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Cognitive Behaviour Based Hypnotherapy for Panic Disorders

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Abstract: **In the treatment of anxiety disorders such as panic disorder, cognitive behaviour based hypnotherapy, also known as cognitive behavioural hypnotherapy (CBH), is used. This article explains and demonstrates specific techniques. The CBH research is being debated. CBH appears to be at least as effective as therapies for behavioural therapy (BT) and cognitive behaviour therapy (CBT), incorporating visualisation and relaxation techniques for anxiety disorders. Nonetheless, due to the lack of sufficient studies comparing CBH with BT and CBT, further research is needed. Clinical considerations and recommendations are given for future research.**

Keywords: **Panic disorder, CBT, cognitive behavioural hypnotherapy, cognitive behaviour treatment, cognitive hypnotherapy, hypnotherapy.**

1. INTRODUCTION

Background

Panic disorder is a very common mental disorder, it affects around 5% of the population at some point in life. It is often disabling, and is leads to substantial dysfunction in day to day life and poor quality of life. The diagnosis 'Panic disorder' was not added to the nomenclature until 1980, The core features of panic attacks are that these can be described as sudden onset of anxiety in which, physical symptoms are predominant. They are followed by excessive worry about having a serious consequence such as heart attack. Earlier, these symptoms have been referred to as: Da Costa's syndrome, irritable heart, disorderly action of the heart, effort syndrome and neurocirculatory asthenia. These older terms were based on the assumption that the patients were right in fearing cardiac function disorder. Later some authors proposed it to be of psychological in nature, but it only during the World War ll, that Paul Wood a cardiologist (1962) showed convincingly that the symptoms belonged to a form of anxiety disorder. Since upto 1980, patients suffering from panic disorder were diagnosed as having either phobic or generalised anxiety disorders. But during 1980, DSM-III authors introduced the new category of diagnosis as: panic disorder, which included those, whose panic attacks presented with or without generalised anxiety, while excluding the one's whose panic attacks occurred in the course of agoraphobia. According to DSM-IV, frequent panic attacks were classified as panic disorder, whether or not it had the components of agora-phobia. According to DSM-5 panic disorder and agoraphobia are to be diagnosed independently and where both conditions cooccur both diagnoses are given. Panic disorder is listed in ICD-10, but when patients have accompanying agoraphobia they are diagnosed with agoraphobia with panic disorder.

Clinical features of panic disorder:

It is not necessary that all the patients have or report all of these symptoms about the panic attack and, to diagnose panic disorder, according to DSM-5 only the presence of four or more symptoms is required.

Few important features of panic attacks are: anxiety is built up quickly and symptoms exhibited are severe , the person fears a catastrophic outcome. Many people hyperventilate during a panic attack, and it adds on to their other symptoms. Hyperventilation is defined as breathing in a rapid and shallow manner that in turn leads to a reduced concentration of

carbon dioxide in the blood. Hence resulting into hypocapnia which might cause the symptoms such as: Palpitations that occur suddenly sensations of choking, dizziness and faintness, pain in chest, depersonalisation, derealisation, fear of dying, losing control, or going mad, feelings of impending doom (ICD 10).

Constant and overpowering feeling of breathlessness which is paradoxical in nature as the person is in-fact breathing excessively. It is important to note as it further leads to an increase in breathing in effect worsening the condition of the person. Attention should be paid to episodes of hyperventilation as a cause of unexplained bodily symptoms. The diagnosis can easily be reached by paying attention to the pattern of breathing while the symptoms occur.

Diagnostic criteria according to the DSM-5 for panic disorder is achieved when: (a) panic attacks happen repeatedly (at least twice) and are unexpected in nature (i.e. not due to exposure or as a response to any existing phobic stimulus); and (b) at least one attack is further followed up by four weeks or more of continual fear of another attack happening and worry about its associations (e.g. having a heart attack), or/and a significant maladaptive change in behaviour (for example, avoiding travel or public transport).

Panic disorder affecting lives:

Panic disorder can cause serious maladaptive behaviours in a person leading to significant problems for a person at both personal and social level. The person might face problems with employment, day to day life such as traveling, going to new places etc. There is a co-existing underestimation of present coping mechanisms and the available rescue factors. Among adolescents and young adults, anxiety is often associated with very high expectations and creating goals that are rather improbable to achieve. Failure is then associated to decreased self-esteem, higher susceptibility to stressors which produce both anxiety and depressive reactions (Holdevici, 2010).

Panic disorder has been studied extensively in Western countries but not enough in India. Srinivasan and Neerakal studied 94 patients suffering from panic disorder attending OPD of a psychiatry department. This study showed that there is significant co-morbidity with major depression in 43 patients (45.7%) suffering from panic attacks. Amongst the subjects, Majority (i.e. 69.8%) of them who suffered with panic attacks had co-morbid condition of primary depression whereas only 30.2% had secondary depression. It was found that, there was a higher prevalence of coexisting generalised anxiety disorder in patients with panic co-morbid with depression (both primary and secondary) in comparison to panic patients without depression. The prevalence of lifetime, an estimation for panic disorder in US adults fall in ranges 2.0% to 6.0%. The 12-month prevalence in adults is 2.7%, of which 44.8% are classified as “severe” cases.

Cognitive- Behavioural Hypnotherapy

Hypnosis is a technique used to induce a relaxed state where suggestibility is high, in which the hypnotherapist may use progressive muscular relaxation or other techniques with suggestions of relaxation. Cognitive, behavioural and hypnotic strategies form the basis of cognitive hypnotherapy, also referred to as CBH, which results from the CBT and CBT application in hypnotherapy, are an efficient approach. One approach for CBT was to include theoretical elements in conventional BT approaches. Goldfried and Meichenbaum (Meichenbaum, 1972) showed by their work that the efficacy was improved by the application of an approach to SD coping skills. Patients learn to use relaxation exercises and to cope with self-statements in the method of coping skills to alleviate their distress through SD. The basis of cognitive hypnotherapy, which is also called CBH, resulting from CBT and HBT applications for hypnotherapy is the cognitive, behavioral and hypnotic strategies. For traditional BT methods one strategy for CBT was to integrate theoretical elements. Their work showed that their effectiveness is enhanced by the application of SD coping skills (Goldfried, 1971, Meichenbaum, 1972). Patients are taught the method of coping with relaxation exercises and self-statements to relieve their distress through SD.

Maladaptive thoughts subject of CBT and CBH therapy. Alladin (2007) says that negative self-hypnosis (NSH) is a harmful form of emotional upsetting self-hypnosis, including self-suggestions. NSH is the same thing as Ellis (1962). What Beck (1985) refers to as unconscious thinking is referred to as "irrational self-talk," which was labeled "negative rumination or rumour" by Nolen-Hoeksema (1991). CBT uses strategies for cognitive therapy to change perceptions. Some of the early hypnotherapists have similar methods (Prince, 1907).

2. RESEARCH EVIDENCE HYPNOSIS AS TREATMENT FOR ANXIETY

Only a few studies have been identified in the evaluations that examined the integration of hypnosis with BT (Humphreys, 1986; McGuinness, 1984), demonstrating that the addition of hypnosis was superior to a non-hypnotic version of BT. Most of the studies included in these reviews are suffering from methodological flaws, such as small

sample sizes, inadequate control groups, and lack of objective outcome measures. Humphreys (1986) concluded that there was insufficient scientific evidence to prove that hypnosis increases the effectiveness of BT. McGuinness (1984) concluded that hypnosis success in phobia treatment is largely the result of enhanced imaging and relaxation and subject variables such as hypnotisability and motivation. On the other hand, for anxiety therapies with CBH, hypnotisability does not accurately predict clinical outcome (Schoenberger, 2000). However, Spinhoven (1987) argued that the findings are at odds with the potential of hypnosis to improve imaging and relaxation, and argues that the advantage of hypnosis as an alternative to BT has an impact on patient preferences and reputation of care. Reviewers believe that there is a need for more research. Spanos and Barber (1976) point out that the majority of studies contrasting hypnotic and non-hypnotic CBT therapies equate hypnotic induction assimilation with the addition of fear-reducing suggestions. It may be the inclusion of the suggestions that reduce anxiety, or the calming imagery, and not the hypnotic induction technique that is responsible for SD's increased efficacy.

The explanation why recommendations improve the effectiveness of CBT strategies, such as SD, is because they provide a coping approach for the patient, according to Spanos and Barber. The explanation why fear-reducing suggestions enhance SD's effectiveness may be the same reason why self-statements coping and imagery coping enhance SD's effectiveness. Woody and Shauble (1969) found that adding fear-reducing suggestions without a hypnotic induction enhanced the effectiveness of traditional SD in support of the Spanos and Barber hypothesis. In their meta-analysis of 18 studies in which CBT was compared with CBH, Kirsch and colleagues (1995) concluded that hypnosis enhances the efficacy of CBT. However, only a few of the meta-analysis studies in Kirsch et al. (1995) were relevant to disorders of anxiety. Based on a literature review, Schoenberger (2000) concluded that while CBH anxiety treatments were more effective than no treatment, there was only one study in which CBH treatment was found to be more effective than comparable anxiety treatment (Kirsch et all 1997). The CBH and the CBT were essentially the same in the Schoenberger et al. (1997) report. By identifying the CBT methods as hypnosis, the CBH therapy varied from the CBT treatment and included suggestions for improvement after the hypnotic induction. A recent study, not included in any of the CBH reports, compared the relative effectiveness of hypnosis SD with relaxation in animal phobias care (Forbes, 2007). A hypnotic induction and recommendations including coping techniques were included in the SD for hypnosis therapy. The hypnosis-free SD featured gradual relaxation rather than hypnotic induction, and did not include coping imagery suggestions. The subjects with hypnosis receiving SD experienced greater reduction in anxiety than the subjects with progressive relaxation receiving SD.

Suggestions to alleviate uncertainty and to deal with self-statements are both cognitive techniques that can be used by patients to reduce anxiety. As previously mentioned, Meichenbaum (1972) found that incorporating self-statements coping and imagery coping during SD enhanced its effectiveness. Likewise, there is some evidence that adding cognitive interventions to hypnotherapy increases its effectiveness. Boutin and Tosi (1983) found that rational stage directed hypnotherapy, which is a CBH approach that combines hypnosis and CBT strategies, was more effective than hypnosis alone in the treatment of test anxiety.

CBT and hypnosis combination is a more effective approach to recovery than either one alone, at least for some patients (Alladin, 2007; Alladin & Amundson, 2011). One of the factors in assessing its efficacy may be the preferences of patients for hypnosis. There is some evidence that patients with strong hypnosis attitudes and values are the most receptive to hypnosis-labeled therapies (Lazarus, 1973; Schoenberger et al., 1997). However, further work is required to establish whether hypnotic induction, expectations, cognitive strategies, or a combination of these factors are due to the enhanced effects observed in CBH.

3. COGNITIVE BEHAVIOUR THERAPY UNDER HYPNOSIS

INDUCING RELAXATION STATE:

Different techniques of calming and hypnotic induction can be combined to create a treatment customised to a patient's needs and preferences. When making decisions about which hypnotic induction and relaxation techniques to use, the patient collaborates with the therapist. Instead of using standardised images, patients are encouraged to create their own relaxation images. Getting patients involved increases the likelihood that they will be responsive and will follow through and use the techniques on their own as part of self-hypnosis. For each patient, individual recordings are made to promote self-hypnosis training. The reader is referred to Golden and colleagues (1987) for detailed descriptions of different hypnotic induction procedures and deepening techniques. The reader is directed to Golden (1986) for recommendations for choosing which hypnotic induction technique to be used with a particular patient.

Self hypnosis:

Patients are advised to use hypnotic methods for induction, strengthening strategies, and hypnotic suggestions as part of self-hypnosis preparation. When teaching self-hypnosis, the author uses many approaches. Hypnotic inductions can be registered for the patient to listen to at home to promote self-hypnosis. After several listening to the tape, they are advised to practice self-hypnosis. Instead, patients are presented with instructions that they can memorise or use in their own voice to record. The basic skills of hypnosis (relaxation, visualisation, suggestion) are also taught.

Patients are taught how to use self-hypnosis in order to prepare for circumstances that cause anxiety/ panic. They visualise dealing with potential stressful events during self-hypnosis and apply hypnotic advice to reduce anxiety and build trust. During in vivo training, they are advised to use their self-hypnosis abilities.

Desensitisation via hypnosis

The desensitisation approach that the author uses involves 5 stages:

(1) Behavioural assessment and hierarchy construction

(2) Hypnosis and relaxation training,

(3) Constructing hypnotic suggestions,

(4) Gradual exposure to feared situations through imagery and the use of therapeutic suggestions given during hypnosis, and

(5) *In vivo* exposure to feared situations.

Hierarchy Construction

Systematic desensitisation presents patients with an opportunity to slowly overcome their fears. Until progressing to a next step, care is taken to ensure that a patient experiences success with one step. The patient's apprehension is broken down into different anxiety-producing conditions as part of the clinical examination. The situations are then rank ordered from least to most anxiety-producing, and are graded on a Subjective Units of Disturbance Scale (SUDS) from 1–100, where 100% is the most anxiety-provoking situation. Table 1 provides an example of an anxiety hierarchy used to treat a patient (T) with panic disorder. Mr. T had his first episode of panic attack 11 months ago when he was under the influence of marijuana and experienced a rapid heart rate, lightness in feet and inability to move, he felt as if he was going to die, he was taken to the hospital and admitted in cardiology for examination but examination revealed a healthy heart, and a complete physical exam revealed an otherwise healthy body. He had a similar episode 12 days later in a movie theatre after which he started to worry about going out and stared having anxiety in going to new places or travelling with public transport. Table 1 shows the products and the SUDS scores.

TABLE 1: Example of an Anxiety Hierarchy With SUDS Ratings

sl.no	Situation	Score
1	Taking a metro to travel	90
2	Taxi cab ride with a friend	50
3	taxi cab riding alone	65
4	Sleeping in a hotel room	80
5	Driving in heavy traffic	75
6	Flying	95
7	Business meetings, and talking to new people	75
8	Office presentation to a big crowd	80
9	office presentation to small crowd	65
10	Going to new places	75

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Identifying negative thoughts and Cognitive Restructuring:

Identifying their key anxiety related thoughts is important as they are directly related to the sensations felt by the client. As stated in table 2 with examples.By applying cognitive modification to hypnotherapy, the idea of negative self-hypnosis can be used to help patients understand how their negative self-suggestions and disturbing thoughts cause anxiety. They're taught to monitor and identify these cognitions. Various techniques can be used for modifying the negative thoughts, such as:

A. Rationale: therapist and client working together to test the modified negative thought, while the therapist presents a rationale by providing and making the client understand the link between thinking, feeling and behaviour.

B. Giving information about anxiety.

C. Distraction techniques example focusing on an object and defining it in detail, pleasant memories and fantasies that provide a calming affect can be linked and associated with a word or colour or three deep breath set by the help of hypnotic suggestion.

D. Activity schedules: asking the client to make an hour by hour daily schedule of their activities and ratin them on a scale of 1-100 for features such as anxiety, fatigue, pleasure and mastery.

E. Verbal challenging of automated thoughts.

Patients are also advised to substitute their negative self-suggestions with hypnotic suggestions to reduce anxiety. Hypnotic ideas may be used during SD and self-hypnosis.

TABLE2: examples of specific links between sensations and thoughts.

sl.no.	Sensation	Thought
1	Palpitations	I am having a heart attack
2	Breathlessness	I will suffocate and die
3	Feeling dizzy	I will pass out and no one will help me
4	Difficulty thinking	I am going mad

Desensitisation via imagery in a hypnotic state:

It is used to remove/ reduce fears when they accompany physical feelings, which are generally not experienced by the client during the process of therapy. A hypnotic state is induced for the client, and inquiry about the emotional feelings that get generated with the fear, anxiety/ panic state. Then the client is taken into deep hypnotic state by various methods prescribed by the hypnotherapy manuals, and then the client is asked to visualise/ imagine themselves in the anxiety provoking situation (recent emotional experience), and let them experience the feelings to the fullest, only the emotional feelings. And then the feelings are allowed to pass with hypnotic suggestions. This is repeated 6 or more times till there is little or no anxiety left associated to the situation or similar situations leading to a feeling of calmness and ability to administer control over their feelings in similar situation (Golden, 1994).

Relaxation techniques and relapse prevention:

Self-hypnosis and hypnotic meditation is taught to the client in order to promote self reliance. Disputing their own negative thoughts is taught as well. An emphasis on how strongly the patient believes in their rational responses is checked by point and counter point which can be done by role play in which the client states their rational response and the therapist counters it and agues against the rational response if weakness is identified then more convincing responses are taught (Garner, 1980).

4. SUMMARY AND DISCUSSION

As previously mentioned, findings have shown that CBT with hypnosis is more successful than CBT alone. Nevertheless, in the management of anxiety disorders, there are only a few studies comparing CBH with CBT or BT. The findings of effectiveness are difficult to reach as many of these studies are subject to methodological problems and lack adequate

control groups and have small sample sizes, as the literature reviews on CBH have shown. In fact, as Spanos and Barber (1976) pointed out, experiments incorporating elements of a therapy kit, such as a hypnotic manipulation and the introduction of disturbing recommendations, are confusing. Future research must be undertaken to explore the effect of adding hypnotic manipulation, strategies for reducing anxiety and visualisation of therapies like Systematic densetisation.

CBH appears at least as efficacious as similar therapies for BT and CBT. In order to be of clinical value, treatments including hypnosis do not have to be higher than any other treatments. As Lazarus (1973) pointed out, we will look at which treatments do the people, under which particular circumstances, for which issues.

Based on research into individual differences, several clinical guidelines can be provided. Imaginative participation is a knowledge or characteristic linked with hypnotic suggestibility (Spanos & Barber, 1974, 1976). One of the factors in assessing their success is patient perception regarding hypnosis (Lazarus 1973; Schoenberger et al. 1997). For patients with moderate to high rates of creativity and for patients with strong hypnosis confidence and values, hypnotherapy should therefore be regarded. Further research is needed for confirmation off the function of individual variables in deciding therapy efficacy, such as hypnotic capacity, creative abilities and optimistic perceptions. Many trials dealing with these issues that help to establish the treatment of CBH for phobia and anxiety as evidence-based.

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