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HYPNOSIS TO ENHANCE TIME LIMITED COGNITIVE–BEHAVIOUR THERAPY FOR ANXIETY

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This case demonstrates the use of CBT and hypnosis in managing the symptoms of anxiety experienced by a retired registered nurse. Her symptoms included panic attacks and heightened blood pressure when she visited medical specialists. Therapy was time limited to five sessions under the Enhanced Primary Care program. A research question was posed about the possibility of achieving success in this time frame, using CBT enhanced by hypnosis for exposure to both the symptoms of panic and situational anxiety. On completion of the sessions, there was a marked decrease in anxiety symptoms, and the patient was able to visit her doctors without undue elevation of blood pressure.

The cognitive theory of anxiety maintains that a person will experience anxiety when there is a stimulus from perceived threat of physical or social harm (Clark, 1999; Salkovskis, Clark, & Gelder, 1996). The stimulus acting is interpreted as a personal threat in order to provoke the anxiety reaction (Salkovskis et al., 1996). In its extreme, threat perception is related to panic disorder where certain stimuli cause feelings of imminent catastrophe (Clark, 1986). The cognitive theory of panic proposes that panic attacks result from those who interpret bodily sensations in a catastrophic way, such that they will have distorted beliefs about the danger of a situation (Clark, 1986, as cited in Ost & Westling, 1995; Clark, 1999). Patients may present with a list of physiological symptoms including appetite loss, weight loss, loss of energy and drive, fatigue, insomnia, sweating, high pulse rates, dizziness, tightness in the chest, palpitations, and shortness of breath (Beck & Zebb, 1994).

A paradox noticed in patients with anxiety and panic disorder is that repetition of experiencing no harm in feared situations fails to correct their fear beliefs (Clark, 1999). In behavioural terms, the fear or panic response is not extinguished by repeated and unreinforced presentations of the conditioned fear-provoking stimulus (Salkovskis et al., 1996). In cognitive terms, the fear

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continues, even though the patient is able to indicate understanding of the irrational nature of the fear reaction (Salkovskis et al., 1996). In spite of this understanding, thoughts or self-imagery of fears being realised are said to be a potent source of information used to reinforce feelings of imminent disaster (Clark & Wells, 1995). For instance, patients with health anxiety are able to describe recurrent images of rapid health decline and even death (Clark, 1999). These recurrent images in themselves become threats to the well-being of the individual experiencing them because they provoke increasing levels of anxiety and even panic.

Clark (1999) posits that a logical response to the imagined threats is to enlist safety seeking behaviour to avert the feared situation. Such behaviour is commonly seen when an individual suddenly leaves social company to seek a cooling breezeway, or leans against a wall seemingly to avoid fainting. In this case study, the example of a safety seeking behaviour in health anxiety would be thought suppression of the recurrent images of disaster related to health problems. The hypothesis is that the apparent safety gain of thought suppression maintains anxiety and panic because it prevents the person facing the imagined fears which, if faced, would assist in disproving the feared imminence of catastrophes. In effect, a simple act of thought suppression is said to maintain negative beliefs.

Thus, interventions to modify catastrophic conditioning suggest challenging fear cognitions directly by having the patient experience the feared situations until the sense of anxiety reduces to sub-clinical levels (Clark, 1999). In cases of health anxiety, eliciting fears using imagery is one method of cognitive–behavioural treatment for anxiety and panic disorder, and it has demonstrated significant successful treatment outcomes (Clark, 1999; Ost & Westling, 1995). Additional management techniques such as teaching breathing control and relaxation have also been used to assist the patient to build behavioural confidence (Ost & Westling, 1995).

Hypnosis is also a probable additional management technique because it has been shown to be effective as an adjunct to cognitive–behaviour therapy in treatment of anxiety disorders (Evans & Coman, 1998). It has been posited that hypnosis supports the mechanism of action in therapy to proceed more rapidly. First, hypnosis is suggested as a technique for securing a vivid, clear and strong image of the feared situation that needs to be cognitively challenged. Second, the client is able to build their confidence to manage anxiety symptoms by facing the fears in trance and obtain reinforcement of the cognition of their

ability to cope, which enhances their self-efficacy and strengths (Evans & Coman, 1998, p. 71).

The specific research question in this case study is whether the number of treatment sessions can be reduced to below the number of sessions generally supported by empirical studies when hypnosis is introduced as a support to therapy. Without the support of hypnosis, 12 sessions were used in research studies supporting the treatment applied in this case study (Clark et al., 1997; Ost & Westling, 1995). Reduction in sessions while maintaining efficacy was considered by Ost and Westling (1995) in their group study comparing applied relaxation and cognitive therapy techniques. Subsequently, Clark (1999) successfully reduced the number to seven treatment sessions in a controlled trial for panic disorder. It is hypothesised that, for this case, the number of treatment sessions required to achieve measurable treatment effect will be reduced when hypnosis is used as an adjunct to CBT.

CASE HISTORY

Ms M was referred by her GP for chronic anxiety management, which he felt was interfering with her ongoing health prognosis related to cardiovascular problems. The referral was made under the Enhanced Primary Care program, which allowed five sessions with a part rebate being given by Medicare.

Ms M presented as verbal and cooperative, although she described herself as shy and anxious. She reported a happy marriage and family over 35 years and a nursing career with retirement at age 55. This career was maintained in teaching hospitals and in her last appointment she cared for cardiac and stroke patients. She acknowledged that her work experiences may have contributed to her anxiety state.

Psychological Symptoms

At age 64, the client presented with symptoms of panic and anxiety related to fear of stroke due to high blood pressure. Symptoms of anxiety were dizziness, light-headedness, sharp 'shard-like' pain in her brain, plus a sense of pins and needles in the scalp, increased heart beat, rise in pulse rate, difficulties in concentration, stomach cramps with toiletry urgencies, nausea, and excessive perspiring. Problems in falling asleep and wakefulness were also reported. The somatic symptoms were increasing in intensity and frequency and were beginning to support the onset of agoraphobia.

Medical Symptoms

The client reported feeling more vulnerable to health problems since menopause. This vulnerability was reinforced when she developed hypertension and was diagnosed with a blood thickening disorder at around retirement at age 55.

At age 57, the patient experienced symptoms of back pain, dizziness, and reported feeling cold and sweaty. She attended specialist referral for review. During an angiogram the client overheard a comment which led to her belief that she was going to die, especially since the only person she had ever observed having an angiogram had died during the procedure. At this point, her blood pressure escalated dramatically.

Indeed, the tests revealed blocked arteries and a quadruple bypass was performed. She reported she had a transient ischemic attack (TIA) or mini-stroke immediately after her operation; however, the TIA left no long-term measurable cognitive effects. Since the procedure, the client had regular checkups, which involved travel to Sydney to consult with specialists. Five years later the client had to have urgent surgery to clear her carotid artery. At the time, her blood pressure was measured at 200/100. These real health issues, together with her special health career knowledge, sensitised the client to possible negative health outcomes and caused catastrophic fears of specialist appointments.

SUITABILITY OF HYPNOSIS IN THIS CASE

A verbal history was taken. There were no contraindications to the use of hypnosis in the treatment design. The client was not clinically depressed or suicidal, and had no indicators of psychosis. The client's motivation and interest in pursuing hypnosis was taken as the first step in the suitability of use of hypnosis. She was able to relate to the explanation of hypnosis being an altered state of consciousness, such as being lost in a book, and indicated that she had good visual imagery. She was curious about the process of hypnosis and willing to experience it as part of her treatment.

Because of time limitations, the Arm Drop Test as described in Barabasz and Watkins (2005, p. 94) was used to give a rapid indication of the patient's potential response to hypnosis. Ms M's hand moved about 10 cm, indicating that she was responsive to suggestion and probably capable of reaching a light to medium trance state. This level of potential hypnotisability was considered sufficient for treatment as planned.

THE GOALS OF THERAPY

The goals of therapy were to:

1. Assist the patient to manage the physical symptoms of anxiety and panic and to develop a sense of mastery over catastrophic thought processes, which fuel anxiety.
2. Reduce the situational anxiety felt when she attended doctors' appointments.
3. Increase Ms M's sense of self-efficacy and enable her to cope.

DIAGNOSIS

A differential diagnosis using DSM-IV was made of situationally bound panic attacks (APA, 1994). This was discussed with the client. A behavioural analysis revealed that symptoms of anxiety and panic increased when she anticipated going to the specialist. In these instances, the client described anxiety and fear reactions, hyper-vigilance, heart palpitations, headaches, and difficulty breathing, together with negative and catastrophic thoughts about what might occur. Anxiety and panic levels were reported to have generalised to other situations, such as going shopping.

METHOD

Design

A five-session program of cognitive–behavioural therapy (CBT) and hypnosis was designed to address specifically the prime therapeutic needs of the client, which were to reduce disabling anxiety and panic reactions to feared stimuli. The clinic sessions were to be supplemented by homework. The first element of treatment was to build coping skills and self-efficacy in order to control the physical symptoms of her anxiety. The second element of the treatment was to expose the client to her identified fear-provoking stimuli and to provide hypnosis to allow the facing of the specified fears during trance. The mechanism of action in the treatment was hypothesised to be exposure that was explicitly used to test the client's beliefs and predictions about the dangerousness of a situation.

PROCEDURE

The client's indicated levels of depression, anxiety, and stress were measured with the Depression, Anxiety and Stress Scale-21 (DASS-21), a 21-item instrument normed in Australia, to enable self-report of symptoms of depression, anxiety, and stress over the previous week (Lovibond & Lovibond, 1995), in two time periods — at baseline (the first assessment consultation) and at the end of treatment (fifth consultation).

Session 1

A history for assessment was taken. The process of CBT was explained after providing psycho-education regarding physiological stress and anxiety response as well as the role of cognitions (thoughts) on anxiety. The benefits of using hypnosis as an adjunct to CBT to increase the efficacy of therapy were discussed.

In the first treatment session, the client's breathing rate was measured at 18 breaths per minute. Next, she was given breathing exercises for controlled breathing, which brought down the rate to normal levels of around 10–12 breaths per minute (Andrews, Crino, Hunt, Lampe, & Page, 1994). This exercise was practised several times with the therapist. She was given homework to practise the procedure regularly. The Subjective Units of Distress Scale (SUDS) (Andrews et al., 1994) was introduced as a way of expressing the degree of anxiety experienced at any time.

For homework, the client was asked to commence to note her levels of anxiety throughout the day, using the SUDS, and to notice her thoughts at the time.

Session 2

Ms M reported some positive success in managing symptoms by using the breathing exercise. She was able to use distraction techniques to reduce triggering to anxiety; for example, using her hobby of spinning on the spinning wheel and knitting. The homework exercise of noting anxiety and her thoughts enabled the client to begin to link her negative thoughts with the anxiety she was experiencing. Discussion of some of her noted thoughts enabled the commencement of the process of challenging irrational thoughts. The drop arm test was performed, indicating a positive response to suggestion. Relaxation exercise using progressive muscle relaxation (PMR), deepening by

counting, and safe place visualisation was presented. Soft background music was chosen to focus the attention and assist relaxation (Walker, 1998). The client appeared to relax quite well after a few minutes. The therapist suggested that her ability to relax would improve with practice, which she was encouraged to do between sessions using the CD of the relaxation session.

Session 3

Ms M reported that she found she had been able to analyse her thought processes during the week, and was challenging negative self-talk. The client reported increased self-belief and confidence in managing her anxieties. She reported practising breathing and relaxation daily and was keen to try hypnosis albeit with a little apprehension.

Naturalistic induction was applied following the Havens and Walters (2002, p. 70) model, which is recommended for patients who are anxious. The client was responsive to the induction, a visualisation of a lovely garden was used, followed by suggestions of becoming more able to cope, becoming more confident, being able to overcome her fears. The symbol of peace suggestion was included (Newton, 1998). A CD of the session was prepared for practice and feedback from Ms M was that she felt very relaxed and heavy.

Session 4

Ms M reported increased confidence in hypnosis and thus it was decided to induce an anxiety state/panic in the therapy session to demonstrate to the client her ability in managing and reducing the physical symptoms. This technique was adapted from Marlene Hunter's script on "Defusing Panic" (Hunter, 1994, pp. 110–114) and the rationale for this process was discussed with the patient. Prior to the hypnosis, Ms M was able to describe her symptoms in the order they occurred and how she felt physically with each symptom, so that the therapist was able to adapt the script to suit her unique context.

The induction that was used was an adaptation of the naturalistic induction as used in Session 3 that the client had said she had particularly enjoyed. The adapted defusing anxiety script was then presented (Hunter, 1994) and Ms M was able to create the symptoms of anxiety in the session and reduce these as the script suggested. The use of ideomotor signalling by index finger during the process and the use of deep cleansing breath when anxiety symptoms had abated proved a sound method of communication. As per the script, the experience of raising anxiety to a higher level, and then lowering it, was

repeated. Ms M expressed surprise and happiness that she had been able to achieve this result and reported feeling confident in her ability to manage her anxieties.

For homework, the client was to practise relaxation. In addition, she was to make a list of the steps involved in visiting the specialist and having her blood pressure taken, so that we could work on hierarchical desensitisation in the next session.

Session 5

Ms M reported that her panic attacks had substantially reduced in frequency and intensity. She said she was feeling some anxiety regarding her impending visits to the specialists, with concern that her blood pressure would be high. However, she had prepared a list outlining the steps involved in visiting the specialist.

In this session, a brief PMR induction was utilised, followed by deepening using the counting method. Ms M was then asked to visualise the visit to the specialist, and as each stage on her list was visualised her SUDS levels were monitored. Ms M was encouraged to remain at each stage, using her skills of defusing and positive affirmation, until she signalled that she was calm and in control and the SUDS levels had significantly dropped to acceptable levels. Therapist observation of her breathing rate and posture also enabled feedback.

Her stages were as follows:

1. waiting in doctor's waiting room,
2. being taken into doctor's examination room,
3. doctor coming in, talking to her,
4. doctor putting blood-pressure cuff on,
5. doctor pumping cuff (positive affirmations: it's okay, my pulse is normal, it's usually very low), and
6. doctor releasing cuff, listening.

The client's response to the exposure was positive and Ms M was given a CD of the session to practise if she wished; it was suggested that she continue to practise her relaxation.

RESULTS

Ms M responded positively to CBT/hypnosis for her anxiety. Two weeks later, she attended specialist appointments and reported remaining calm prior to, and during, the visits. She said she used affirmations to strengthen confidence and told me her blood pressure had not become elevated as it had on former visits, and was measured at 170/70. She said she felt further encouraged by the specialist commenting favourably regarding her relaxed demeanour. Ms M reported that anxiety and panic responses brought about by fears triggered by thoughts of medical appointments were substantially reduced to acceptable levels.

The client's DASS results at Session 1 for depression and stress were in the severe range and anxiety in the extremely severe range; however, by the end of session 5, her scores on depression, anxiety, and stress were in the normal range.

DISCUSSION

This case partly answers the research question of whether a limited number of treatment interventions could demonstrate treatment effect. However, although hypnosis was used, it is not possible in one case study to form a nexus between its efficacy in treatment support and a consequent reduction in the number of therapy sessions. The client's compliance in completing homework exercises and her strong motivation were also likely factors in treatment success.

However, with these limitations in mind, it appears that the use of hypnosis enhanced the CBT to enable the management of anxiety within the limited sessions available. The client certainly responded positively to hypnosis by suggesting it as a main component responsible for her treatment outcome and the process of induction and deepening generally relieved anxiety (Hammond, 1990). Moreover, the use of hypnotic trance to work on exposure allowed the imaginal exposure to be more realistic, and the resulting lowering of anxiety symptoms more rapid. It has been found that enhanced scene visualisation using hypnosis produced better and quicker results during the desensitisation process than with traditional behavioural desensitisation (Glick, 1970, as quoted in Hammond, 1990).

In some way, this case study has added to the literature that supports the addition of hypnosis as an adjunct to a specific model of cognitive and behavioural treatment of anxiety with panic disorders. The prime element of this treatment is that clients learn strategies to manage physical symptoms and

understand how specific triggers of their anxiety produce negative automatic thoughts that falsely predict catastrophic outcomes. The treatment ingredients included in this case study were education, verbal discussion, imagery modification, attentional manipulations, exposure to feared stimuli (Clark, 1999), and breathing control inspired by the success of Ost and Westling (1995). Hypnosis was able to enhance the efficacy of treatment (Evans & Coman, 1998, p. 97).

CONCLUSION

The use of hypnosis as an adjunct to CBT was shown to be a successful, brief, solution-focused approach to provide relief from anxiety and panic. Hypnosis enabled benefits to be experienced quickly, and the adherence to practice between sessions reinforced these benefits. Further research would be needed on a larger scale, however, to be able to generalise from the findings of this case study.

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