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The Place of Hypnosis in Psychiatry Part 5: Treatment of Specific Phobias—Animal and Situational Subtypes

David Kraft
Private Practice, Harley Street, London

Part 5 of this series concentrates on the practical use of hypnosis as an adjunct to therapy in the treatment of specific phobias, focusing on animal and situational subtypes. The author evaluates the effectiveness of a range of interventions which have been shown to have been valuable in treatment. The report shows how hypnosis may be employed effectively in conjunction with behavioural approaches, including cognitive restructuring and systematic desensitization, psychodynamic psychotherapy, and dental treatment. There are a surprisingly large number of advertisements in the media which claim that phobias can be treated quickly using behavioural therapy; however, although in vitro desensitization and imaginal exposure have been employed successfully by clinicians, when the source of the phobic anxiety is in early childhood further psychological investigation is often required. This study discusses the implications of using a number of hypnotic techniques which have been employed in clinical practice.

Keywords: specific phobia, animal phobia, situational phobia, desensitization, integrative psychotherapy.

INTRODUCTION

Specific phobias have been treated using psychodynamic psychotherapy (Seligman, 1995), but the treatments of choice have been systematic desensitization with or without hypnosis (Craske, Mohlman, Yi, Glover, & Valeri, 1995; Emmelkamp, Bouman, & Scholing, 1989; Kraft, 1994), EMDR (De Jongh, Ten Broeke, & Renssen, 1999) and Virtual Reality Exposure Therapy (VRET) (Carlin, Hoffman, & Weghorst, 1997; Côté & Bouchard,

Correspondence regarding this paper should be sent to David Kraft, 10 Harley Street, London, W1G 9PF, UK; dmjkraftesq@yahoo.co.uk.

2008; Garcia-Palacios, Hoffman, Carlin, Furness, & Botella, 2002). DSM IV (American Psychiatric Association, 1994) states that the, "essential feature of specific phobia is [a] marked and persistent fear of clearly discernible, circumscribed objects or situations." Specific phobia is also accompanied by one or more of the following features: an anxiety response, uncontrollable fear, avoidance reaction and an interference of one's daily routine, including occupational and social functioning—and, as with agoraphobia, individuals usually experience one or more panic symptoms (Kraft, 2011). In almost all cases, specific phobia is related, in some way, to a fear of losing control (Kraft & Kraft, 2004; Kraft & Kraft, 2010), and sometimes patients fear having a panic attack or being embarrassed in public (Arntz, Lavy, Van den Berg, & Van Rijsoort, 1993). Some phobic patients fear, or anticipate fear, that they will come in harm's way: for instance, being scratched by a cat (cat phobia) or hit by a car (driving phobia). However, many adults come to realize that their fear is irrational—for example, the arachnophobic who is unable to say the word "spider" or read a children's book on spiders; alternatively, the phobia has symbolic value and is a manifestation of a deeply rooted trauma in early childhood or a traumatic incident later in life.

This report focuses its attention on two of the subtypes within the specific phobia category—animal phobias and situational phobias. The following table does not represent a complete list of studies which have used hypnosis to treat these conditions, but it nevertheless provides the reader with examples of both subtypes. An extensive search of the literature using MEDLINE, PsychInfo and EMBASE (in the first instance 1980–2010; and then 1930–80) has revealed a number of case studies and clinical trials that have used hypnotherapy in treatment—some comparative studies have also been included here for further reading.

Table 1: Specific Phobias Treated With Hypnosis

Animal type		
Phobia type	Author(s)	Treatment strategy/experimental design
Phobia of cats and dogs	Spiegel (1960)	Posthypnotic seed
Bird phobia	Scott (1970)	Relaxation; age regression; abreaction; theatre visualization and systematic desensitization
Bird phobia	Brann (2012)	Safe place imagery; "reason room" technique; use of older, wiser self-dialogue

Fear of dead birds	Van der Hart (1981)	Safe place imagery; gestalt dialogue
Mouse phobia	Kraft and Kraft (2010)	Systematic desensitization in vitro and in vivo; special place imagery; playfulness
Dog phobia	Schneck (1952)	Hypnoanalysis; visualization; ego strengthening; in vivo exposure
Dog phobia	Kraft and Burnfield (1967)	Systematic desensitization in vitro and in vivo
Snake phobia	O'Brien, Cooley, Ciotti, and Henniger (1981)	Systematic desensitization and posthypnotic dream suggestion vs desensitization only
Snake phobia	Milne (1988)	Age regression[1] in hypnosis
Spider phobia	Horowitz (1970)	Hypnosis. Relaxation vs fear arousal; suggestion vs no treatment
Spider phobia	Brown, Summers, Coffman, Riddell, and Poulsen (1996)	Reframing in hypnosis
Spider phobia	Brann (2012)	Cognitive reasoning in hypnosis; use of empathic metaphor
Wasp phobia	Brough, Yorkston, and Stafford-Clark (1965)	Systematic desensitization in hypnosis
Worm phobia	Brann (2012)	"Reason room" technique; psychotherapy
Slug phobia	Gustavson and Weight (1981)	Dream interpretation; age regression directed imagery; theatre technique

Situational type

Phobia type	Author(s)	Treatment strategy/experimental design
Dental phobia	Golan (1971)	Mastery imagery and suggestions
Dental phobia	Bills (1993)	Self-hypnosis; visualization; affect bridge
Dental phobia	Moore, Abrahamsen, and Brodsgaard (1996)	Hypnosis vs group therapy and individual desensitization
Dental phobia	Gow (2006a)	"Needle desensitization" (McGoldrick, 2001, see Gow, 2006a) and hypnosis; special place imagery; calm mantra; glove anaesthesia (Gow, 2002)
Dental phobia	Gow (2006b)	Hypnosis education; special place imagery; calm mantra; "tell/show/do" technique; implied causative communication, clenched fist technique, use of gate control theory (Melzack & Wall, 1965)

[1] Throughout this study the author refers to the term "age regression"; however, it is important to note that this technique should be used with care and he advises that, in most cases in clinical practice, some form of dissociative mechanism should be put in place before accessing previous traumatic experiences.

Dental phobia	Wilson (2006)	Hypnosis and systematic desensitization
Dental phobia	Rauch and Panek (2008)	Hypnosis and analgesia (anchoring); control of bleeding and gag reflex
Cancer phobia	O'Donnell (1978)	Implosion techniques
School phobia	Lawlor (1976)	Uncovering; strategic family support
School phobia	Valente (1990)	Hypnosis and mastering self-esteem
School phobia	Brown et al. (1996)	Hypnosis and use of metaphors and imagery
School phobia	Hudson (2009)	Hypnosis and solution-focused techniques
Claustrophobia	Kraft (1973)	Systematic desensitization and in vivo exposure
Claustrophobia	Velloso, Duprat, Martins, and Scoppetta (2010)	Management of claustrophobia in MRI examinations; use of safe place
Claustrophobia	Brann (2012)	Use of protective bubble (Alden, 1995)
Contamination phobia	Scrignar (1981)	Systematic desensitization; flooding; cognitive restructuring
Flying phobia	Deyoub and Epstein (1977)	Use of anchoring words; dissociation, positive mental rehearsal
Flying phobia	Bakal (1981)	Behaviour modification in hypnosis
Flying phobia	Spiegel, Frischolz, Maruffi, and Spiegel (1981)	Hypnosis and problem restructuring (systematic follow-up data)
Flying phobia	Milne (1988)	Systematic desensitization; bonding with baby
Flying phobia	Brann (2012)	Special place imagery; retrograde desensitization; calmness anchoring
Flying phobia (aeroplane phobia)	Volpe and Nash (2012)	Supportive psychotherapy; exposure therapy in hypnosis; anxiety management
Exam phobia (severe test anxiety)	Spies (1979)	Systematic desensitization. Biofeedback vs hypnosis vs no treatment
Fear of public speaking	Schoenberger (1996)	Hypnosis with cognitive behavioural work
Fear of eating	Spiegel (1960)	Hypnoanalysis; an uncovering of the symbolic nature of the phobia
Fear of eating	Culbert, Kajander, and Reaney (1996)	Hypnosis and self-management techniques
Penetration phobia	Frutiger (1981)	Dilation exercises; psychotherapy and systematic desensitization; masturbation leading to coitus
Hospital phobia	Waxman (1978)	Age regression; systematic desensitization in vitro; self-hypnosis

Driving phobia	Morgan (2001)	Systematic desensitization; psychodynamic psychotherapy; special place imagery
Driving phobia	Kraft and Kraft (2004)	Systematic desensitization in vitro and in vivo; psychodynamic psychotherapy
Driving phobia	Williamson (2004)	Special place imagery; unconscious search; self-hypnosis; use of metaphor; covert conditioning; cinema technique
Driving phobia	Hill and Bannon-Ryder (2005)	In vivo dessensitization; visualization; special place imagery
Bus driving phobia	Kraft and Burnfield (1967)	Systematic desensitization in vitro and in vivo; social support
Traffic phobia	Kraft & Al-Issa (1965)	Systematic desensitization especially to noise
Wedding phobia	Kraft (1970)	Systematic desensitization in vitro using emotional imagery

Case studies which have used hypnosis in treatment tend to fall into two discrete categories: (a) studies which involve an investigation and uncovering of insights into the source of the phobic disorder, and (b) studies which work on behavioural lines, focusing more on coping strategies, use of systematic desensitization and emotive imagery. However, there are some studies that use a combination of these approaches. This report outlines treatment programs and techniques which have been shown to be effective in treatment and examines their use in clinical practice.

ANIMAL TYPE

Animal phobias have been treated by a range of approaches from traditional systematic desensitization (Marks, 1969; Pagoto, Kozak, Spates, & Spring, 2006) to virtual reality exposure therapy (VRET) (Carlin et al., 1997); however, surprisingly few papers have explained how hypnosis can be used in the treatment of this subtype. Generally, the source of an animal or insect phobia is in childhood (American Psychiatric Association, 1994) and, despite the number of advertisements on the internet claiming that phobic anxiety is easy to treat, often the fear is part of a more complex and deep-rooted problem (Brann, 2012). Nevertheless, there are examples in the literature which have shown that animal phobia can be treated successfully using eye movement desensitizing and reprocessing (EMDR) (De Jongh et al., 1999; Ten Broeke & De Jongh, 1993; Young, 1994); systematic desensitization (Marks, Gelder, & Edwards, 1968; Pagoto et al., 2006); cognitive therapy (Choy, Fyer, & Lipsitz, 2007); in vivo exposure therapy (Emmelkamp et al., 1989); VRET

(Carlin et al., 1997; Côté and Bouchard, 2008); and hypnosis (Spiegel, 1960) without the need for a psychotherapeutic investigation.

A possible reason for the lack of recent reports may be due to the fact that individuals suffering from animal phobia have not had an impact on the number of hospital admissions (Brann, 2012); nevertheless, animal phobia can have a deleterious effect on an individuals' sense of wellbeing. Some patients develop elaborate avoidance behaviours and this often reduces mobility and effects quality of life.

The following section looks at how hypnosis has been employed in the treatment of animal phobia. In some instances, a psychodynamic investigation of the problem was required; whereas, on other occasions, therapists were able to reduce or completely eliminate the phobic anxiety with systematic desensitization only, or by using a multi-modal approach. In the examples that follow, hypnosis is used as an adjunct to therapy.

The present author treated a young man, Steven, with a life-long fear of spiders. His avoidance behaviour had worsened over the last 10 years and, when he came for treatment, he said that he even feared reading the newspaper in case he would unexpectedly come across a picture of a spider. In addition, for some years his phobia had had an impact on his choice of holiday destination. In the first session, Steven was encouraged to experience a special place in which he could feel like "his best self" (Callow, 2003), and this consisted of him experiencing all the emotions connected with finishing a marathon abroad. The graded desensitization on the first day of treatment consisted of the following—(a) saying the word "spider," (b) looking at a small spider in the corner of a room, (c) looking at a children's book of spiders or real dead spiders, (d) looking at a book on real spiders, (e) looking at a television program about spiders and (f) going to the zoo to look at spiders. We worked through each scenario together and, whenever he became anxious, he was returned to his special place for a boost of relaxation and confidence. These situations were rehearsed during the first two sessions and were reinforced with in vivo work which involved looking at the children's book, *The Itsy Bitsy Spider* (Trapani, 1993). In the third session, we added to the graded hierarchy and worked towards looking at exotic spiders in a biology book. After the hypnosis, the author placed a dead spider in the corner of the room and asked him to approach it to have a look. Steven also looked at pictures of real spiders: he turned over each picture, one by one, and graded them on an anxiety scale from zero to 10. He also practised touching plastic spiders and putting them in his hands. The process of desensitization—in vivo and in vitro—continued over the following four weeks and, eventually, Steven

was able to hold a dead spider in his hand. In the final session, Steven reported that he had gone camping and that something—he assumed it to have been a spider—unexpectedly crawled across his body, and this did not cause him any problems whatsoever.

An interesting approach to treatment is one reported by Brown et al. (1996) who, in the treatment of an 11-year-old girl with spider phobia, used systematic desensitization and an elaborate re-framing technique. The authors pointed out that children, in general, enjoy hypnosis because it helps them to fulfil their intrinsic need to gain mastery of themselves and of their environment: They can do this best through fantasy (Brown et al., 1996; Erickson, 1958). Before the induction, her therapist read a story about a fictional spider in a book called *Charlotte's Web* (White, 1980) in order to seed the idea of spiders being both non-threatening and human-like. Age regression did not reveal the source of the phobia and, therefore, the author gradually desensitized the girl to spiders by using characters from the story: She was asked to visualize Charlotte and her baby spiders all wearing pink clothes made out of her web. Charlotte was depicted as a caring mother and she soon became the heroine of the visualization. In the third session, further age regression revealed her first encounter with a large spider; the therapist reconstructed the experience and pointed out that it was probably Charlotte or a member of her family. The girl was able to perceive the scene as being a happy experience in which the spiders took on human-like qualities—nurturing and love. The girl made a remarkable recovery in four sessions.

Avoidance behaviour can become so severe that it can have a serious effect on mobility. Brough et al. (1965) reported a case of a 39-year-old woman with a severe wasp phobia. The patient was housebound during the summer, she had lost her job and had a non-existent social life. Unlike the Brown et al. study (1996), the treatment approach, which largely consisted of systematic desensitization and anchoring in hypnosis, did not make any attempt to re-frame the traumatic event, nor did it use positive or special place imagery; and, thus, the process, although successful, took a considerable amount of time—46 sessions.

It is, therefore, recommended that, if systematic desensitization is used with hypnosis, it should at least be combined with in vivo exposure, while positive imagery and cognitive restructuring techniques can increase the efficacy of the therapy still further. For instance, Kraft and Kraft (2010) reinforced the in vitro desensitization by encouraging the patient, a mouse phobic, to hold a toy mouse, to look at pictures of real mice and to work towards holding a

dead mouse in the palm of her hand. The in vivo work, therefore, enhanced the graded desensitization that was done in the hypnosis in that she was not only able to visualize her improvement but was also able to build on her newly acquired skills in real life. Further, by holding the toy mouse (Mini Mouse) in her arms, the feared object was re-framed as a playful, non-threatening object which supported and comforted her throughout the session.

It is helpful in therapy to help the patient to change his or her perception of the feared animal. Another example of this change of perception can be found in a case reported by Scott (1970), although a more thorough investigation of the source of the phobic anxiety was required during treatment. The patient was a 27-year-old woman with a life-long fear of birds, and the treatment consisted of general relaxation, ego-strengthening, age regression, in vitro desensitization, and auto-hypnosis. During the age regression, it was confirmed that she had been attacked by a hen as a young girl and, although she had had no conscious memory of this event at the start of treatment, her mother confirmed the story. She also recalled seeing a hen in a dark cupboard at home. This scene was abreacted each session, but further age regression, using a "speedometer technique" and theatre visualization, revealed how terrified she was when she saw the pantomime *Mother Goose*, aged three. It then became apparent that, throughout her early childhood, her elder sister, who had played a big part in her upbringing, was also terrified of birds and had transferred her fear onto the patient. Scott carefully worked through a detailed fear hierarchy, and he later encouraged her to associate positive feelings towards birds—such as looking after them and feeding them outside. The patient made a remarkable recovery and her positive feelings of nurturing birds continued after treatment; indeed, she began to feed birds in her back garden and fed ducks in the park.

Van der Hart (1981) also used a technique which encouraged his client to associate positive feelings towards the feared object—which in this case was a fear of dead birds. He did this by encouraging his client, Myra, to have an internal dialogue—akin to Gestalt therapy (Perls, 1969, 1973)—during hypnosis, and this helped her to effect a profound change with regard to her phobia. After induction, Myra was asked to elucidate a possible reason for her phobic anxiety, to which she replied that, perhaps, she was "like a bird" herself. After the initial in vitro exposure, which caused an abreaction, her therapist utilized her feelings of being connected with birds, again, in order to connect positive emotions to the feared object. He did this by suggesting that she imagine herself in a safe place—a park—and by giving her the opportunity

to fly. Indeed, she was encouraged to become a bird and to fly away. A conversation ensued between the bird and "Old Myra." During this internal dialogue it became clear that the "Old Myra," which represented herself as a young girl, began to trust the bird, and she told her that she was afraid that all birds would have an accident and would die. She also feared that all people would die, and this caused another abreaction. After a period of silence, Myra began to understand and resolve the differences between the two conflicting parts of herself: the "bird self" agreed to fly carefully and both Myra and the bird flew away together. Finally, Myra buried the dead bird, and with it all her feelings of impending doom; and, now as an integrated whole, she was able to tolerate dead birds without any difficulty.

Positive reinforcement (Cautela, 1975; Rowen, 1981) and re-framing (Erickson, 1985; Williamson, 2008) are extremely important techniques in treatment because, as the therapy moves forward, patients are able to associate both relaxation and positive feelings with the feared stimulus. Positive associations can be evoked using an empathic metaphor (Williamson, 2012), and an example of this technique is reported by Brann (2012). In this vignette, the patient, Peter, who had a fear of spiders, was advised that he should not worry about the spider approaching him for two main reasons. First, he was several hundred times bigger than the spider and, second, the build-up of lactic acid in its stomach meant that it could not walk much further than the distance of its web. The therapist then spontaneously imagined a spider trying desperately to play the violin while trying to dance at the same time—this image was then recounted to the patient, who burst out laughing, and this immediately reduced his anxiety.

On occasions, it is necessary to spend some time in the therapy investigating any associations a patient might have with the feared animal: The best way to do this is in the psychotherapy or by way of age regression in hypnosis. In these instances, hypnosis can be used to help the patient to uncover repressed memories and come to terms with these situations: By understanding the significance of these associations, the patient can begin to reduce his anxiety. However, these associations are often symbolic and it is not always a repressed traumatic incident that is responsible for the phobia; on occasions, repression of the affect associated with the memory can lead to defence processes which, in turn, produce phobic behaviour. Gustavson and Weight (1981) pointed out that "straightforward" phobic anxiety can often be resolved by systematic desensitization but that more deeply entrenched phobias are likely to require, to a greater or lesser extent, a psychodynamic investigation. This premise is

supported by Schneck (1952), Basch (1974) and Brann (2012), the last of whom warned, "Beware the simple phobia!"

A case reported by Gustavson and Weight (1981) clearly illustrates how age regression can be used in treatment. The patient was a 21-year-old female with a long-standing fear of slugs; she had developed a number of avoidance behaviours and, like the spider phobic reported by the present author, had become panic-stricken at the thought of unexpectedly coming across a slug. In the first instance, the patient visualized scenes involving slugs, and this, interestingly, did not produce anxiety. The therapist, therefore, used hypnosis and asked her to have a dream about slugs in order to gain insight into the source of her phobia. The patient said that she saw a number of slugs in a "meeting" and, in the age regression that ensued, she recalled an episode as a young girl in which a boy was forced to eat a slug. The therapist rehearsed this scene and encouraged her to have an abreaction. Using a theatre technique, the patient was asked to observe the scene while he gave her suggestions of relaxation and reassurance. During this process, the patient commented that her friends laughed at her when she began to cry and she feared that she would also have to eat the slug. Gradually, she realized that slugs represented an innate fear of being isolated, alone and helpless; in the following session, she spoke of her continual resentment of her parents—the fact that their relationship was far from adequate and that this had led to her feeling lonely, depressed and rejected. Further, slugs represented many of these previously unaccepted feelings, and coming to terms with this realization was a turning point in the therapy.

It is often important in the psychotherapy to investigate the symbolic meaning of the feared animal; and this investigation can also be done in the hypnosis by asking accessing questions (Yapko, 2003) with regard to the meaning of the phobic anxiety. Further examples of symbolism include worms representing the penis (Brann, 2012) and dogs representing a vindictive superior officer in the army (Schneck, 1952). It is important to note, however, that symbolism often works on many levels.

Some authors (e.g., Degun-Mather, 2001; Walters & Oakley, 2006; Williamson, 2008) have shown how effective it is to use a technique in which the older, wiser self advises the other self of more appropriate ways of how to think and behave. An interesting example of this technique is a study reported by Milne (1988) who used implosive desensitization in the treatment of a 56-year-old woman with snake phobia. Using age regression, he returned her to a remembered trauma rather than attempting to uncover a repressed

situation. Before the hypnosis, the lady recounted a memory in which her father returned home drunk and woke her up by coming into her bedroom with a live snake. In the hypnosis, her older, wiser self comforted her and embraced her—this situation was rehearsed and the abreaction repeated until she became more comfortable with snakes in general. The "older, wiser self technique" has also been used effectively in the treatment of 25-year-old lady with bird phobia (Brann, 2012): here, the patient was encouraged to visit the "corridors of her mind" and to visit her "reason room" in which she would be able to establish the causes of her problem. The patient, Natalie, recalled a traumatic event, aged three or four, in which a cockerel flew towards her on a holiday. The therapist normalized this event while the older, wiser self comforted her during the process. She was also given the opportunity to delete this memory using her "internal computer" and this was combined with further desensitization. This treatment strategy emphasizes the fact that there is not always a symbolic meaning attached to the phobic stimulus; sometimes a frightening experience is rehearsed and, therefore, amplified over a period of time, and the patient's perception of it is as if (s)he is still a child.

Spiegel (1960) reported the successful treatment of a 16-year-old girl with a fear of cats and dogs, and this was done in hypnosis by transferring her fear onto lions and bears. After disengagement, she had complete amnesia for the posthypnotic "seed" and experienced a shift in attitude towards both dogs and cats—indeed, she pointed out that she no longer feared domestic animals and only feared wild animals or more fearsome animals in the zoo. Within a few months, she had bought herself a pet dog and her substituted fear of wild animals had also subsided.

SITUATIONAL TYPE

The situational subtype refers to phobias which are "cued by a specific situation" (American Psychiatric Association, 1994), including: being entrapped in enclosed spaces, taking public transport, driving, flying, going to school and the fear of visiting a dentist or having dental treatment. Due to the fact that phobics tend to experience panic in the feared situation, this category is closely connected with panic disorder without agoraphobia (Kraft, 2012a). Within this subtype, there have been a number of cases that have reported the successful use of hypnosis, specifically in the treatment of flying phobia (Bakal, 1981; Brann, 2012; Deyoub & Epstein, 1977; Milne, 1988), driving phobia (Hill, & Bannon-Ryder, 2005; Kraft & Kraft, 2004; Morgan, 2011;

Williamson, 2004), dental phobia (Bills, 1993; Brann, 2012; Gow, 2006a, 2006b; Wilson, 2006), claustrophobia (Brann, 2012; Kraft, 1973; Velloso et al., 2010), hospital phobia (Waxman, 1978), fear of buses (Kraft & Burnfield, 1967), and more unusual phobias including fear of contamination (Scrignar, 1981) and penetration phobia (Frutiger, 1981).

Driving phobia is perhaps one of the most prevalent of the situational phobias. Driving phobics often experience fear and panic behind the wheel, but also often feel anxious when anticipating the possibility of driving (Wald & Taylor, 2000). With others, however, the fear is focussed on specific driving situations, for example, the motorway (Kraft & Kraft, 2004), in traffic, on quiet roads, on bridges or through tunnels (Ehlers, Hofmann, Herda, & Roth, 1994). Again, this leads to avoidance or safety behaviours, and the more complex the strategies become—for example, taking an aeroplane home from, say, Manchester, rather than driving home—the more it has an effect on mobility and day-to-day functioning (Williamson, 2004). In addition, driving phobics often experience bullying from members of the family (Taylor & Deane, 2000).

Much of the literature has focussed on patients who have become phobic as a result of having had one or more motor vehicle accidents (MVAs) (Taylor & Deane, 2000) or near collision (Munjack, 1984); however, driving-related fear is not always a function of previous accidents (Taylor & Deane, 1999). Nevertheless, in all four of the examples included in this report, patients had experienced at least one accident. And, in three out of four case studies, it was a second incident that precipitated the phobic response, having been primed by the original traumatic event (Kraft & Al-Issa, 1965; Kraft & Kraft, 2004).

Driving phobics are usually highly motivated and are ready to make the necessary changes in their lives. For instance, in the Morgan study (2001), the patient, Maureen, knew that, for her to complete her nursing studies, she had to overcome her fear. When establishing that the patient has the motivation for treatment, it is essential to define treatment goals in the first session. Morgan, for example, devised four goals which consisted of her being significantly or completely phobic free as a driver, passenger and pedestrian. She also wanted to develop coping strategies and her emotional resilience. The treatment approach worked along the lines of gradual desensitization, although this was placed within a cognitive–behavioural framework; indeed, using the principles outlined by Bruce and Sanderson (1998), the first few sessions consisted of (a) assessment, (b) psycho-education with regard to the management of stress and understanding phobic anxiety, (c) the development of coping strategies and cognitive restructuring, and (d) preparation for the imaginal exposure. In

the fifth session it was evident that Maureen was not improving, and so the therapist asked the strategic question, "What is stopping you from overcoming the phobia?" to which she replied that she did not believe in herself enough "to be able to cope." Further investigation revealed that her family had been bullying her about her fear. As a result, the therapist decided to use hypnosis to re-develop her confidence and self-esteem by "acknowledging previous skills" and by giving suggestions that previous "positive experiences" would return. This was built on in the next session in which, using a lake metaphor (Stanton, 1994), she was encouraged to find three pebbles which represented serenity, courage and confidence. A posthypnotic suggestion was also seeded in that this personal landscape of courage could return whenever she wished. After the hypnosis, the therapist suggested that rather than listening to what she described as "the woes of the news" and "delta blues"—which are often melancholic—she would be better off listening to more "affirmative" music in the car. Maureen devised driving tapes which, in turn, developed her confidence over the next three appointments. The last session involved in vivo desensitization at a bus intersection, which she coped with without any difficulty.

Hill and Bannon-Ryder (2005) also used motivation as a "driving force" for the therapy in the treatment of a 37-year-old woman with driving phobia. Her motivation became her main goals for treatment, and these were: (a) being able to visit her mother-in-law locally, (b) visiting her parents in the country, and (c) being able to drive on holiday. As in the previous study, it was felt that a fair amount of psycho-education was needed, and, to this end, she was asked to read a paper by Nash (2001) about hypnosis and its use in clinical practice. After establishing suitable goals, she was asked to visualize successfully completing a familiar journey, and to experience feeling relaxed and confident in her special place (Callow, 2003). Over the next two appointments, she reported that she had made a number of successful journeys and, at the beginning of each session, she gave herself a new goal for the following week—for example, visiting her mother-in-law. In the third session, although she had some thought intrusions which had affected her confidence, she said that she had made significant progress and had experienced no anticipatory anxiety. The therapist capitalized on this progress by encouraging her to use her special place to clear her thoughts, to realize her goals and to solve any problems that were still present. She was also given the opportunity to look at the sky and to imagine her unwanted thoughts drifting away like clouds; further, she was asked to visualize her goals, and this was combined with the anchoring word "success." The authors commented that the success of the treatment—in four sessions—was due to her determination

and motivation to drive, as well as her ability to use imagery to reduce her "negative evaluations" of driving in general.

One's ability to visualize, or to project one's self into the imagined situation, can be a significant factor in the successful treatment of driving phobia. This can be seen clearly in a case reported by Kraft and Kraft (2004) in which the patient, a 55-year-old married woman, was able to re-create vivid scenes in the hypnosis, using all the sensory modalities. The authors pointed out that it was "this verisimilitude, akin to 'virtual reality exposure therapy' (VRET), that contributed significantly to her complete recovery." Once the patient was able to visualize a familiar route without any difficulty, a graded hierarchy of more challenging scenarios was devised; and, as her phobic anxiety reduced, she no longer felt the need to control the situation by describing the minutiae of each journey.

Visualization was also incorporated into the treatment program of a 34-year-old driving phobic, reported by Williamson (2004); however, this study used a multi-modal approach which included self-hypnosis training (Heap & Aravind, 2002), use of a calmness anchor (Bandler & Grinder, 1979) and positive mental rehearsal, while the visualization consisted mainly of dissociative imagery (Ibbotson & Williamson, 2010; Williamson, 2008).

After the initial explanation of the efficacy of hypnosis, using the concept of right and left brain, the therapist (Williamson, 2004) explained that hypnosis was akin to being completely absorbed in a good book; and, as her focus of attention became more inward, she described how calm she felt, and how she would lose track of time when she painted. She was given the opportunity to develop a special place—real or imaginary—where she felt calm, safe and happy; while, at the same time, she performed an "unconscious search" (Erickson & Rossi, 1979) in order to find that special place. Further re-vivification (Kroger & Fezler, 1976) of a time when she was painting moved her into hypnosis. After a brief period for reflection, the patient, Mrs T, visualized a rubbish shute in which she could throw away any unwanted "symptoms," emotions or thoughts; and, in her special place, she was given the opportunity to look around to find something that symbolized calmness to bring back with her. She was also asked to practise self-hypnosis in order to reactivate this calmness throughout the week.

It was perhaps her ability not only to visualize but also to experience—using all her senses—that helped her to feel this strong sense of calmness and confidence. The therapist employed more visualization, using the cinema technique (Ibbotson & Williamson, 2010); here, the patient was able to exercise

greater control over her driving, first, by being the projectionist and, second, by directing the film and making the necessary changes to each scenario. Owing to the fact that many driving phobics report having had at least one traumatic event which has precipitated the phobic anxiety, traditionally, this type of fear reaction has been treated using regressive techniques (e.g, Balson & Dempster, 1980) which often lead to an abreaction. However, dissociation seems to be as effective, and the combination of using this with further imagery and re-framing, as in the Williamson report (2004), helps patients to make the appropriate changes to increase their coping strategies and resourcefulness.

Dissociative imagery can be employed simply by asking the patient to imagine someone else in the situation and this can be done using the "My friend John" approach (Erickson, 1964), a technique which was utilized by Bakal (1981) in the treatment of flying phobia. The therapist explained that he took each patient through the flight, step by step, while normalizing any unusual features during the journey. For example, he re-framed turbulence and described it as being similar to a drive on a bumpy road. Bakal also pointed out that airport and flight staff often unintentionally use negative words and phrases which might acerbate unconscious fear—for example, the use of the words "terminal," "last and final call," and "don't be alarmed." He also explained how unhelpful it was that one of the first things that a passenger experiences on the flight is how to cope with a possible crash. Bakal encouraged each patient to notice and be aware of these negative comments—thus reducing their impact—and to enjoy the scenes from the window, while perceiving the noises of the landing gear retracting and the flaps moving up and down as "safe," "comforting" sounds.

Deyoub and Epstein (1977) also employed visualization in the treatment of a 30-year-old female with flying phobia. After the induction, the patient was asked to imagine a plane flight as someone who had successfully completed the therapy. She was able to imagine the journey in great detail, feeling calm and relaxed; however, during the landing process, she felt anxious, and so the therapist set up an anchor to reduce this tension by instructing her to touch her forehead while saying the word "relax." She was asked to rehearse these hypnotic visualizations during the week; and, when she arrived for her third and final appointment, a day before her flight, she reported that she had been able to reduce her anxiety significantly during each rehearsal. Her therapist built on these treatment gains and told her that she would be even less fearful if she could now describe, and subsequently resolve, the main focal point of her anxiety. During this process, she reported a previous episode in which she feared being completely out of

control, and in the hands of a complete stranger. In the hypnosis, the therapist set up a scene in which she met the pilot and he was described as being confident and distinguished. He then gave the suggestion that it was "often advantageous to allow others to be in control" and this important insight contributed significantly to a complete elimination of her phobia. Importantly, the patient gained control by giving it freely to the pilot—indeed, the authors pointed out that, "the appropriate acceptance of dependency [was given to] … someone else (the pilot), while the anchor and positive mental rehearsal provided her with the self-mastery she needed to effect change."

Control is one of the main components in most, if not all, phobias (Aizley, 1999; Kraft & Kraft, 2004; Ritow, 1979; Segal, 1954) and dental phobia is no exception to this rule (Sartory, Heinen, Pundt, & Jöhren, 2006). It is for this reason that Gow (2006a) emphasizes that rapport and complete trust must be built before any major dental work can be done. For example, he points out that it is important not to underestimate the time of a dental procedure because, if any unexpected complications occur, the dental procedure is likely to become a lengthier process, and this might result in a breakdown of trust (Gow, 2006a). Patients suffering from dental phobia often experience a great deal of anticipatory fear (Kent, 1997) and this leads to avoidance of having regular check-ups or dental surgery (Kent & Blinkhorn, 1992). In addition, patients often fear the unknown (Epstein & Roupenian, 1970; Smyth, 1999) and this has the effect of exaggerating the fear associated with dental treatment: It is perhaps for this reason that Gow shows the dental equipment to his anxious patients and explains how each piece of equipment is used.

In the treatment of a female patient requiring extraction of the upper left third molar, Gow (2006a) employed a seven-stage "needle desensitization" hierarchy in order to help her to cope with the anaesthetic,[2] and this was done in the second session after the intra-oral examination and radiographic investigation. Adapted from McGoldrick (see Gow 2006a), this technique is useful for two main reasons: First, it makes clear what was previously unknown and thus reduces an exaggeration of the fear, and second, it provides the patient with more control in the surgery. For example, he first showed the patient the tropical anaesthetic and explained that this allows the needle to glide into the mucosa without pain; the patient then holds the local anaesthetic cartridge and the syringe. The next stage is to look at the

[2] Although the patient feared needles, a diagnosis of dental phobia was given due to high Corah and Modified Corah Dental Anxiety Scores of 16/20 and 25/30, respectively (Corah, Gale, & Illig, 1969; Gow, 2006a).

needle, and here it is important to accentuate the fact that it is "very, very small." Gow also recommends practising applying the topical anaesthetic and holding the needle up to the mucosa, first, with the cap on, and then with it off. Once the patient feels comfortable with these seven stages, extraction can take place—this desensitization process normally takes two or three sessions. In the case reported by Gow (2006a), he was able to perform an emergency extraction in Session 3. He employed special place imagery utilizing all the sensory modalities (Callow, 2003; Kalisch et al., 2005; Kraft, 2012b), asked her to repeat the words "calm, control and confident" and, with the additional use of glove anaesthesia, he was able to extract her molar without any difficulty. (Battino & South, 1999; Gow, 2002).

No greater trust can there be between a dentist and a blind patient, and Gow (2006b) utilized all his skills as a dentist and therapist during the treatment of a blind lady, Jo, with chronic adult periodontitis (Mitchell & Mitchell, 1996), requiring extraction. Here, Gow used the "Tell/Show/Do" technique (Locker, 1989) in order to build trust and to reduce her anxiety. Indeed, after two sessions, which included an intra-oral examination, rapport building and hypno-education, she created a special place using her four intact senses—hearing, smelling, taste and touch—and she held the dental instruments in her hands while her dentist gave her an explanation of their use. The following week, Jo returned for a scale and polish. Approximately three months later, she coped extraordinarily well with the extraction, following local anaesthesia: Incidentally, Gow also used "rubbing it better" suggestions based on Melzack and Wall's (1965) gate control theory of pain during the process.

The term claustrophobia is a compound word which comprises the Latin word *claustrum*, which denotes "a place that is shut up" (Lewis & Short, 2002)—for example, an enclosure, lock, door or gate—and the Greek word *phóbos*, meaning fear. Many individuals suffering from this condition fear being unable to escape or being trapped—for example, on the underground, in lifts, in tunnels, cellars or in a crowded place—and this often can lead to panic. The fear of being trapped is often associated with a traumatic incident in the past, and it is, therefore, important for the patient to come to terms with this event during the therapy. An example of this investigative process in treatment can be found in a case study reported by Kraft (1973), although the bulk of the therapy involved desensitization and hypnosis. The patient, a 57-year-old married woman, stated that her phobia began when she was trapped on a train 22 years previously; however, the onset of her phobic symptoms coincided

with the death of her husband, and her problems were exacerbated when she found out that her second husband was having an affair.

In the psychodynamic psychotherapy, the patient investigated her feelings of being trapped at home and the connection between this and her phobic state. By contrast, in the hypnosis, she worked through a graded hierarchy in which she practised travelling by bus, being left alone in rooms of increasing size—with the door open and shut—using a lift, and being locked in a bedroom. The patient made a dramatic improvement and this was maintained at the two-year follow-up.

Re-visiting a traumatic event can be done in hypnosis safely using dissociative imagery (Williamson, 2008). An interesting approach, and one which helps clients to feel detached and also protected from danger, is the "magic bubble technique" (Alden, 1995), a modified version of which was employed in a vignette reported by Brann (2012). The patient, Helen, was able to explore the source of her claustrophobia—which consisted of being shut in various enclosed spaces as a punishment for resisting abuse—by entering her protective bubble which removed unpleasant thoughts and feelings, allowing more positive ones to flourish inside. She was also able to use this technique, combined with a visualization of her "relaxing place," so that she could have an MRI scan without experiencing anxiety.

Claustrophobia can be a major problem for radiographers performing MRI examinations; in fact, it has been shown that between 25% and 37% of all patients experience moderate to high levels of anxiety during the procedure (McIsaac, Thordarson, Shafran, Rachman, & Poole, 1998). Sedation is offered for some patients, but this requires an anaesthesiologist being present, and constant monitoring. The use of hypnosis reduces any risks that may occur as a result of the anaesthetic—for example, respiratory depression or other collateral effects—and is, therefore, a cost-effective adjunctive approach to treatment (Simon, 1999). In addition, patients who use hypnosis are able to remain still throughout the scan so that a good image quality can be obtained (Westbrook & Kaut, 1998); they can also maintain voluntary apnoea if required (Velloso et al., 2010).

Velloso and colleagues (Velloso et al., 2010) used hypnosis with 20 claustrophobic patients, and post-treatment results indicated that 15/16 of patients (93.8%) showed no signs of fear, and were able to complete the MRI scan without sedative drugs. The approach used the following techniques:

1. use of the safe place,
2. suggestions of stillness throughout the procedure,
3. suggestions of time distortion,

4. suggestions of analgesia,
5. re-framing the sounds of the scan, and
6. suggestions to reduce heart rate.

After the examination, further reinforcement was given to each patient.

The use of systematic desensitization (in vitro) has been shown to have been effective in the treatment of other situational phobias—for instance, bus driving phobia (Kraft & Burnfield, 1967); wedding phobia (Kraft, 1970), in which emotional imagery was used because of her lack of ability to visualize adequately; hospital phobia (Waxman, 1978); and traffic phobia (Kraft & Al-Issa, 1965). In all of these examples, hypnosis was employed in order to enhance the desensitization process, develop their coping strategies, and capitalize on their resourcefulness. However, in some instances, a multi-modal approach to therapy is needed to effect change. In a case described by Scrignar (1981), for example, in the treatment of contamination phobia with concomitant hand-washing compulsion, the initial desensitization had had little effect on the patient's behaviour and fear response. The patient, Mr M, had a morbid fear of "anything that [came] from other human beings," and this included faeces, sweat, saliva, urine, germs, nasal and mucous discharge. Scrignar employed imaginal flooding (Stampfl & Levis, 1967) in which he asked Mr M to imagine lying in the bath and to watch a man pour a bucket of nasal discharge all over him. After 20 minutes of this visualization, his anxiety subsided, and he was instructed to visualize having a shower. At the next session, he reported that his daily hand washing had significantly reduced—from approximately 200 times a day to 12 times—although he was still unable to touch certain objects around the house. The therapist then asked him, in the hypnosis, to touch everything that he thought was contaminated without washing his hands, and this had an immediate effect on Mr M's behaviour. This improvement was maintained at the two-year follow-up.

Another example of how the general principle of systematic desensitization can be augmented by other approaches is one presented by Frutiger (1981) who treated a 26-year-old married lady with penetration phobia. The patient was unable to have coitus with her husband and engaged exclusively in oral sex; this had had an effect on her marriage, and, during the term of treatment, she was separated from her husband. In the initial stages of treatment, she reported that she had never discussed sex, she had never masturbated, nor had she engaged in pre-marital sex. Indeed, she had never managed to have intercourse successfully and her phobia was reinforced on each failed attempt: On each occasion, she would experience a great deal of anticipatory anxiety

which caused her vaginal muscles to tighten. In the hypnosis, Frutiger used the principles of desensitization to reduce her anxiety about penetration: He then gradually introduced the possibility that she should begin to practise masturbating, and slowly and systematically worked towards her imagining having intercourse. Further in vitro desensitization was employed, and this consisted of her imagining a man of her own choice getting into bed, caressing her, and, again, this would lead to sexual intercourse—from the female superior position. She was also given suggestions to practise masturbating each night after progressive muscle relaxation. In further sessions, the therapist introduced the idea of dilation exercises[3] and sought advice from a local urologist who recommended the use of specifically designed test tubes. Frutiger consulted the patient's gynaecologist and psychiatrist and, with their agreement, asked her whether she would be willing to try a series of test tubes for dilation purposes. Her permission given, she began to practise each night and, after some resistance, made a dramatic recovery; she also reported that she was able to achieve orgasm with the largest test tube and, after four months, she and her husband were back together. Interestingly, a graded hierarchy was used here both on a psychological and physical level: The desensitization helped her gradually to visualize having mastery and control of her sex life, while the dilators helped her progressively to have more control of her vaginal muscles and increase her levels of sexual pleasure. It might have been helpful in this situation to bring the husband into the consulting room. In this case, this was perhaps not possible due to their temporary separation, and it is not certain whether this would have helped or hindered the therapy. Certainly, the patient benefited considerably by being given the chance to reduce her anxiety on her own.

COMMENT

This report has demonstrated that hypnosis can be used effectively in the treatment of animal phobias and situational phobias. In most cases, when patients were able to access their inner resources, their perception of control altered, and they were able to effect change on their behaviour. Patients were able to gain this control through systematic desensitization, by using coping strategies, by re-framing the feared stimulus or by uncovering and

[3] It is important to note here that the therapist consulted both the patient's gynaecologist and psychiatrist before offering this treatment. This type of intervention—that is to say, advising the use of dilators and recommending masturbation—should not be employed by therapists who are not medically qualified and, further, it is recommended that all therapists have additional training in psychosexual dysfunction before working with individuals suffering from sexual disorders.

understanding the source of the phobia. In many instances, however, a multimodal framework, which is tailor-made to suit the individual needs of each patient, is recommended. Hypnotherapy, therefore, offers a rapid and cost-effective form of treatment for these conditions, and it is recommended that these procedures are used as a first-line treatment approach.

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