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# The Place of Hypnosis in Psychiatry, Part 4: Its Application to the Treatment of Agoraphobia and Social Phobia

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*This paper, the fourth in the present series, is based on a world-wide search of the literature, and focuses on the use of hypnosis in the treatment of social phobia and agoraphobia. Both disorders are complex and difficult to treat. Several explanations of the aetiology of social phobia and agoraphobia have been suggested over the years, but researchers are in agreement that, in both disorders, patients have frequently suffered inadequate parenting and experienced a huge amount of anxiety in early life. It is for this reason that therapists using psychodynamically orientated psychotherapy in treatment, must take great care to provide patients with the space to come to terms with these inner conflicts. Hypnosis is employed as an adjunct to therapy: It is used to help patients to reduce cognitive and physical symptoms of anxiety and provides them with more control in everyday situations. The author reviews a range of treatment procedures which have been shown to be highly effective in the treatment of both social phobia and agoraphobia. Some of these treatments are based on behavioural lines, but all of the approaches, to a greater or lesser extent, explore the psychodynamics responsible for the condition. Detailed accounts of the treatment procedures are given so that practitioners may incorporate these techniques in clinical practice. Implications of treatment are discussed.*

Phobias, according to the DSM IV classification (American Psychiatric Association, 1994), are contained within the category, "Anxiety Disorders." In this journal, Kraft and Kraft (2006) gave an account of the use of hypnosis in the treatment of both anxiety disorders and sleeping disturbances. It is clear that, from the classification above, phobic anxiety comes under the remit of

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anxiety disorders; however, due to the complex nature of both agoraphobia and social phobia, the author has decided to devote this paper to the subject. The following study looks at the way in which hypnosis has been employed as an adjunct to psychodynamic psychotherapy in the treatment of agoraphobia and social phobia. These disorders will be elaborated now and the role of hypnosis in their treatment considered.

## AGORAPHOBIA

Agoraphobia is a very complex condition and varies from person to person. The *Shorter Oxford Dictionary* (OUP, 1993) defines the term as "an irrational fear of open spaces"; however, the Greek word "agora" literally means "assembly" or "market place." Individuals suffering from agoraphobia are anxious about a range of places or situations outside the comfort and safety of their home, although this can be extended to other places near or around the local area. These places are known as "comfort zones" (Chambless, 1982). Agoraphobics can indeed fear open spaces, but can also be afraid of being in a crowd, standing or walking across a bridge, travelling in a car, on a train or bus, being alone, standing in a field, meeting friends, climbing hills, going shopping, walking amongst tall buildings, and some fear different types of weather. The effects of agoraphobia vary considerably: some individuals are housebound while others are able to venture into the outside world, albeit with varying degrees of success (Buglass, Clarke, Henderson, Kreitman, & Presley, 1977; Chambless, 1982); further, each person can experience fluctuations within a week or month, and traumatic incidents in everyday life can often have a deleterious effect on wellbeing. In many instances, agoraphobic patients feel that they cannot escape a situation and most go at lengths to avoid difficult situations which might potentially set off a phobic response: Agoraphobia is often accompanied by panic attacks and these, according to DSM IV, can produce a range of symptoms. These include: palpitations and accelerated heart rate, hyperhidrosis, trembling or shaking, shortness of breath, choking sensations, chest pain, nausea, abdominal pain, dizziness or light-headedness, dissociation and/or feelings of depersonalization, feelings of losing control, fear of dying and hot flushes.

More often than not, individuals with agoraphobia stop working or begin to develop phobic attacks as a result of having stopped work (Ellis, 1980; Katerndahl & Realini, 1997); furthermore, their reduced mobility outside the house affects overall quality of life (Leon, Portera, & Weissman, 1995;

Milne, 1988). Others continue to work or expose themselves to their own personal feared situation or place, but continue to be anxious, and this is often associated with intermittent panic attacks. However, agoraphobia is selective and in some cases, for instance, on special occasions, individuals are able to cope with a feared situation with a companion or "safe partner." However, these associated panic attacks can be so traumatic that many sufferers avoid any situation which might lead to a reaction and, as the condition worsens, more complex avoidance patterns begin to emerge. Some individuals who have been suffering from agoraphobia for a period of time complain that the mere anticipation of having a panic attack is enough for them to avoid, or be fearful of, a specific situation or place: Some authors refer to this as "the fear of fear" (Goldstein & Chambless, 1978; Kraft & Kraft, 2004).

Agoraphobia is very difficult to treat and its aetiology often centres around complex and irregular family dynamics: It is for this reason that treatment tends to be long-term (Milne, 1988). A number of case studies has shown that agoraphobia can be treated using behavioural procedures, and successful results have been reported using systematic desensitization (Kraft, 1967; Wolpe, 1958), group exposure (Teasdale, Walsh, Lancashire, & Matthews, 1977), flooding (Matthews et al., 1976), in vivo exposure (Emmelkamp, 1980), and hypnosis (Mellinger, 1992; Gruenewald, 1971). Agoraphobia has also been treated using antidepressants (Mavissakalian & Michelson, 1986), psychotherapy (e.g., Shilkret, 2002) and CBT (Beck & Emery, 1985). However, whether hypnosis is used as an adjunct to therapy or not, due to the complexity of this condition, it is extremely important for clinicians to provide clients with the opportunity to come to terms with the psychodynamics responsible for their condition. The following looks at how hypnosis can be employed to accelerate and enhance treatment in clinical practice.

An extensive search of the literature has uncovered seven studies which have used hypnosis in the treatment of agoraphobia: The first two studies (Gruenewald, 1971; Jackson & Elton, 1985) use a hypnoanalytic approach with age regression, the third and fourth studies (Hobbs, 1982; Schmidt, 1985) both use audiotapes, the fifth study (Mellinger, 1992) employs a hypnotically augmented multidimensional approach, while the sixth study (Roddick, 1992) uses a fantasy technique to encourage cognitive re-structuring. Finally, the seventh paper (Milne, 1988), is useful in that the therapist employs a number of approaches in treatment including group therapy, ego strengthening and the gradual introduction of hypnosis from a process similar to meditation. In all of these studies, with perhaps the exception of the final study (Roddick,

1992), the treatment hinges on an exploration of the family context in order to uncover the sources of the agoraphobia.

## Hypnoanalysis and Age Regression

Often in treatment, agoraphobic patients are highly resistant, and therapists need to make some important decisions about the treatment program and how to utilize these actions in order to effect change. In addition, the source of the phobia may lie in the distant past and focus on traumatic events in childhood involving one or both of the parents. When using age regression and/or hypnoanalysis in hypnosis, it is important to encourage the patient to explore safely their recollections of these traumatic events, but this must be done with care, and, at all times, exposure to these events should be combined with positive enhancement and ego strengthening. It is also recommended, when using age regression, to employ a dissociative technique during the process: This might include, for example, the patient watching a younger version of herself, watching a film or seeing a reflection. It is essential that the therapist should provide the patient with the opportunity to integrate the present with this past, traumatic experience and that the purpose of the regression should be to help her to learn from this event and to become stronger as a result.

Gruenewald (1971) described in detail the successful treatment of a 58-year-old woman who had had a 43-year history of agoraphobia with concomitant vertigo and anxiety attacks. She had an overwhelming fear of crossing the road, and she was petrified that she would fall over and hurt herself. In addition, she felt helpless, insignificant and small in comparison with tall buildings; these buildings seemed to close in on her and "crush her to death." In the past, her over-protective husband would accompany her for short distances around the neighbourhood, and would fulfil daily tasks for her, thus self-perpetuating her condition; however, her husband's failing health caused him to be less protective. As a result, she derived fewer secondary gains from her condition, and this, in turn, provided her with a rejuvenated motivation for therapy.

Born in Russia, the patient recounted early in treatment the fact that she had lost her only sister at the age of five, and as a result of her father's underground activities had had to leave the country shortly after this event. The patient described her mother as "hostile towards men," and she passed this hatred on to her daughter. She described the move to the U.S.A. as a frightening one: Both she and her mother, with some justification, felt that

they would be attacked or sexually assaulted by the soldiers on the train. But her main fear was one of abandonment: She feared that she would be left behind. This feeling was exaggerated when she arrived in the U.S.A. because she was retained on Ellis Island in order to recover from residual trachoma.

Later in treatment, the patient described her fear and trepidation when going to high school, and it was essentially at this time, aged 15, and at the time of menarche, that she developed agoraphobia and depression. She was unable to go to school, and were it not for her two brothers, who later took her to and from school, she would not have had a high school education at all. At the age of 20, the patient described having a complete breakdown and said that she had become "totally immobilized," and consequently spent most of her time in bed with severe headaches. With her father's help, aided by his optimism and humour, she was able to work locally; at 24, she married, and at 30 gave birth to a daughter. Twelve years later, after a phantom pregnancy which turned out to be a hydatidiform cyst, she suffered from a second depression which centred around the fact that she had a disappointing marriage and, consistently, sexual intercourse was a frustrating experience for her.

After several weeks of psychotherapy, a treatment strategy was formulated which would consist of three to six months of systematic desensitization, some hypnoanalysis, together with further psychodynamically orientated psychotherapy. It was clear that during the first hypnotherapy session, there was a huge amount of resistance to treatment: This manifested itself in the patient's ambivalence towards the therapist. However, the therapist overcame this using an authoritative invitation to lie down and experience "a new kind of relaxation." After the induction and deepener, she spontaneously abreacted and, after this subsided, she was encouraged to feel sensations of soothing and was given direct suggestions of reintegration. The therapist used the first hypnotherapy session to establish herself as a figure of authority and control, and she felt that this would encourage the patient to have a positive transference.

However, after several weeks it became clear that, every time the patient was asked to be active in the hypnosis, she resisted: She refused to give ideomotor signals, she was unable to simulate any sensory changes given by the therapist, and she refrained from carrying out the progressive muscle relaxation exercises at home. Later on in the treatment, the therapist employed scene visualization and sensory imagery and this started to reduce her anxiety; however, she began to develop a second psychosomatic symptom—sciatic pain. The therapist cleverly suggested that her unconscious mind "didn't have

to acquire a secondary symptom" if she wanted to get rid of the old one, but, if she wanted, she could consult a medical doctor on the subject about her "symptom substitution." This suggestion had the desired effect, as the mere prospect of having to pay extortionate private medical fees was enough to eliminate this secondary manifestation.

The psychodynamic psychotherapy at the beginning of each session was used to encourage the recall of stimuli in the hypnoanalysis. In the following weeks, the patient recalled three memories in her past which illustrated the roots of her agoraphobia. One recurring image was at the age of four or five. The patient described nearly drowning, and looking at nude men and women bathing in a lake; although the mother was there to revive the patient, she was absent in the fantasy image. This reinforced the therapist's opinion that one of the sources of her problem was her fear of being abandoned; the therapist gave the patient space to come to terms with her infantile erotic fantasies, her fear of abandonment and death.

The second memory was when the patient was aged seven, and it was here that she recalled various children taunting a psychotic woman. After some time, she realized that the significance of this visualization was that she identified with this lady, and it was connected with her fear of failure. The third memory dated back to her ninth or tenth year. The memory consisted of her riding on her bike only to have her mother reprimand her when she got home. Her mother told her that there were many dangers outside: She realized at this point that she was made to feel that the outside world was a place that was associated with fear and trepidation. The patient also said that she enjoyed lying in the meadow, and the therapist utilized this memory to encourage feelings of strength and renewed hope. The age regression, in all cases, was used to set the patient on a new path, where she was in charge of her destiny. After these hypnotherapy sessions, the therapist then encouraged the patient to address this material and work through it, and she also set a time limit for the end of treatment. At the follow-up, a year later, she said that she was coping well, she had improved control of her anxiety and was coming to terms with her husband's increasing lack of mobility.

Jackson and Elton (1985), treated four females all of whom met the criteria for agoraphobia. In two of the cases reported, hypnosis was used as an adjunct to treatment. In the first case, the authors described the treatment of a 41-year-old lady, Mrs B, who had had a long history of suffering from agoraphobia. When she was considered for treatment, she reported that she was unable to travel on public transport and could not cope with crowded places on her

own. At the time, she was still taking amitriptyline (75-100 mg daily), and clorazepate (15 mg at night), and this was gradually stopped before treatment began. Over the next six months, Mrs B went to the senior author (Jackson) for treatment, and she experienced significant gains in the initial stages using in vivo exposure therapy alone. However, these gains stopped in their tracks and the patient complained that she had experienced anticipatory anxiety. Further, she pointed out that, although she was able to travel on a train, she had had a number of panic attacks, especially when visiting her mother or when she was the only woman in the carriage.

Using hypnosis with age regression, Mrs B described a traumatic party scene at the age of eight in which her mother encouraged strange men to undress and fondle the petrified girl. At this point, Mrs B abreacted and screamed that she hated her mother. Her ambivalent feelings toward her mother engendered guilt because she was now old and frail, but the acknowledgement of this was extremely empowering for the patient. She also pointed out that she projected the molesters' faces onto the men on the train and felt that they were going to harm her or undress her in a similar way. The therapist made sure that, during the age regression, she was connected with the present, and that she should use this past event to make her stronger in the future. Following this important session, Mrs B was able to tell other people—including her friends and family—about this experience, and this had a huge relieving effect on her anxiety. As a result, Mrs B was able to travel freely on public transport. However, this caused further problems in the family context: It seemed that the husband had a vested interest in keeping Mrs B immobile and, now that she was able to travel more freely, he became increasingly more introspective, increased his alcohol intake and underplayed her treatment gains. In the psychotherapy, Mrs B revealed that she had not had sexual intercourse with her husband for some time, and that he was impotent. It was clear that her phobia camouflaged her husband's condition and the therapy focused on accepting her ambivalence and feelings of guilt. At the follow-up, the patient was completely asymptomatic.

The second patient described by these authors was a 42-year-old lady who feared leaving the house, shopping and using public transport. The patient had sessions once a week for 11 weeks. Early on in the treatment, the patient complained that she would be unable to practise the in vivo desensitization work because of her uncontrollable fear that she would be attacked by her ex-husband. This fear was eliminated in a single two-hour hypnosis session in which she was exposed to scenes in which she was being attacked by her

ex-husband. She then began to carry out various in vivo exercises on public transport.

After several weeks, the patient reported that, although her children upset her, she was unable to voice her opinions because of her uncontrollable fear of losing them, and this caused her to carry around with her a huge amount of repressed anger towards her children. Over a number of sessions, the patient was encouraged to express these feelings to her family. She also continued to practise her in vivo exposure tasks and made significant improvement.

## Use of Audiotapes

In some cases, particularly in the early stages of treatment, agoraphobic patients are unable to get out of the house and go for treatment. It is, therefore, helpful to provide telephonic sessions or to arrange home visits in order to help patients overcome the immense fear associated with leaving the "safe zone."

Schmidt (1985) used a unique approach in the treatment of a 28-year-old female with agoraphobia. To begin with, she explained that she had developed agoraphobic symptoms after a prolonged trauma at work. In the first instance, she was unable to go shopping, and this caused a huge amount of anxiety; but this developed, and after a while she was unable to go further than her neighbour's house across the street. The therapist arranged for a house call, at which the patient insisted that her neighbour be present at least somewhere in the house. The treatment strategy was designed to start with autogenic training (Luthe & Schultz, 2001), and then moving on to goal-centred hypnotherapy: This was combined with the use of specifically designed audiotapes. The rationale behind this was that the initial training in hypnosis would give the patient immediate success and feelings of empowerment, and that a carefully designed imagery program on audiotape, if practised regularly and consistently, would desensitize the patient to public places.

In the first session, after initial history taking, the therapist demonstrated the six steps of autogenic training as described by Schultz (Jencks, 1973; Luthe & Schultz, 2001): During this part of the therapy, the patient was encouraged to attain relaxation by imagining changes through progressive muscle relaxation, temperature, feelings of heaviness or lightness, and reducing heart and respiration rates. Following this, the therapist discussed with the patient the treatment program which consisted of (a) audiotapes, which helped her to experience different levels of relaxation, using all the sensory modalities, and (b) a graded imagery program. The first scenario in the graded imagery

program was to practise, in hypnosis, going on a trip with her husband near to the house, and gradually these distances were increased. As the therapy progressed, the patient negotiated with the therapist that one of the final goals would be to be able to go to the shopping mall.

It is important in treatment that the patient begins to exercise control not only in the consulting room but also in everyday situations. The therapist recognized this and, when the patient stressed the importance of moving slowly towards each goal, he responded appropriately and to the benefit of the patient. Each new scenario, which gradually moved closer and closer to the shopping mall, was incorporated into a new audiotape, and subsequently mailed to the patient; further, on completion of each task, the therapist arranged for a telephone session. These sessions were essential for the following reasons: They provided her with the support and encouragement that she needed, but they also gave her the opportunity to discuss her progress, and also to make any necessary changes to treatment strategy. She also felt that she had involvement in the process, and her somewhat obsessive nature and motivation were utilized by the therapist: Indeed, she consistently practised the autogenic training on a day-to-day basis and reported back a huge amount of material relating to her personal associations and thought intrusions each stage of the treatment. Her therapist also gave her direct suggestions to meet friends during the week, and these suggestions were accompanied by feelings of lightness. He pointed out that these lighter steps would build her self-confidence and provide her with a new sense of optimism. The treatment lasted six months and, in a letter to her therapist, she commented that her progress had been maintained.

Another approach which utilized the use of audiotapes is one by Hobbs (1982). She outlines a treatment program emphasizing the fact that the agoraphobic patients become introspective and self-analytical and that the therapist should interrupt this pattern of behaviour in order to effect change. In addition, agoraphobic patients are often overwhelmed by external and internal stimuli—for example, sound, heat and cold, light, climate, crowds—and this hyper-suggestibility to all the sensory modalities can be utilized by the therapist in the hypnosis in order to provide them with the opportunity to effect change in their own environments.

Hobbs emphasized that the first consultation is critically important for agoraphobic patients—and all patients for that matter. When a patient comes for the first session, (s)he has made a conscious decision to comes to terms with the fact that (s)he has a problem that needs to be resolved; and, for some, the wait in the consulting room can be enough to provoke a panic attack of

some kind (Kraft, 2011). Hobbs points out that it is important not to keep the patient waiting for too long, and it is important to build good rapport—one that is based on trust and continued support— as quickly as possible.

Quite rightly, the author points out that the first two or three sessions vary from individual to individual, but suggests that all patients should be educated about the condition, and be provided with audiotapes and explanatory diagrams which explain the physiological changes which occur during panic attacks. Patients were also given questionnaires to complete in which they were asked to construct a hierarchy of difficult, potentially anxiety-provoking scenarios. Hobbs recorded the audiotapes in order for the patient to become used to her voice, and, although the tapes were educative, she included a large number of positive terms which, working as indirect suggestions, encouraged patients to become more confident. She also gave patients relaxation tapes to use at home. The first tapes used progressive muscle relaxation, and gradually hypnosis was introduced with guided imagery. As the treatment continued, Hobbs introduced patients to their hierarchy and worked through each scenario through the use of cue cards on which self-coping statements were written. As the patients became more desensitized to their own feared situations (Wolpe, 1958) they developed the ability to cope with their anxiety and eliminated the possibility of having a panic attack.

## Multi-Dimensional Approach

An interesting approach to the treatment of agoraphobia is one presented by Mellinger (1992). This report stresses the importance of the therapist being adaptable in his treatment approach; indeed, Mellinger had to change his strategy after the initial stages of treatment. The patient, Mrs G, suffered from agoraphobia with panic attacks, and had a number of associated phobias including a fear of flying, driving and shopping. In the first eight weeks of treatment, Mrs G was given the opportunity to talk about her situation and her fears. She was then briefed on cognitive restructuring techniques that would help her in the future, and on the basic principles of exposure therapy—that is to say, in vivo desensitization. She was also given a thorough explanation of her disorder and was taught progressive muscle relaxation. Further, she was given alprazolam which was gradually reduced to a maintenance dose of 1.5 mg three times a day.

In the next stage of treatment, Mrs G was prepared to begin her exposure therapy which consisted of gradually exposing herself to more difficult

anxiety-provoking situations. She planned to go to an all-night convenience store in order to buy some food; however, despite her preparation, applying both cognitive–behavioural strategies and using relaxation exercises prior to the expedition, she had a small panic attack in the shop. Mrs G reported that she had had a near escape in this situation, and as a result it was decided that they would use hypnosis and guided imagery in order to enhance her ability to cope in difficult situations before returning to the in vivo work. In this process, Mellinger also provided Mrs G with a powerful anchor which consisted of her touching her fingertips on her solar plexus, whispering the word "relax," and this method provided her with a sense of calm and even respiration. Mellinger also encouraged her to visualize herself watching herself on a television screen where she was able to adjust the volume, brightness and focus controls (Clarke & Jackson, 1983). She was able to adjust the volume in order to reduce the intensity of affect and, when working through the scenario of going to the shops, she was able to cope using this strategy. Further, she was encouraged to practise auto-suggestion by herself at home. After six weeks of this work, she started the in vivo desensitization again, using anchoring whenever she became anxious, and she practised this four to six times a week. A further five weeks of this work meant that she was able to go shopping regularly without panic and reduce her alprazolam intake. Mellinger commented that the hypnotherapy acted as a "flexible vehicle for fortifying [her] coping skills" and helped her to be more equipped to tackle real life situations, even after an initial relapse.

### Fantasy Technique

Roddick (1992) briefly described a case of agoraphobia in which he employed a fantasy technique in hypnosis. The patient he described was a lady who was unable even to be driven by her husband for more than a mile from her home. She had a number of associated symptoms which included dry mouth and nausea and had had to give up a successful career because of her condition. Roddick must have had problems of resistance during the initial stages because he pointed out that it took four sessions for her to get used to his approach and to be able to relax in his presence. He pointed out that, once she had got used to her therapist, he was able to use hypnotherapy successfully in the consulting room, and she began to make more rapid progress.

After the induction and deepener, Roddick addressed her unconscious mind and focused on the following:

1. The importance of practising self-hypnosis and general relaxation,
2. Being able to sit and travel in a car, and
3. Being able to eat and drink.

The therapist then suggested that the three parts should be combined in order to come up with a strategy that would enable her to cope with her agoraphobia without any problems whatsoever: This was confirmed as being an acceptable approach by the patient by way of an ideomotor signal. The strategy consisted of a "secret place fantasy" in which the patient was encouraged to throw out all her negative feelings and aspects of her life. After only two sessions, she reported that she was able to travel 200 km away to visit her family and, after a further eight sessions, she was able to drive herself to the consulting room. At the time of writing the paper, Roddick said that she continued to make progress, and had secured a full time job in the local area.

## Use of Group Therapy and Hypnosis

Gordon Milne (1988) reported the treatment of three women with complex agoraphobia, the most successful of which is reported below. At the start of treatment, the patient was still able to drive her car but only when accompanied by her husband. Her panic attacks were severe: She suffered from hyperhidrosis, dizziness, weakness of the legs, tingling of the hands of the feet, and, more alarmingly, depersonalization. On journeys, when she lost sight of her "safe partner(s)"—namely, her husband or her sister—she would suffer from constant thought intrusions which centred around the following fears: (a) worrying about collapsing in public, (b) going mad or (c) dying.

During the initial case history taking, she pointed out that she suffered from periods of depersonalization at school at the age of 12, and that she experienced a great deal of frustration due to the fact that no one understood her condition. She managed to control her panic attacks and feelings of depersonalization with psychotropic medication, and these attacks lessened as she grew older; however, two sudden deaths of close members of her family had reactivated her condition.

The patient was delighted to find that there were other individuals who were suffering from the same condition, and she became a regular member of the support group at the community centre. She pointed out her life was made a misery because her husband couldn't understand why she was unable to socialize, and he consequently spent more time drinking with his colleagues after work, which in turn caused a number of arguments late at night.

Essentially, the first part of the treatment was to get the husband on board, and to brief him about the nature of agoraphobia and the treatment strategy. The therapist arranged a joint counselling session to this end.

The next stage of treatment focused on reducing the panic attacks without the use of medication: A treatment strategy was put in place so that she would gain more control of her panic attacks and gradually reduce her psychotropic medication. Hypnosis was introduced as an extension to meditation, and she was gradually able to respond adequately well to the therapist's suggestions. Later in the treatment, in the hypnosis, she was given ego strengthening to provide her with the ability to function outside the comfort of her home, and, using guided imagery, she began by sitting in the car on her own and worked towards driving to the supermarket. This process of systematic desensitization was slow. Whenever she became anxious, she raised her finger and was able to reduce her anxiety by taking five deep breaths. This exercise was taped and she practised this religiously at home twice a day.

As a result of her work in the consulting room, at home with her practice tapes, and with the continued support which she gained from being able to share and listen to other people's experiences in the support group, she made a significant recovery. Indeed, the support group was extremely helpful in this process: Not only were they able to support each other during group sessions, but they were also able to help by giving each other lifts to and from the therapy sessions. By the end of treatment, the patient was able to drive herself without support from anybody else, and was regularly going out on social events with her husband. At the follow-up, a year later, her improvement had been maintained.

## SOCIAL PHOBIA

According to DSM IV, Social Phobia is characterized by a noticeable fear response to social or performance situations, and this is connected with a fear of embarrassment, or being judged by other people. When social phobics experience a difficult social situation, they invariably become intolerably anxious, and this can lead to a panic attack. Often, they will go at lengths to avoid these threats and, in many cases, this can lead to a significant reduction in mobility and contact with other people. Avoidance in social phobia takes on many forms: Some patients will even avoid eating, drinking or talking in public because they fear that others will notice their behaviour or concomitant symptoms (Milne, 1988). Individuals with social phobia may suffer from

the following—shaking hands, palpitations, blushing, hyperhidrosis, muscle tension, stuttering, gastrointestinal discomfort, persistent feelings of wanting to urinate and nausea.

Like agoraphobia, social phobia is extremely difficult to treat. In many cases, the source of the phobia is inextricably interconnected with the quality of their attachment with their mother from birth until the age of five (Bowlby, 1999). This attachment is essential for individuals to develop. If adequate love, attunement and comfort are provided at this stage, infants are able to begin to explore the world around them and this, in turn, leads to individuation, separation, the ability later to engage in meaningful personal relationships and to pursue a professional career (Frankel & Macfie, 2010; Kohut, 1984; Winnicott, 1984). Inadequate attachment at this stage leads to a poor sense of identity and lack of both confidence and personal autonomy in adolescence and childhood (Winnicott, 1984): This can cause a constant fear of losing significant partners and friends. Some use self-sacrificing techniques in order to maintain relationships (McWilliams, 1994), while others are unable to assert themselves or display independence in their everyday lives.

The literature search revealed only a small number of case reports that used hypnosis to treat social phobia. The treatments of choice had tended to be psychotherapy (Leichsenring, Beutal, & Leibing, 2007), CBT (Taylor, 1996), pharmacotherapy (Versiani et al., 1992) or systematic desensitization (Marzillier, Lambert, & Kellert, 1976). However, there are two studies that used hypnosis in treatment: Lipsett (1998) who combined cognitive therapy with systematic desensitization (both in hypnosis and in vivo), and Frankel and Macfie (2010) who reported a case in which the therapist used insight-oriented psychodynamic psychotherapy and hypnosis. It was clear that, in both cases, to a greater of lesser extent, it was important that the hypnosis was combined with a thorough psychodynamic investigation of patients' dependency and separation, avoidance behaviour, feelings of guilt, and fears of rejection in both present-day relationships and as an infant.

Lipsett (1998) used a multi-modal approach in the treatment of a 26-year-old man with social phobia. In the first session, the patient, Eric, described how uncomfortable he felt in what he called "unstructured" social situations: He complained that he was unable to relate to people and, although he had some good friends, felt that he was handicapped in social situations, particularly with new people. Eric was asked for a goal to work towards, and he said that he wanted to be able to approach strangers with ease and to make new friends; the first goal, however, was to be able to walk into a hotel and

have a conversation with a stranger. Eric was then given direct suggestions of wellbeing and how the hypnosis would provide him with more control of his life, his control being enhanced with ideomotor signalling. In the second session, a cognitive approach was used in order to help Eric fulfil his potential with his communication skills. He was also taught self-hypnosis and was asked to practise this twice daily: It was explained to him that this would condition his sense of relaxation when it was required. He was also asked to read Matthews' (1990) *Making Friends*.

In the third session, these "unstructured" social situations were reframed so that Eric would be able to define the parameters of the interactions—for example, he would be able to engage in conversation, talking about the topic of his choice. During the hypnosis, and using the principles of systematic desensitization, Eric was then encouraged to buy a drink and to have a conversation with a stranger in a hotel. The therapist also gave Eric ego strengthening and asked him to imagine in detail a mental representation of a confident Eric engaging comfortably in social situations in the future. This was combined with self-image work (Langton & Langton, 1983), tracing back all the steps that helped him achieve this goal. Finally, as a homework task, Eric was asked to go into a hotel and to make conversation with a stranger, and that this should be done between now and the next session.

In the fourth and final session, Eric reported that he had had a successful conversation in a hotel and had been bought a drink. Eric did, however, point out that he dreaded walking in and that he felt chest pains. Lipsett asked Eric to move from chair to chair. First, he asked him to say what he saw when he wanted to be able to enter the hotel; secondly, in the next chair, he asked him what he heard when about to enter the hotel, and at this point he said that he heard his father's voice tell him that he "could not go in there." Using a somatic bridge, Lipsett instructed Eric to follow his paralysed feelings back in time: He identified that the source of his problem was at the age of three when he was terrified of his father's anger, and he said that he wanted to 'be safe'. The therapist then instructed the older, wiser Eric to comfort this little boy, telling him that he would "be safe." As a result, Eric said that he was able to enter a hotel with feelings of being in control and that he no longer froze or had the unpleasant chest pains.

The second study, provided by Frankel and Macfie (2010), consisted of a single case study of a lady in her twenties who, although described as having social and performance anxiety, displayed all the features of social phobia. She avoided confronting friends and family when she was angry; she experienced

accelerated heart rate and impaired attention; she had extreme difficulty in forming meaningful relationships with friends and potential romantic partners; and was obsessed with time management and meeting deadlines at work. The treatment consisted of 13 months of insight-orientated psychodynamic psychotherapy on a weekly basis, which amounted to 58 sessions in total, and this was combined with hypnosis.

In the psychotherapy, the therapist revealed that, as a result of inadequate attachment experiences as a child, the patient, Ms A, had struggled to develop into an independent and autonomous adult and was left feeling insecure and fearful of social situations. Her mother had developed cancer when Ms A was very young, and her fear of losing her mother was reactivated when the mother's cancer returned when Ms A was an adolescent. Importantly, the therapist provided the patient with a "safe space" and she was given support and encouragement in the consulting room: This secure environment made it possible for the patient to experiment with possible new interpersonal behaviours and explore the view of herself and others in her everyday life. The therapist provided an adequate attachment bond which, unlike her childhood experience, encouraged her to practise autonomous behaviours. The psychotherapy also focused on her avoidance of intimacy during adolescence and in adulthood; she explored the effect that her consistently unavailable mother had on her interdependence and began to shape a sense of identity.

Hypnosis was used in order specifically to focus on reducing anxiety in social situations. The therapist devoted several sessions to teaching Ms A self-hypnosis. During the hypnosis, the patient was encouraged to bring her mind to a "soothing and peaceful place," allowing the physiological manifestations of her anxiety—namely, the irritability, loss of concentration, accelerated heart rate, confusion and impaired attention—to disappear, and her mind to "refocus." Unfortunately, the patient used hypnosis inconsistently during the course of treatment; however, Ms A did used hypnotherapy successfully during difficult social situations, and she regarded it as an "on the spot intervention tool."

At the beginning of therapy, the mother's illness became rapidly worse and this had an effect on progress. The treatment significantly reduced her worries about time management but did not reduce the peak level of daily anxiety. The patient did, however, report that she had less rumination with regard to time management, while the daily self-reports indicated that there was a definite cognitive shift away from her anxious fears and worries. Ms A also

said that she had begun to place her own needs before other people's needs and felt that her behaviour was "less distressing": In the past, she felt unable to be forward with other people about her needs and preferences, but she was now able to communicate more successfully with others and to be consistently more "open." This resulted in a shift in her ability to trust others and, with the addition of hypnotic intervention, provided her with increased confidence in social situations.

## COMMENT

In the case studies reported in this paper, the main focus of the treatment was to establish the source of the phobia through the process of psychotherapy and, in both social phobia and agoraphobia cases, this source was associated with early trauma or inadequate parenting. It was also necessary to consider the role that marital and/or parental figures played in effectively maintaining or perpetuating the condition (Hand & Lamontague, 1976). The efficacy of in vivo exposure therapy has been established (e.g., Jansson & Ost, 1982), and it is recommended that clinicians incorporate in vivo desensitization into the treatment program using a hierarchy of anxiety-provoking situations—this work can be done between sessions.

The Milne study (1988) showed how helpful it was for patients to receive help from other people: Indeed, the patient in this study benefited significantly from the encouragement of her colleagues in the support group. Unfortunately, few support groups of this type exist; however, if group therapy is not available, it is important for patients to feel that they are not alone (Clarke & Jackson, 1983), and, as was the case in the Hobbs (1982) study, to be given education so that they can understand the physiological changes that take place during a panic attack.

Hypnosis is a powerful adjunct to therapy. The case studies presented here demonstrate that it has been highly effective in helping patients (a) to explore feared situations in a safe environment; (b) to reduce anxiety using desensitization; (c) to gain more control using anchoring, fantasy techniques and autogenic training; (d) to enhance coping strategies using ego strengthening and breathing techniques; and (e) to reduce affect using television screen imagery. Age regression (f) was also employed effectively to help a patient to address, and come to terms with, inner conflicts and traumatic events in early childhood. Finally, carefully designed audiotapes were employed to encourage two patients to practise self-hypnosis at home, and this had the effect of enhancing treatment outcome.

The use of hypnotherapy in clinical practice offers are more rapid and cost effective treatment for social phobia and agoraphobia, and it is recommended that it be used in conjunction with psychodynamic psychotherapy and/or in vivo exposure therapy.

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