be my niche early into my career." When describing the outcome of treatment approaches, she has utilized, she expressed feeling very confident in the use of CBT. Still, she went on to express that hypnotherapy could be just as, if not more, valuable than more modern approaches. HCP4 expressed, "I completed a weekend-long seminar on the use of hypnotherapy to treat complex traumas, and I was mind blown. I had the opportunity to be placed in a trance and gain a full understanding of what being under hypnosis means for people. Though I have not used this approach, I am currently working on a certification to do so."

Each participant HCP1-HCP6 made it very clear that they have not utilized clinical hypnotherapy in their practice but that they see many benefits in clients being treated using this approach. Each participant expressed different levels of comfort in their current treatment approaches to treat adult CSA survivors; however, they all proclaimed that more approaches to treatment could aid in timelier recovery. Though clinical hypnotherapy is widely underutilized as a treatment option for trauma, studies show that its hypnotherapy has assisted in providing mental and emotional comfort to survivors of childhood abuse and neglect (Sigurdarodottir et al., 2016).

Hypersexuality

Research indicates that individuals who have experienced CSA are at a higher risk of developing hypersexual behavior in adulthood. Based on perception, this is thought to be a coping mechanism, or a consequence of the trauma experienced (Aaron, 2012).

According to Briere and Elliott (2003), CSA is significantly associated with later life problems such as sexual compulsivity, which is a common feature of hypersexuality.

When asked if adult CSA survivors struggle with hypersexual behaviors, all participants provided similar responses. Participants were also asked if they believe that hypersexual behaviors can exist in the unconscious. HCP1 mentioned, "I do believe that CSA survivors often struggle with sexual compulsions, even when they do not begin showing signs of these behaviors right after the abuse has occurred. I also have worked with several clients over the years who expressed having more anxiousness about their hypersexual behaviors than the actual abuse due to feelings of no control over their behaviors." Lack of interpersonal knowledge of the irrational behaviors of CSA survivors caused many survivors to engage in sexually deviant activities that often traumatized them further following abuse (HCP4 and HCP6). HCP2 expressed, "Over the last decade, at least 95% of adult CSA survivors that I have treated expressed having hypersexual behaviors and struggling to remain faithful in romantic relationships due to these behaviors. It honestly came as no surprise to me as research has shown hypersexual behaviors are common for CSA survivors."

HCP3 and HCP5 expressed that they have had mixed experiences with adult CSA survivors presenting with hypersexual behaviors, as about a little less than half of their clients had the opposite behaviors (withdrawing from sexual behaviors in totality) due to the abuse. HCP3 recounted, "Most of my clients who are CSA survivors begin treatment expressing concern for not feeling like they can control their actions if they engage in sexually intimate behaviors; some ignore rationally and show no regard for wanting to

understand their behaviors as the behavior is seen as normal to them." Any form of abuse as a young child will have lasting effects on the individual as they develop mentally and emotionally over time. Once abuse has occurred there is usually a sense of "no control" through the eyes of the survivor (HCP5). Choosing to be sexually compulsive or deciding to withdraw from the activity provides survivors with the control they feel is needed to cope properly (HCP5).

Attachment

Attachment was the third theme in this study. Data indicated that all adult CSA survivors, at some point in their lives, struggle with forming healthy attachments. These challenges in forming health attachments throughout their lives are well-documented in psychological and clinical research, highlighting various impacts on emotional and relational functioning. Survivors of CSA frequently struggle with emotional regulation, which can manifest as heightened sensitivity to stress, anxiety, and depression. These emotional challenges can impede their ability to form and maintain healthy attachments (Briere & Jordan, 2009).

HCP1 expressed, "I have yet to meet anybody who was dealing with some type of sexual trauma who was able to form a healthy attachment. Often, it is a very reactive response, like they crave attention, but you can't get too close." She continued to explain that CSA survivors can't allow anyone in their personal space, physically or emotionally. Once you get too close, even if authentic feelings have developed, they often begin to pull away. HCP2 noted, "Any survivor who has experienced complex abuse such as CSA has a difficult time establishing not only healthy romantic relationships but relationships

in general." HCP2 also expressed, "Most CSA survivors lack interpersonal understanding of themselves, thus causing them to lack the ability to connect with and understand others enough to form healthy attachments."

HCP4 and HCP5 explained that one of the most common attachments CSA survivors struggle with is establishing healthy attachments with their children. Challenges in their roles as parents regarding providing secure attachments can perpetuate a cycle of attachment issues across generations (Mannarino, 1996). HCP4 stated, "From birth to adolescence are very pivotal years in a child's life; thus, the disruption caused by trauma in those developmental years affects these children throughout their lives. The lack of trust most survivors have with others due to the abuse usually occurring by someone that made claims to care for them is what causes the inability to establish true healthy attachments." Additionally, HCP3 noted, "Most adult CSA survivors failed to establish secure attachments in childhood due to fear or being manipulated into believing their abusers were acting in their best interest during abuse. I have worked with many clients who expressed they attempted to seek comfort and refuge in their caregivers, but they did not provide the needed attention and support that was needed, causing a lack in attachment bonding." HCP6 explained, "It is very often that CSA survivors report difficulties in maintaining intimate relationships, including trust issues, struggling with emotional and physical intimacy, and just overall dissatisfaction in the relationship."

Lack of Knowledge

Many licensed healthcare professionals do not receive comprehensive training in hypnotherapy during medical or psychological education, which leads to a lack of

familiarity with its techniques and potential benefits (Hammond, 2010). Hypnotherapy's historical association with stage hypnosis and its portrayal in the media contribute to ongoing skepticism and misunderstanding among licensed healthcare professionals (Heap & Aravind, 2002).

HCP1 stated, "While I'm well-versed in traditional therapeutic approaches, clinical hypnotherapy is new. I attended a training course over the weekend, but I still lack experience, particularly in its application to adult survivors of childhood sexual abuse." HCP1 went on to explain, "I understand the potential benefits of hypnotherapy in trauma treatment, but I haven't pursued specialized education in the modality, so I don't feel equipped to effectively use it with my clients who have experienced childhood sexual abuse."

HCP2 said, "Hypnotherapy is a complex tool that requires specific expertise, especially when dealing with sensitive issues like childhood sexual abuse. I believe it could be beneficial; however, this is not an area I have delved into deeply in my professional practice." HCP3 and HCP4 expressed that they have encountered positive outcomes from hypnotherapy anecdotally. Still, due to a lack of formal training and the opportunity to practice, the approach is not currently being incorporated into developing treatment plans for adult CSA survivors. HCP6 stated, "As a psychotherapist, I prioritize evidence-based practices and my proficiency in treatment methods. Since my familiarity with clinical hypnotherapy is minimal, I prefer to refer clients seeking this approach to specialists with more robust training."

Although there is growing evidence supporting hypnotherapy in treating trauma, this research is not always disseminated widely enough to reach practicing clinicians. There is a disconnect between the growing body of research on hypnotherapy and its practical application in clinical settings, leading to underutilization (Alladin, 2016). Other researchers on this topic expressed similar findings. Access to quality training in clinical hypnotherapy is limited, contributing to the lack of knowledge and utilization among licensed healthcare professionals (Barabasz & Watkins, 2005).

Fear

Fear is presented as the fifth and final theme in this study, specifically fear of forming attachments, fear of being under hypnosis with no control, and overall fear of re-traumatization with no proper recovery. Three of the six participants expressed that when working with adult CSA survivors, there is always an expression of fear in establishing connections or relationships with others. HCP3 expressed, "Trauma does different things to each survivor in most cases, but there are some things that seem to be common for survivors. I worked with several survivors recently, and they all expressed that they are constantly afraid that if they let someone in, they'll see how damaged they are and leave." HCP5 reflected on some of her earlier experiences of fear expressed by clients. HCP5 stated, "Survivors would always say things like, ‘Every time someone tries to get close, I push them away because it's safer to be alone.’ Survivors have expressed that forming attachments feels impossible because the only examples they've had are of betrayal and abuse.”

It is not uncommon for a survivor of complex trauma such as CSA to express fear or discomfort in not having control in situations they encounter. HCP3 expressed, "In the few instances I believed that a referral for hypnotherapy would be beneficial for a client, I was always met with some of the same responses. They told me they're scared of hypnotherapy because the idea of not being in control terrifies them. They have also said things like being in a vulnerable state during hypnotherapy feels too risky because they need always to feel safe and in control." HCP4 reflected on their experience with the topic of fear in treatment for survivors and expressed, "They shared that they have trust issues and couldn't deal with the thought of someone else having control of their mind for any reason." Several participants also expressed clients expressing fear of not being able to protect themselves and feeling powerless as they did during the abuse has contributed to specific treatment approaches, such as hypnotherapy not being an option they are open to.

Disassembling the Data

Once statements were collected and organized into emerging themes in the first phase of the five-phase system, I began the second phase, disassembling the data. This phase required me to take the data collected (statements from participants) and break them into more minor themes to assign labels to the emerging themes later in the study. I only needed to complete this process twice before feeling confident in the themes and categories that became apparent during this process. I utilized Excel to create a spreadsheet that allowed me to keep track of themes found and ensure those themes were adequately categorized.

Reassembling the Data

The third phase is reassembling the data. This phase consisted of reassembling all data collected and documented from phases one and two of the five-phase system. As I reviewed the themes that emerged from the first two phases, I began to make inferences about the data I collected. During this phase, I also reviewed other data collection tools besides the interviews, such as journaling, which I completed during each interview. Making inferences can lead to possible bias; however, in this case, I remained self-aware and focused only on similarities and dissimilarities in the data, which allowed me to use critical thinking to make sense of my interpretations.

Interpreting the Data

During the fourth stage of Yin's five-phase system, the study's findings were based on the reassembled data from the previous phase. During this phase, I focused on the main research questions and how patterns and themes emerged across interviews. I considered several things to ensure I was interpreting data comprehensively: (1) Are the data complete? (2) was I fair and free of bias while interpreting? (3) was I empirically accurate in my interpretation of statements and observations? (4) are the data I collected adding to the literature, and (5) I reflected on whether and how other researchers after me will view and critique my interpretations. Finally, in this stage, I completed one final and thorough review to ensure there were no significant changes or discrepancies that occurred that would cause the data collected to now be inaccurate.

Concluding the Data

The final stage of Yin's (2016) 5-phase data analysis process is concluding the data. During this stage, all themes established in the first four stages were used to draw conclusions and determine inferences regarding the study results. Five emerging themes were established and represented the experiences and perspectives of licensed healthcare professionals as they related to the main research question. The data collected from each healthcare professional include a narrative and quotes from the five themes extracted from the interview transcripts during the first data analysis stage. These themes accurately represent the experiences and perceptions of licensed healthcare professionals who treat adult CSA survivors, as well as their efficacy of utilizing clinical hypnotherapy as one of their treatment options.

Evidence of Trustworthiness

Credibility, transferability, confirmability, and dependability indicate a study's trustworthiness (Ravitch & Carl, 2016). I achieved credibility by utilizing persistent observations, notating participant quotes, member checking, and actively listening and engaging with participants during the interviews to ensure that the data recorded was perceived accurately and interpreted correctly. I used journaling to document all nonverbal responses I believed would be helpful to the study's outcome. By collecting different forms of data, I could identify and assess factors that allowed me to separate typical from atypical responses. To ensure validity, I frequently rechecked the accuracy of my findings by engaging with participants, reviewing notes taken, and examining the themes that emerged from participants' expressions (Lincoln & Guba, 1985).

Detailed descriptions and an in-depth understanding of the experiences and perceptions expressed could show the transferability of a study's findings (Lincoln & Guba, 1985). I achieved transferability in the study by first clearly explaining to each participant the details of the study and my reason for conducting the study. It was explained and understood that the hope is that similar studies can be created based on this study's findings. Providing documentation that details the context of the study and its participants (excluding identifying information) increases chances for transferability (Holloway, 1997). Ravitch and Carl (2016) describe a study's dependability as stable data that produces consistent research. Reviewing reflexive notes from journaling during data collection provided consistency in the study's findings, allowing me to confirm or challenge the findings. I achieved dependability by utilizing this process. The sources of information represent the confirmability of a study in qualitative research (Ravitch and Carl, 2016). In this study, I was the source of information and acknowledged any personal biases I may have had before or during the study. I needed to continually assess my knowledge about the study throughout the data collection process to not taint the findings. I ensured confirmability by journaling, observations, and transparency while reflecting on potential biases.

The research initially planned for the study to include 15 participants who met the inclusion criteria, but the sixth participant's interview met saturation. All six participants met the inclusion criteria. Each participant's response enabled me to address the research questions, capturing a realistic expressed experience from each participant on their treatment and perceptions of working with adult CSA survivors. I made every effort to

avoid bias, thus not including identifying information about participants in the study's data and using a semi-structured interview guide to allow for open-ended questions and promote honest responses.

Summary

Chapter 4 presented all findings from the data analysis. The purpose of this study was to gain knowledge on the experiences and perceptions of licensed healthcare professionals who treat or have treated adult CSA survivors. Achieving this purpose consisted of conducting a basic qualitative study with six licensed healthcare professionals who expressed their experiences, perceptions, and treatment observations in working with adult CSA survivors. Criterion purposeful sampling occurred from a population of licensed healthcare professionals who met the inclusion criteria in treating adult CSA survivors.

The research questions for this study were:

RQ: What are the shared experiences of licensed healthcare professionals treating adult survivors of CSA?

Sub RQ: What are the lived experiences and perspectives of licensed healthcare professionals with clinical hypnotherapy to treat adult survivors of CSA?

This chapter presented participant quotes and observations taken during data analysis to accurately show their experiences and perceptions of treating adult CSA survivors. The research steps were determined by recruitment, data collection, emergent themes, and how the findings of the research questions were organized. Chapter 5 outlines how the results were interpreted, the study's limitations, recommendations for

future research, implications for social change, and a conclusion that ties all study aspects together.

Chapter 5: Discussions, Findings, Recommendations, and Conclusions

Introduction

The purpose of the study was to discover the experiences and perspectives of healthcare professionals with hypnotherapy for adult CSA survivors. The SCT served as the theoretical foundation for this study. SCTH posits that an individual's expectations, beliefs, and attitudes are critical in the hypnotic process. SCT also posits that behaviors are influenced by the interaction of personal factors, environmental factors, and different behaviors (Bandura, 1986). The socio-cognitive approach guided this study to increase awareness, inform stakeholders, and provide insight into healthcare professionals who treat adult CSA survivors' experience with treatment for survivors.

Knowing the experiences of healthcare professionals' treatment for adult CSA survivors could also help determine whether clinical hypnotherapy is a valuable treatment option for the successful recovery of CSA or if this treatment approach is helpful at all. This research study uses a generic qualitative design and semi-structured interview questions. It consisted of purposefully selected participants who shared their professional experiences and beliefs on treatment approaches, including hypnotherapy to treat adult CSA survivors. Utilizing this generic qualitative approach, participants provided straightforward descriptions and interpretations of the phenomenon being studied, as it is grounded in the participant's own words and perspectives (Kahlke, 2014).

CSA is a complex trauma that has lasting negative effects on more than half of its survivors. CSA has also been described as the most prevalent form of abuse experienced in childhood (Newsom & Myers-Bowman, 2017). Healthcare professionals play a critical

role in the treatment and recovery of these survivors. However, studies show there is not a high percentage of survivors that ever seek assistance for recovery. Schnur et al. (2018) completed a study that found only about 30 % of survivors ever seek treatment for one reason or another. CSA survivors who choose to seek treatment have often reported that treatment approaches commonly utilized have not assisted in recovery. This expression from survivors highlights the need for additional treatment approaches that could aid in recovery. Despite research showing that hypnotherapy can assist with the recovery of other complex traumas, there was very little information available that shed light on the use of hypnotherapy for treating CSA survivors (Schnur et al., 2018).

The data revealed the shared experiences and perceptions of healthcare professionals who treat adult CSA survivors. In this chapter, I discuss the findings related to the study's purpose, interpretation, study limitations, recommendations for further research, and implications for positive social change. I interviewed six participants who treat or have treated adult CSA survivors to obtain their lived experiences and perceptions of treatment options for the survivors in question. In this chapter, I present an overview of the research purpose, how my findings align with the literature, the interpretation of the findings, and possible implications of said findings. The data analysis showed that healthcare professionals do not widely utilize clinical hypnotherapy, though most professionals believe it could be a useful treatment approach. The data also showed that due to a lack of training and education on hypnotherapy, healthcare professionals are not well versed in hypnotherapy and struggle to find ways to become more informed. The themes that data analysis generated indicated that there remains a

need for more successful treatment approaches in treatment for adult CSA survivors and that most survivors share similar experiences over their life span, making it more difficult to recover from the abuse.

Chapter 5 includes information about participant's experiences and perceptions in treating adult CSA survivors and how different treatment approaches help or hinder the client's recovery process. I describe and highlight the participant's expressions of common feelings and behaviors they experienced from treating the survivor and if they believe hypnotherapy will aid in better recovery. Finally, I offer recommendations for research and practice while discussing the implications for social change. This study generated the following themes: treatment approaches, hypersexuality, attachment, lack of knowledge, and fear.

Using a generic qualitative research approach allowed the themes to be investigated by comprehensively understanding participants' experiences and viewpoints. This method allowed for in-depth exploration of the described themes above without being restricted by a particular qualitative tradition. The generic qualitative approach allowed me to analyze how different treatment methods affect individuals, how hypersexuality appears and influences styles in shaping behaviors, and how ignorance and fear impact experiences. This approach was valuable for gaining detailed and nuanced insights into how these factors interplay, thus informing practice and future research recommendations effectively.

Like the findings of Rosmalen et al. (2016) and Schwartz (2015), this study's themes represented major commonalities that adult CSA survivors face throughout their

life spans while seeking treatment from the viewpoint of healthcare professionals. These themes emerged from participants' lived experiences that were shared, as well as how they perceived their experiences in providing treatment for adult CSA survivors. All participants in this study shared their experiences in treating adult CSA survivors, their treatment approaches, their knowledge of clinical hypnotherapy as an approach and common recurrent issues noted while providing treatment overall.

In this study, several key themes emerged regarding healthcare professionals' expression of experiences and perceptions with treating adult CSA survivors. Firstly, various treatment approaches were identified to address the needs of survivors, which were found to be useful for the most part. Secondly, the prevalence of hypersexual behaviors among these individuals was repeatedly noted, highlighting a significant area for intervention. Thirdly, attachment issues were found to be prominent among survivors, underscoring the importance of addressing relational challenges in therapy treatments. Additionally, the study revealed a concerning lack of knowledge among healthcare professionals regarding clinical hypnotherapy, indicating a need for further education. Finally, the fear of reliving trauma and loss of control during hypnotic trances emerged as a significant barrier to accessing this treatment modality among survivors. These findings collectively underscore the complexity of addressing the multifaceted needs of adult survivors of CSA and suggest important implications for clinical practice and education.

Interpretation of the Findings

This study partially filled an identified gap in the community of healthcare professionals who treat adult CSA survivors. This study described the shared experiences

of these healthcare professionals regarding their overall treatment for adult CSA survivors. It also provided insight into their experiences and the efficacy of the use of clinical hypnotherapy as a treatment option for survivors. A more thorough understanding of treatment options became known; however, the researcher could not identify if clinical hypnotherapy is useful for survivors. In this section, I address both research questions with supportive data. The interpretation of the findings aligns with the two research questions that follow.

Research Question: What are the shared experiences of licensed healthcare professionals treating adult survivors of CSA?

The healthcare professionals described their treatment of adult CSA survivors in a variety of ways, though each expression was very similar. The participants reflected on their overall experiences with treating CSA survivors, which one identified as "unpredictable internal chaos," and others described it as "deeply eye-opening." Concerning their experiences, the participants shared details about their interactions with clients that led them to utilize certain treatment approaches, though all approaches were unsuccessful. Several healthcare professionals discussed the challenges they encountered when the treatment approaches they used for survivors proved ineffective despite being the only methods extensively researched and documented in the literature.

A trend identified during data analysis revealed that many healthcare professionals observed survivors engaging in irrational and self-destructive behaviors, which typically started in adolescence and persisted into adulthood. This finding supports Rosmalen et al.’s (2016) notion that adults who now have problematic behaviors have

lived through experiences of emotional or physical deprivation separation or were placed in neglectful situations in childhood. In this study, all healthcare professionals expressed that adult CSA survivors they treat struggle with forming healthy attachments, somewhat romantic, platonic, or with family. Grady et al. (2018) spoke about different attachment styles: the anxious-ambivalent/resistant style, attachment avoidance, and attachment anxiety. Attachment avoidance style is often present in adulthood if no healthy attachments are formed in early childhood; however, attachment avoidance is most often present in adulthood for complex trauma survivors if no healthy attachments are formed in early childhood (Grady et al., 2018).

Each healthcare professional's lived experience provided needed insight into the treatment of adult CSA survivors. The healthcare professionals share that more useful treatment approaches could aid in quicker and more thorough recovery for CSA survivors. One participant discussed her experiences with researching holistic treatment approaches that may be useful for adult CSA survivors. She said,

> As a mental health therapist, I've dedicated myself to finding more holistic treatment approaches for CSA survivors. However, the journey has been challenging due to the limited literature on effective methods. This gap underscores the urgent need for more research and shared knowledge in these critical areas of mental health.

The findings from this study aligned with Grady et al.'s (2018) view on survivors' struggle with forming secure interpersonal relationships, causing them to develop insecure attachments with others. According to healthcare professionals, adult CSA

survivors experience emotional detachment when they experience trauma in the developmental years of childhood, making it hard to secure healthy relationships as adults (Gewirt-Meydan & Ofir-Lavee, 2021).

The in-depth, semi-structured one-to-one interviews provided insight into the lens of participants' experiences while providing treatment for adult CSA survivors—participants' descriptions of their perceptions of treating this population aligned with Fredrickson (1992). They shared the belief that if CSA memories were recovered after being repressed, the survivor must be experiencing psychological distress at present. Some healthcare professionals found that survivors attended less than five sessions before expressing that they do not think the treatment approaches being utilized are beneficial to them. This finding mirrors a study conducted by Lynn and O'Hagen (2009) on SCT, which also found that clients only attended a few sessions of traditional talk therapy before giving up on finding substantial treatment options.

Sub Research Question: What are the lived experiences and perspectives of licensed healthcare professionals with clinical hypnotherapy to treat adult survivors of CSA?

No participants in this study had ever utilized clinical hypnotherapy as a treatment approach. However, participants reported having some knowledge of the benefits of using this approach for CSA and other complex traumas. According to participants, clinical hypnotherapy is not a widely discussed or taught clinical skill in the healthcare community. Only one participant expressed having minimal training on the use of hypnotherapy as they attended a continued education units (CEU) event. However,

all other participants expressed knowing the benefits of hypnotherapy from individual research conducted on their own. The goal of healthcare professionals while treating complex trauma survivors is to have survivors focus on their beliefs in their efficacy to control their functioning and have control over events that affect their lives, such as CSA (Benight & Bandura, 2004).

Socio-cognitive theories, such as SFBT, emphasize the role of cognitive processes and social interactions in shaping behaviors and problem-solving skills (Trepper et al., 2010). SFBT focuses on identifying solutions rather than problems, encouraging clients to envision their desired future and leverage their strengths. Three participants (HCP1, HCP2, and HCP5) indicated that the approaches they attempted to use with some survivors mirrored this framework, but something was still lacking. These participants also stated that if more knowledge was held, they believe clinical hypnotherapy would be a good treatment approach for sustainable results. HCP1-HCP4 expressed a thorough understanding of SFBT and often compared it to hypnotherapy. SFTB and hypnotherapy foster a sense of agency and hope for survivors (Yapko, 2012).

Participants expressed that due to a lack of training and experience in utilizing clinical hypnotherapy, which was described by HCP2 and HCP6 as a technique that can complement SFBT by addressing deep-seated trauma and enhance therapeutic outcomes. The gap in experience and utilization of clinical hypnotherapy among healthcare professionals underscores the need for broader education and integration of diverse therapeutic modalities to support this vulnerable population effectively. Based on participant responses, I was unable to concur if clinical hypnotherapy should be more

widely utilized in treatment for adult CSA survivors, as neither participant ever utilized clinical hypnotherapy as a treatment approach, and all participants lacked in-depth knowledge of this treatment approach overall.

Limitations of the Study

The participants in this study were licensed healthcare professionals who treat adult survivors of CSA. Though most participants were licensed professional counselors (LPC), all participants held some form of a professional healthcare license. One limitation of this study could be confirmation bias, which refers to the research forming a belief about the study's outcome and using the data collected by participants to confirm that belief (Sarniak, 2015). Before completing interviews, journaling personal thoughts, and acknowledging preexisting assumptions about the study's outcome aided in avoiding this limitation. Though it was difficult at times, I remained mindful of my thoughts regarding the outcome of the study so as not to taint the results gathered during data collection.

Another limitation could have been my lack of awareness of the participants being overwhelmed or burnt out due to an increase in healthcare professional's caseload, thus causing their responses to the interview questions to be unreliable. The demand for mental health services has exceeded the available clinicians, causing an influx of new clients (Bailey et al., 2021). To my knowledge, burnout was not a factor during data collection; however, I did not ask either participant about their caseloads prior to completing interviews. At the start of the study, I was concerned about access to participants. Utilizing purposeful sampling appeared appropriate as it allowed the

researcher to choose only participants who met the criteria established for the study (Merriam & Tisdell, 2016). However, data saturation occurred among the sixth participant, thus eliminating the concern of not having a significant number of participants to provide data for the study. A smaller sample size allowed me to generate meaningful qualitative data and capture more in-depth information, providing quicker data saturation. Smaller sample sizes can foster increased trust between researchers and participants, leading to a greater willingness among participants to share sensitive data (Zhi F. et al., 2023).

Recommendations

Based on the findings from this qualitative study, several key recommendations were made that can advance the field of healthcare for healthcare professionals who treat clients with complex traumas such as CSA. Firstly, further research should be conducted to replicate the results across different populations and settings. This study did not utilize any personally identifiable information from participants, such as age, race, level of education, and gender; however, if a similar study is conducted, some of these factors should be considered to see an identified trend. Considering these factors would help to confirm the generalizability of the findings and provide a more comprehensive understanding of the need for additional treatment of CSA.

I would also recommend that future studies employ mixed methods approaches to enrich the data and capture the complexities of the need for education and practice in the use of clinical hypnotherapy to treat CSA survivors. Quantitative methods can provide robust statistical evidence, while qualitative methods such as those used in this study can

continue offering more profound insights into healthcare professionals' experiences and perspectives. Perhaps this combination can lead to a more nuanced understanding and actionable recommendations. Moreover, healthcare professionals and the licensing boards that govern their requirements and practice should consider integrating the findings of this study into their practices and requirements.

Additionally, collaboration between researchers, licensing boards, healthcare professionals, and survivors is important to ensure that research findings are effectively translated into practice. Healthcare professionals are mandated to engage in CEUs to maintain their healthcare licenses. It is important to advocate for increased funding and resources, such as CEUs, that cover topics surrounding clinical hypnotherapy for treating other complex traumas so that healthcare professionals can feel confident to utilize this approach for treatment. Supporting ongoing research and implementation efforts will also provide survivors who are seeking recovery treatment with knowledge on the use of hypnotherapy and debunk commonly believed myths about being placed under trance. As evidenced by this study, further research and practice are necessary to determine whether clinical hypnotherapy should be more frequently utilized as a treatment approach for adult survivors of CSA.

Implications of the Study

The insights from the study could contribute to positive social change by creating more opportunities for healthcare professionals to gain knowledge on the use of clinical hypnotherapy and how this treatment approach can provide quicker recovery than more commonly used treatment approaches. Researchers could use the study's findings to

advance professional practice and the community on treatment approaches that can aid adult CSA survivors in recovery in a timelier manner. Healthcare professionals must advocate for the accessibility to more education and training on holistic approaches such as hypnotherapy to aid in recovery for their clients with complex traumas.

Conclusion

I conducted this study to understand and describe the lived experiences and perspectives of licensed healthcare professionals regarding their treatment of adult survivors of CSA. Through one-on-one interviews with six participants, I generated a picture of the essence of their experiences, highlighting the treatment approaches they found to be effective, approaches they lacked, and the behaviors of the survivors being treated. I conducted interviews via video with licensed healthcare professionals who currently, or in the past, have treated adult CSA survivors.

Healthcare professionals rely on the available resources and education to treat clients. These healthcare professionals are knowledgeable of several treatment approaches for treating adult CSA survivors. Still, they all agree more knowledge on less commonly used approaches, such as hypnotherapy, can assist them in leading their clients to optimal recovery. Hypnotherapy has been used over the last decade for psychological treatment, thus being a form of recovery that can provide positive results for survivors who experience this form of trauma (Laveture et al., 2002). The insights gained by this study will also help the scholarly and healthcare community by shedding light on the minimal usage of holistic approaches in treating complex traumas such as CSA. While I have a better understanding of expected behaviors CSA survivors exhibit, there is still a

lack of knowledge on whether clinical hypnotherapy should be utilized more frequently to treat adult CSA survivors.

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Appendix: Participant Interview Questions

1. How long have you been a healthcare professional, and what areas do you specialize in your practice?
2. Throughout your professional career, describe your experiences treating adult childhood sexual abuse survivors (CSA). What have you observed regarding the outcomes of the treatment approaches you utilize treating CSA survivors?
3. What is your awareness of the efficacy of using clinical hypnotherapy for adult survivors of childhood sexual abuse?
4. If any at all, is it often that you have made referrals for clinical hypnotherapy for CSA survivors?
5. What are some indicators that you typically notate for referrals of CSA clients for clinical hypnotherapy? If there are no current indicators, what would be appropriate to notate for this reason?
6. Can you describe any barriers or hesitations you have had, or would have to referring an adult CSA survivor for hypnotherapy treatment?
7. What does the treatment of survivors look like from the view of the survivor? How do choose which treatment approach to use for each survivor you treat?
8. We know that CSA survivors exhibit irrational or destructive behaviors. Do you feel there is a link to possible unresolved trauma? If so, can you explain further?
9. Do CSA survivors struggle with forming health attachments? If so, what have you experienced with your clients?

10. In your experience as a clinician, do you feel CSA survivors struggle with hypersexuality, and do you believe this behavior can exist in the unconscious?
11. Is there anything else you would like to share regarding your experiences that I may have overlooked but need to be informed on when working with CSA survivors?