

## THE PLACE OF HYPNOSIS IN PSYCHIATRY PART 6: TREATMENT OF SPECIFIC PHOBIAS — NATURAL ENVIRONMENT TYPE, BLOOD-INJECTION-INJURY TYPE, AND OTHER TYPES

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*Part 6 focuses on the use of hypnosis in the treatment of the following subtypes within the specific phobia category—natural environmental type, blood-injection-injury type, and other types. The author reviews a range of treatment strategies which have been shown to have been effective in clinical practice. The report examines the efficacy of hypnosis in the treatment of conditions such as wind phobia, heat phobia, balloon phobia and aquaphobia, while attention is given to the blood-injection-injury type which includes needle phobia, a problem which affects a large proportion of the population. Detailed accounts of each treatment strategy are given so that practitioners may incorporate these techniques both in a hospital setting and in private practice.*

Keywords: hypnosis, specific phobias, natural environment type, blood-injection-injury type.

The following study focuses its attention on three further subtypes within the specific phobia category—natural environment type, blood-injection-injury type and other types (American Psychiatric Association [APA], 1994). The report looks at the way hypnosis has been employed as an adjunct to psychodynamic psychotherapy, counselling and approaches which fall within the remit of cognitive-behavioural therapy. Table 1 does not represent a complete list of the studies which have employed hypnosis in treatment, but provides the reader with a cross section of approaches in the world-wide literature.

**Table 1:** Specific Phobias Treated With Hypnosis

Phobia type	Author(s)	Treatment strategy/experimental design
<b>Natural environment type</b>		
Thunderstorm phobia	Heap (1981)	Diary keeping; desensitization in vivo and in vitro; use of audiotapes
Wind phobia	Walters & Oakley (2003)	Cue-controlled relaxation and desensitization
Aquaphobia	DePiano (1985)	In vivo and in vitro desensitization
Phobia of bovine sounds	Cohen (1981)	Dissociation; visualization; use of humour (re-framing)
<b>Blood injection injury type</b>		
Blood phobia	Noble (2002)	Systematic desensitization
Injection <sup>1</sup> phobia	Daniels (1976)	Systematic desensitization; in vivo exposure
Injection phobia	Kraft (1984)	Systematic desensitization; safe place imagery; psychoanalytic investigation including dream analysis
Injection phobia	Medd (2001)	Client-centred counselling; time regression; reframing and use of affect bridge
Injection phobia	Abramowitz & Lichtenberg (2009)	Use of “hypnotherapeutic olfactory conditioning” (HOC)
Needle phobia	Morse & Cohen (1983)	“Meditation-hypnosis”; desensitization hierarchy
Needle phobia	Cyna, Tomkins, Maddock & Barker (2007)	Early learning set; “switch wire” imagery
Needle phobia	Brann (2012)	Special place imagery; silent abreaction; age regression; guided exposure
Chemotherapy phobia	Kraft (1993)	Special place imagery and desensitization in hypnosis

<sup>1</sup> It is difficult to distinguish between needle and injection phobia; however, the author has retained both terms in order to correspond with the terminology used in each study.

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Other type		
Bleach phobia	Deiker & Pollock (1975)	Systematic desensitization and guided imagery
Balloon phobia	Kraft (1994)	Systematic desensitization in vitro and in vivo; psychodynamic psychotherapy
Heat phobia	Kraft & Al-Issa (1965)	Systematic desensitization in vitro and in vivo
Vomiting phobia	Wijesinghe (1974)	Flooding in hypnosis
Vomiting phobia	Ritow (1979)	Paradoxical techniques; cognitive restructuring; emetic medication; psychotherapy

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These disorders will be elaborated now and the role of hypnosis in their treatment considered.

## **NATURAL ENVIRONMENT TYPE**

Some individuals fear their surrounding environment, although the phobia is often limited to a specific feature—for example, types of weather (e.g. a thunderstorm), the wind, heights and earthquakes. Those who suffer from a natural environment phobia develop safety behaviours in order to limit the chance of experiencing the feared stimulus; and, if the phobia develops, these avoidance or safety behaviours become more complex. Some patients become housebound for periods of time and this can lead to full-blown agoraphobia (Kraft, 2011). When using desensitization in treatment, it is helpful to re-create, as closely as possible, each scenario in the graded hierarchy in order to produce “maximum realism” (Heap, 1981); in cases where patients are unable sufficiently to imagine or be involved in a scene, external cues can be employed in order to increase verisimilitude (Heap, 1981).

A case study reported by Heap (1981), who successfully treated a 47-year-old with a life-long fear of thunderstorms, shows clearly how a patient’s ability to experience the feared event can play a significant part in the treatment process. Indeed, during the desensitization, minimal visual and auditory imagery were required; and yet, she had the feeling that she was actually experiencing a thunderstorm, and even sensed a “cooling sensation” which signified a drop in temperature as the storm progressed. During the initial stages of treatment,

it was revealed that she had equated her fear of thunderstorms to the sounds of bombs during the Blitz and these sounds brought on feelings of loneliness and a fear of abandonment.

The patient constantly checked the weather reports, and so Heap asked her to keep a record of these checks, writing down her feelings and experiences with regard to the weather. The stimulus hierarchy consisted of her experiencing a number of scenes in different weather conditions ranging from sunny to a full-blown thunderstorm. She also practised at home, and this treatment was continued for approximately six sessions. In the next phase, the therapist focused on her fear of thunderstorms at night and, in the hypnosis, he asked her to imagine lying on her bed, feeling comfortable and relaxed. Heap played her tape recordings of rain and thunder and gradually increased the volume during each session; further, lightning was simulated using two Xenon-filled flash tubes. Very early on in this phase, she reported that she had reduced her obsessive checking of the weather reports and, although she continued to experience some anxiety during thunderstorms, the effect they had on her were short-lived and they ceased to limit her daily activity.

An interesting approach to the treatment of a natural environment phobia—in this case, a fear of wind—was reported by Walters and Oakley (2003). Again, the patient's ability not only to visualize but also vividly to experience "being there," directly engaging in each imaginal situation, were key components in the success of the treatment. The patient, Sarah, also commented that it was helpful for her to be able to re-frame frightening sounds to noises that comforted her: for example, she imagined changing the sound of the wind near her home to a sound of a waterfall. The authors described an approach which used systematic desensitization, special place imagery and the use of coping strategies which, in combination, helped her to eliminate her safety behaviours. They also explained the rationale of the treatment to the patient—that is to say, her phobia had been learnt (Wolpe, 1958), and then exaggerated over the last two years, and that the hypnosis would help her to discover new and more appropriate ways of thinking about wind. However, it must be pointed out that, although a cognitive-behavioural framework provided the main thrust of the treatment, and the hypnosis enhanced this process by pairing the feared stimulus with pleasurable sensations (Kraft, 2012; Weitzenhoffer, 1972; Wolpe, 1958), a psychodynamic approach was also needed in order to reveal, and then help her to come to terms with, the source of the phobic anxiety. In this case, her fear may well have been closely connected with, and therefore triggered by, the death of

her previous partner and four other family members, as well as a particularly stressful Christmas period when the weather was very windy.

The source of the fear in the case reported by Walters and Oakley (2003) was a traumatic set of incidents approximately six years before the start of therapy; however, often environment phobia is developed in childhood (APA, 1994). In a case of aquaphobia, reported by DePiano (1985), the source consisted of the patient, Mrs A, being spanked for going near water as a child, while her mother's intense fear of water had also been transferred onto her. When using systematic desensitization, *in vitro*, it is often helpful to combine this with *in vivo* work (Kraft & Kraft, 2010); but it is important to make sure that patients work through each potentially anxiety-provoking situation gradually so that they build on their successes. This is more difficult to control when patients work on their own, outside the consulting room. However, one way of effecting therapeutic change is to encourage one's patient or client to begin with simple tasks and, like the graded hierarchy in the hypnosis, they should gradually work towards more difficult scenarios. In the treatment of aquaphobia, DePiano (1985) used systematic desensitization in hypnosis over a period of three sessions, while between appointments, the patient practised socializing by a swimming pool and worked towards being able to submerge herself under water. By the end of the fifth session, Mrs A was able to rehearse these scenarios without any anxiety. Nevertheless, her therapist urged her not to test her confidence; but, instead, he met her at the local swimming pool early in the morning and, using further hypnosis, helped her gradually to enter the pool. Over a period of two weeks, she moved from the side of the pool to being able to submerge herself in the shallow end. Mrs A was also encouraged to grade her anxiety levels (from 1–5) throughout the process. At the year follow-up, Mrs A admitted that she still felt uncomfortable swimming but that she was able to socialize near water, and both her anxiety and her avoidance behaviour had disappeared.

## **BLOOD-INJECTION-INJURY TYPE**

Blood-injection-injury (BII) phobia is a common condition and many sufferers avoid seeking medical treatment due to their uncontrollable fear. Over 75% of individuals have reported that they have fainted or have felt faint after having seen or even talked about blood, injuries or needles (APA, 2000; Ayala, Meurat, & Ritz, 2012). In these situations, often patients experience bradycardia and hypotension, while a sudden drop in blood pressure frequently

leads to fainting (Graham, Kabler, & Lunsford, 1961; Medd, 2001).

Probably the most common of the BII phobias is needle (or injection) phobia; although it is sometimes connected with dental phobia or dental anxiety, it should be considered as a distinct phobia (De Jongh et al., 1998; Medd, 2001). Needle phobia affects approximately 19% of children within the 4–6 age group, and about 10% of the general population (Hamilton, 1995; Majstorovic & Veerkamp, 2004).

A case study reported by Kraft (1984) has shown clearly how a specific phobia, although seemingly “simple” on the surface, is in fact a manifestation of a deeply-entrenched inner conflict; this study is also an example of how behavioural therapy and hypnosis can be used successfully within, principally, a psychoanalytic framework. The patient, Mrs T, suffered from injection phobia and also had problems listening to people talking about illness or operations; she had also fainted on numerous occasions while watching programmes on television—particularly themes related to childbirth.

During the psychotherapy, it became apparent that she had a difficult relationship with her father and was not close to him. When she was 15, her father, who was not a doctor, decided that she should have a blood test and, as he was working at a laboratory, he took the blood himself. Mrs T was given the opportunity to discuss her feelings of being let down by her father and the complications which arise when one sees one’s father in two opposing roles. The treatment initially focused on the presenting phobia, and both therapist and patient constructed a hierarchy which concentrated on complications associated with giving birth, including the actual delivery, having stitches and a transfusion. These situations were rehearsed in the hypnosis and, whenever she felt anxious, she was returned to her safe place. After disengagement, she spoke of her problems speaking to a friend who had a wired-up jaw, and her boss who was heavily pregnant. In the next session, Mrs T explored a series of scenarios in which she imagined possible causes for her friend’s fractured jaw. The aim of this was to increase her ability to cope with medical themes without fainting; indeed, she reported that, during the week, she had been able to talk to her boss about the complications of having raised blood pressure during pregnancy. She was also keen to learn more about obstetrics: she spoke to her therapist, asked his advice and began to read a book on the subject.

As the therapy continued, the transference relationship between therapist and patient grew stronger. She pointed out that her father had never qualified as a doctor and that had disappointed her; and yet, she found that she was able to talk to her therapist—who was, in fact a physician—about medical themes.

Her therapist, therefore, represented the father she had never had. Further, she stressed that having injections was a “question of penetrating.” During the next two sessions, Mrs T recounted two dreams. The first was a phantasy about having sex with her therapist on the couch and the second involved her making love to her boss at work. Indeed, her injection phobia was inextricably interconnected with her hostilities towards her father (Stoller, 1976); indeed, her sexual partners, including her husband, were always older men and were, she confessed, substitute father figures. As the injection phobia subsided, Mrs T continued to work through her inner conflicts and hostilities towards her husband and, at the year follow-up, she stated that she had had a baby and was able to describe the whole process without any difficulty. This example shows how a psychodynamic approach can be combined successfully with hypnosis. Interestingly, as the presenting phobia subsided, she began to discover and deal with more complex issues in her family life: in fact, it is possible that the earlier desensitization work, and the space given to her in the hypnosis, were important factors in helping her to develop these insights (Cautela, 1965).

Coming to terms with the source of the phobia can have immediate effects on treatment gains. In a case reported by Brann (2012), the patient, on establishing her safe place, was given the opportunity to search the “depths of her mind for the beginning of the problem.” This “unconscious search” (Erickson & Rossi, 1979) helped her to regress to a time at boarding school in which a girl repeatedly stuck sewing needles into her arm. The therapist helped her to deal with and resolve this trauma using the “dead tree” silent abreaction (Ibbotson, 2012; Ibbotson & Williamson, 2010), the “older wiser self” technique (Degun-Mather, 2001; Williamson, 2008) and graded in vitro exposure to seeing and touching hypodermic needles. At the end of the treatment, she was able to hold the needle herself.

The study by Kraft (1984) above demonstrates how hypnotic interventions can be used in conjunction with a psychoanalytic approach; but hypnosis can equally be employed in counselling. Medd (2001), for example, reported two cases of note which utilized this combined approach: both patients suffered from needle phobia and had other fears and anxieties. In the first case, the patient, who was constantly in pain as a result of a stroke, received client-centred counselling. This was followed by repeated hypnosis work which helped her to experience being pain free so that she could make “safe contact with [her] suppressed traumatic memories.” In the second case, relaxation, ego-strengthening and the use of the affect bridge helped the patient to reframe her traumatic experiences in the past relating to needles. Medd also

paired having injections with feelings of relaxation and this had the effect of reducing anxiety and building confidence.

Another useful technique for the treatment of needle phobia is the “switch wire approach” (Hammond, 1990), and this can be used in order to create analgesia and/or anaesthesia. Cyna, Tomkins, Maddock, and Barker (2007) used this technique successfully in the treatment of a five-year-old boy with severe needle phobia. The anaesthetist trained the boy in hypnosis and then explained the fact that all houses have a number of wires and switches which can be turned off and on at will and that, once a switch was off, the electrical device—light bulb or heater—does not work. The anaesthetist went onto explain that, like a house, the brain also consists of a number of switches and wires which can be turned off at will; he pointed out that one can even “turn off” the leg or arm so that it doesn’t work anymore. The boy responded excellently to these suggestions and was able to produce a fair amount of anaesthesia at will. Two days after this treatment, the boy received venepuncture without the need for a topical anaesthetic cream, and experienced no pain whatsoever. He was also able to cope with the i.v. injection without difficulty.

Blood phobia (haematophobia) is an interesting variant of the BII subtype. In a case reported by Noble (2002), the patient exhibited extreme safety and avoidance behaviours and her anxiety affected her daily life. For instance, she was unable to prepare steak for her husband because the mere sight or smell of any blood caused her to feel nauseous; she often experienced a gag reflex and avoided dental treatment to the extent that she had even extracted some of her teeth herself. When she came for treatment, her remaining eight teeth had advanced periodontitis and active caries, with evidence of periapical infection. It was decided that these teeth needed to be extracted and that dentures should be fitted; but this was impossible due to her fears, constant expectoration and retching. Thus, Noble, used a multi-modal approach to treatment with the aim that she could eventually tolerate dental surgery. In the first instance, she asked the patient to visualize a safe place and was told that she could return to it at any time. Ideomotor signalling was then set up so that non-verbal communication could take place during the procedure. Importantly, hypnosis was used during these initial stages to prepare her for the ensuing dental procedure and was also used during the treatment itself. An anchor was set up in order to reduce anxiety, and the patient was given an imaginary pebble in her hand which she could stroke whenever she became anxious. She also used this anchor to re-direct her choking from the throat to her hand. As her perception of control grew, the dentist cleverly



built on this success by working in stages. While her upper partial denture was relined, it was noticeable that her gagging had significantly reduced. She also opened her eyes during the hypnosis and sipped water to reduce her nausea. During rehearsal, Noble used a re-framing technique in which she compared having new dentures to wearing a new pair of shoes. The patient was further instructed to visualize preparing steak for the family and to enjoy watching them eating the meal. Noble also used a video-playback technique and the patient practised each dental scenario again and again in order to increase her mastery of being able to have dental surgery. As a result, she was able to proceed with full treatment, including impressions, extraction and the placement of dentures.

## **OTHER TYPE**

The literature search revealed four papers of note which fall within the Other subtype: all four studies employed hypnosis but they all used very different therapeutic regimes to resolve the phobic anxiety. In the first paper (Kraft, 1994), the therapist encouraged the patient to explore the associations between the feared object and early childhood experiences, and used both in vitro and in vivo desensitization. The second paper (Kraft & Al-Issa, 1965), by contrast, used a systematic approach, and the client made considerable progress without the need for a regressive psychoanalytic investigation. The third case, reported by Ritow (1979), utilized her motivation for change in order to eliminate her phobic anxiety, while the fourth study (Wijesinghe, 1974), employed a flooding technique in hypnosis.

Kraft (1994) reported the successful treatment of a 60-year-old lady with a lifelong fear of balloons. Due to the complex and deeply entrenched symbolic associations between balloons and her past history, the treatment lasted several months and she needed over 40 sessions. During the first four appointments, the therapist used systematic desensitization to reduce the amount of anxiety that she had. Her phobia was so severe that the desensitization hierarchy began by her imagining, in hypnosis, pictures of balloons in children's books, visualizing a sealed packet of balloons on a shelf and steadily working towards being able to tolerate an unopened packet on her lap. Next, she was encouraged to touch a balloon which was not inflated and to gradually blow it up, increasing its size—this was done first in hypnosis and then live in the consulting room. She practised touching these balloons at home with the help of her husband. During the in vivo work in the consulting room, the patient

revealed that touching, or even thinking about balloons, produced vaginal discharge and made her feel sexually aroused: further, at home, she insisted that her husband hold her during the process and this often led to sexual intercourse—which she initiated. Her therapist commented that there was a connection between the sound of the balloons bursting and early recollections of hearing her parents having sexual intercourse. However, he did not point out further associations between the blowing of a balloon and, for example, increasing sexual desire, the increase in the size of a man's penis from flaccid to erect and the development of her breasts at puberty.

By the eighth session, she was able to hold a fully inflated balloon, first, in the hypnosis and, secondly, during the *in vivo* work. However, she pointed out that she was still terrified of bursting balloons and was particularly sensitive to the noise it produced. During the next few sessions, the patient rehearsed the idea of the therapist bursting a balloon in the next room and gradually working his way towards the consulting room. After the hypnosis, the therapist repeated this work *in vivo*, and then prepared cassette tapes in 10 volumes for her to use at home: the importance of this was that she was able to control the volume herself. Using a noise hierarchy, the tapes consisted of a series of balloons being burst in the room next door, and gradually moving towards her. The patient wanted to talk about why the balloons were so frightening for her and, after a discussion, she realized that the sounds of the balloons bursting were symbolic of exploding bombs during the Second World War. The sounds at the time were closely connected with being separated from her parent and frequent changes of school. These more exploratory sessions were particularly emotional for her.

Over the course of the next few months, the systematic desensitization and mental rehearsal (*in vitro* and *in vivo*) continued and the patient became more confident in that she was able to burst balloons herself in the consulting room. It was also revealed that there was a connection between explosions and having an orgasm and this insight had the effect of reducing her anxiety still further. At the termination of therapy, she was able to burst balloons without any problems whatsoever, and she was also able to go into restaurants in which she knew that children would be playing with balloons.

The case of a female patient suffering from a lifelong fear of heat was reported by Kraft and Al-Issa (1965). The source of her phobia was described by her mother who explained that, aged 5, she witnessed a blazing fire and, terrified, she saw two charred bodies being carried out of a burning house. Throughout her life, the patient exhibited a great deal of avoidance behaviour:

she was reluctant to put her hands in warm water, she could not use an iron, she experienced problems eating and drinking hot food and became anxious whenever she saw burns on people's faces. The therapist (TK) constructed a hierarchy scale which comprised a list of 16 anxiety-provoking stimuli, and these focused on visual and tactile modalities. Each situation was further subdivided into temperature levels. For example, when the patient was asked to visualize "seeing water heated," he asked her to imagine it first at 55° F, in which she was anxiety free, and gradually worked up to 210° F. This same principle was used when she was asked to imagine safely "putting her hands into the oven." After eight sessions, the patient was able to enjoy taking a bath, use a hot iron and sit in the sun; and, as the therapy progressed, her perception of water began to change. By the end of the therapy, she was completely anxiety free and this was maintained at the year follow-up. Interestingly, there was no need to investigate the original trauma in the psychotherapy or include it in the stimulus hierarchy, and progress was made by systematic desensitization in hypnosis alone. This emphasizes the efficacy of using a graded hierarchy of potentially anxiety-provoking stimuli, *in vitro*, particularly when the patient is unable to recall the original source of the phobic anxiety.

Individuals who suffer from vomiting phobia are not only terrified of being sick themselves but also frequently fear anything that is associated with sickness in others (Ritow, 1979). So the phobia is a fear of sickness as well as a fear of being sick. As a result, patients develop elaborate avoidance behaviours in order to eliminate the possibility of coming across anybody being sick or even feeling sick. In 1979, Ritow reported a case of a 21-year-old female with vomiting phobia. She had previously received psychoanalysis and had not responded well to his non-directive approach. Her avoidance behaviour was severe: she was unable to eat chewing gum or large quantities of food, she was unable to go near sick people, she could not take care of her husband when he was ill, and, although she wanted children, she felt that she would be unable to care for them adequately. In the first session, the patient questioned the therapist's qualifications, challenged him on his competence to treat her, and transferred a huge amount of aggression towards him. Ritow explained that, in essence, the therapeutic strategy was to motivate her make the necessary changes for her to lead a fulfilled life and that this would be done seamlessly in the hypnosis and in the psychotherapy. Most of the session involved a discussion in which the patient explored how her phobia had limited her personal and social life. She also explored the role that she played in society and how her anxiety had often caused her to be aggressive towards others—

needless to say, this now included her recent hostility towards her therapist. Ritow prepared her for the necessary changes that would need to occur in her life in order significantly to reduce her phobic anxiety, and he seeded these suggestions before, during, and after the hypnosis (Erickson, 1954; Zeig, 1990; Geary, 1994; Williamson, 2004); furthermore, he pointed out that by removing the central symptom—her fear of vomiting—she would be able to eliminate further “constructs” which restricted her life. As the patient had not responded to a non-directive approach, Ritow asked her directly to confirm that (a) she was ready for this cognitive change and (b) she was willing to follow the therapist’s instructions. She agreed to both of these terms.

In the next session, the patient asked angrily, “Are you going to make me sick and throw up?” The therapist confirmed this intention but pointed out that there was only a 50% chance that she would succeed. He also said that, if she wanted to continue with therapy, she must provide him with her doctor’s contact details, and arrange for a further appointment. The therapist used a paradoxical technique in which he encouraged resistance: thus, she was unable to defeat the therapist because he had already pointed out that she might not continue with therapy. The patient did in fact call for a further appointment and, together with the physician, it was agreed that she could safely take an emetic in order to induce vomiting. In the next session, she angrily reported that she had been sick; again, she questioned the therapist’s competence but agreed that the experience “had not killed her.” Ritow reiterated the fact that a cognitive restructuring process would occur as a result of her being able to vomit, and that this would help her to make the necessary changes in her life. The following week she pointed out that this transition had indeed taken place: She was more positive about herself, less aggressive towards others, and had significantly reduced her avoidance behaviour—for example, she visited a sick person in hospital. She was again reminded that more cognitive readjustments would take place and, over the next three sessions towards termination, she began to eat normally, she helped change a baby’s nappies and was anxiety-free with regard to sickness and vomiting.

Flooding techniques have also been used in treatment. Wijesinghe (1974) reported a case of a 24-year-old woman with a 11-year history of vomiting phobia. At the beginning of treatment, using visualization only, he exposed her to the maximum threat situation which was being trapped on a crowded carriage on the underground. He also presented anxiety cues as follows: “becoming increasingly apprehensive,” “being surrounded by people,” “feeling sick in the pit of the stomach,” “hearing someone retching,” “vomiting

herself” and “being unable to escape.” The patient, however, was unable vividly to hold onto these images and failed to produce an anxiety response. Wijesinghe, therefore, decided to continue the flooding in hypnosis and, after induction and deepener, the patient was able to visualize the journey in detail and showed a great deal of discomfort: the emotional intensity was maintained by her being asked to describe the scene visually as well as her feelings towards the images presented to her. Gradually, her anxiety reduced and, after approximately 85 hours, she was able to tolerate the experience “with equanimity.” In the final session, she reported that she was free from anxiety and this was maintained at the year follow-up. Here, the hypnosis had two profound effects: first, it enabled her to maximize her visual and emotional capacity, and secondly, it reduced her anxiety to vomiting using the principles of reciprocal inhibition—that is to say, the pairing of the feared stimulus with relaxation eliminated the fear response (Kraft & Kraft, 2010; Wolpe, 1958).

This report has shown clearly that hypnosis is a powerful adjunctive tool for the treatment of a range of specific phobias and can be employed in conjunction with behavioural therapy as well as psychodynamic psychotherapy. In many of the examples illustrated during this paper, hypnosis has provided a platform by which patients or clients can eliminate their fears and gain more control and mastery in their lives. And, for patients who fear medical or dental intervention, it is hoped that more hospitals across the world will consider hypnosis so that individuals will be able to seek necessary treatment before conditions worsen or become irrevocable.

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