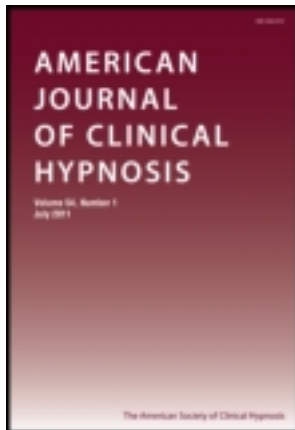


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# Hypnosis Aided Fixed Role Therapy for Social Phobia: A Case Report

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This case study details how hypnosis aided fixed role therapy (HAFRT) was employed in the successful treatment of a case of social phobia with a history of refractory outcomes to previous therapy trials. The treatment consisted of 10 office sessions, scheduled every two weeks, of HAFRT along with twice a day self-hypnotic sessions where the patient performed multiple visualization rehearsals of the vignettes that were successfully mastered in hypnosis during office visits. The results indicated that this patient was able to engage in social and professional affairs that were impossible prior to treatment. The patient retained the therapy gains at follow up 6 months later.

**Keywords:** hypnosis, fixed role therapy, social phobia

Individuals suffering from this anxiety disorder experience unreasonable fear or anxiety in connection with exposure to social situations involving contact with people they do not know or who they expect may judge them and because of this avoid such situations whenever possible. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association, 2013) defines social phobia along the following dimensions:

- A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).  
Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.
- B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).
- C. The social situations almost always provoke fear or anxiety.  
Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
- D. The social situations are avoided or endured with intense fear or anxiety.

- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

*Specify if:*

Performance only: If the fear is restricted to speaking or performing in public. (pp. 202–203)

### Hypnotic Aided Psychotherapeutic Approaches

There are numerous reports in the literature which support the combination of hypnosis with psychotherapeutic modalities. Treatment with hypnosis aided systematic desensitization was documented by Iglesias and Iglesias (2014) in the case of a highway phobia. The consensus reached by these authors was that a pivotal benefit accrued from combining these modalities was an abbreviation of the duration of therapy. Moreover, combined systematic desensitization with hypnosis was deemed superior to systematic desensitization by itself as a result of the superior depth of relaxation and vividness of visualization that is obtainable with hypnosis but not with ordinary relaxation techniques (Glick, 1970; Iglesias & Iglesias, 2014). Hypnosis can also help the patient to restructure negative thinking toward more positive expectations from treatment. Combined applications of these modalities have been employed in treatment of odontophobia (Moore, 1990), agoraphobia (Surman, 1979), phobia of a laundry product (Deiker & Pollock, 1975) and recurrent distressing dreams in a patient under treatment of obesity (Surman, 1979).

The combination of hypnosis with cognitive behavioral therapy (CBT) has possibly received the greatest attention in the literature of hypnotic aided therapeutic approaches (Alladin, 2013). This therapeutic hybrid has been deemed superior to CBT alone and has been recognized an effective approach for the treatment of temporomandibular disorder (Ferrando et al., 2011). Cognitive hypnotherapy has also been reported effective in the treatment of bulimia nervosa (Barabasz, 2012). It has also been employed effectively in the treatment of dissociative disorders (Fine, 2012). This combined or hypnotic aided approach has been used to treat patients with chronic pain syndrome (Elkins,

Johnson, & Fisher, 2012). Moreover, it has been employed successfully in the treatment of depressive disorders (Alladin, 2010). Hypnosis was combined with existential psychotherapy in the treatment of end stage terminally ill patients (Iglesias, 2004). The principles of existential theory, including death anxiety, the finality of life, and loss and grief were recognized and addressed in hypnosis. The author (Iglesias, 2004) concluded that to the degree that the existential concerns were surmounted, the physical symptoms that were unresponsive to medical treatment, including nausea and vomiting, became responsive to the prescribed palliative medical regimen. The combined approach with hypnotic aided existential psychotherapy proved to be efficacious in the management of secondary symptoms in terminally ill patients. There is also documentation of a combined approach including hypnosis with -analytic therapy (Wolberg, 1996). This combination, titled hypnoanalysis, was documented in the treatment of a case of total amnesia (Eisen, 1989). There is documentation of treatment of orgasmic dysfunction with hypnoanalysis (Stewart, 1986). Kampman and Kuha (1974) provided an account of a case of conversion hysteria treated successfully by an approach based on the combination of these modalities. While some of these authors are dated, their pioneering work was pivotal and remains important.

In general, the superior depth of relaxation and vividness of visualization that is obtainable with hypnosis, but not with ordinary relaxation techniques, (Glick, 1970; Iglesias & Iglesias, 2014) renders hypnosis a desirable and suitable technique to combine with existing therapy orientations in order to facilitate the acquisition of therapy goals. Fixed role therapy was originated by George Kelly (1955, 1963, 1969) who has been credited as one of the pioneers of the cognitive-behavioral orientation. Kelly's fundamental view of people as naive scientists was incorporated into most later-developed forms of CBT. It also influenced the development of intersubjective psychoanalysis (Stolorow, Bernar, & George, 2000) which leaned heavily on Kelly's phenomenological system. Kelly's (1955, 1963; Bannister & Fransella, 2013) therapy often involves homework—things the patient is asked to do outside the therapy situation. The best known technique in Kelly's system is called fixed-role therapy (Kelly, 1955, 1963). It requires the patient to follow a preconceived role or fixed-role sketch, as Kelly referred to it (Bonarius, 1970), and actually be the person described in the fixed-role sketch for a period of a week or two. This is a full time commitment: The patient is asked to be this person 24 hours a day, at work, at home, even when alone. Fixed role therapy has been documented as the modality employed in the treatment of social anxiety (Beail & Parker, 1991). It has been reportedly employed as a collective class exercise in a graduate seminar on personal construct psychology (Neimeyer et al., 2003).

### Case Report

The case presented was chosen because the clinical history indicated a refractory pattern of results to therapy. This individual fit the criteria for a diagnosis of social phobia. The phobic reaction was focused on social situations of meeting people for the first time.

This was a 32-year-old, single, White male who was a chemical engineer employed by an international petroleum company. He had an illustrious career and an impressive reputation based on his patents. However, he limited his expansion, prosperity, and opportunities to achieve even greater renown by the inability to attend congresses and conferences, by failing to present his work in symposia, and by remaining, in general, an anonymous figure. He was indeed impaired by the phobia as far as not being able to promulgate his work among his peers. He was equally limited in his abilities within the social realm. The disorder dictated a social life devoid of intimacy and meaningful interpersonal contacts. Although desirous of an amorous relationship this individual was compelled to remain virtually isolated.

### Case Overview

A case overview indicated an individual with a family history of anxiety disorders. The patient reported that males on the paternal side of this family had positive clinical histories of obsessive compulsive disorder, generalized anxiety disorder, and agoraphobia with panic attacks. There was no history of alcoholism or drug abuse in this family. The patient's mood and affect were anxious and he had no other gross psychopathology other than the phobia in question. He was precisely oriented, was of superior intelligence and thinking was organized and goal directed.

### Formulation

The etiology in this case included features of panic disorder which created an optimal environment for phobic conditions to develop. The patient dated the onset of the social phobia to a cocktail gathering for upper management executives wherein he felt panic when he was introduced to the president of the company. From that instance the discomfort generalized to situations where he met new acquaintances. The patient proceeded to employ avoidance of social situations as a defense. The patient described the panic as debilitating, visible, and obvious to those around him. The episodes were accompanied by frightening sensations including shortness of breath and palpitations. Panic features have been documented to serve as precipitant in a host of anxiety disorders including PTSD, specific phobia (Iglesias & Iglesias, 2014), as well as social phobia—the diagnosis in this case report. Hypnosis has a well-documented literature in the care and management of anxiety disorders (Kirsch, Capafons, Cardena, & Amigo, 1999; Smith, 1990). Hypnosis has been reported in the successful management of panic disorder (Iglesias & Iglesias, 2005). Hypnosis has been associated with the management of depersonalization disorder (Hollander, 2009). This condition has been differentiated from post-traumatic stress disorders and has recently been conceptualized as a subtype of panic disorder (Baker et al., 2003; David, 2004; Phillips & Sierra, 2003; Seguí et al., 2000).

## Treatment

The therapy consisted of the following steps: (1) He was asked to identify desired personality traits that he wished to possess. (2) The patient was instructed to construct lengthy and detailed vignettes of elementary and simple social interactions. He was to be depicted in the vignettes endowed with the desired personality traits. (3) Hypnosis was employed to play out the elementary vignettes. The emotional component “was shut off” during this step. The disconnecting of emotions was accomplished by means of Wolberg’s (1996) “Theater Technique.” (4) Lengthy vignettes of complex social situations were constructed. (5) The complex vignettes were played/rehearsed in hypnosis with the emotional component available. (6) The patient played out/rehearsed in self-hypnosis, twice a day, in 15 minute-sessions, the vignettes that were mastered at the office. The treatment visits were scheduled every 2 weeks.

The list of desired personality attributes included: (1) confident; (2) articulate; (3) poised; (4) assertive; (5) stable emotionally; (6) close attention to personal grooming; (7) dress elegantly; (8) appropriate body weight; and (9) conversant on current events. The list of simple and elementary simple interactions included: (1) saying hello to a stranger; (2) asking for directions from a mail carrier; (3) offering assistance to a disabled person; (4) speaking to attendant while pumping gas; (5) small-talk with the waiter while ordering lunch in a restaurant; (6) asking for help from an employee at a department store; (7) conversing with sales persons in different areas of a department store; and (8) going to an auto dealership and asking about a certain car. The following list of complex vignettes was constructed: (1) He is asked to host a recently hired engineer and introduce him to the department’s staff. (2) He is invited to a social for engineers and upper management personnel the president and CEO are expected to attend. (3) He attends a social function and sees a woman by herself and struggles with urges to meet her. (4) He presents a paper at a meeting of a prestigious professional society. (5) He introduces himself to a colleague who works in the same department of another company and has the same research interests. (6) He has the opportunity to get to know a woman that has shown interest in him. (7) He has to report preliminary findings of his investigations at a meeting of stockholders.

*The first phase of therapy.* After hypnosis was induced using an eye roll technique (Spiegel & Spiegel, 2004) the following instructions were given:

You are at the movie theater and are waiting for the featured presentation of the day to be shown. The selected movie is a presentation of several vignettes that showcase you engaging in *elementary and basic* social activities. These activities are prerequisites for mastering more complex interpersonal interactions. We will focus on the basic and elementary interactions at this time and will address the complex ones at a later date. When the film begins you will recognize and see yourself endowed with the characteristics that you designated as desirable. Remember that you are in a state of hypnosis that affords a sense of safety. You are now ready to see yourself perform certain tasks. As the following scenarios play out you will see yourself in the situations without any distress. You will also watch

your involvement devoid of emotions. You are not affected by the events on the screen. You are emotionally disconnected. Let's start.

The lengthy and detailed simple and elementary lengthy and detailed vignettes constructed by the patient are read/played out in hypnosis on the theater screen. The protagonist (patient) is endowed with the desired characteristics. The vignettes are read/played out slowly and repeated numerous times. The vignettes are presented two to a session.

*The second phase of therapy.* After hypnosis was induced using an eye roll technique (Spiegel & Spiegel, 2004) the following format for performing the protocols in hypnosis was presented:

You are at the movie theater and are waiting for the featured presentation of the day to be shown. The selected movie is a presentation of several vignettes that showcase you engaging in *advanced* social activities. You have already mastered the elementary interpersonal interactions. The elementary interactions that you mastered were prerequisites for the complex interactions. When the film begins you will recognize and see yourself endowed with the characteristics that you designated as desirable. Remember that you are in a state of hypnosis that affords a sense of safety. You are now ready to see yourself perform certain tasks. As the following scenarios play out you will see yourself in the situations without any distress. You will also watch your involvement with your emotional channel turned on. Emotions that you desire will remain "on" and they will be appropriate and manageable. Let's Start.

The lengthy and detailed complex vignettes are read/played out in hypnosis on the theater screen. The protagonist (patient) is endowed with the desired characteristics. The vignettes are read/played out slowly and repeated numerous times. The vignettes are presented one to a session.

## Results

The character/protagonist/patient in this version of fixed role therapy was exposed to vignettes of social situations in hypnosis. Emotions were suppressed with Wolberg's (1996) theater technique which allowed the vignettes to be viewed devoid of emotions. This safe exposure to the elementary social encounters in HARFT was an effective approach which allowed for the second phase of treatment: exposure to complex social encounters in HARFT without the suppressing effect of the theater technique. To summarize: In addition to 10 office visits, scheduled every other week, an initial assessment visit and a final summary visit, the patient completed two 15 minute sessions daily of self-hypnosis on days without a scheduled office visit. This provided approximately 200–225 self-hypnosis sessions to the patient during the 20 weeks of treatment. The patient reported that he retained the therapy gains at follow up 6 months later.

## Discussion

HAFRT allowed for a smooth flow of the presentation of the social phobia related imagery. Under hypnosis and with the added emotional distance afforded by the use of Wolberg's theater technique (Wolberg, 1996) the images were played out, observed, and examined in a fraction of the time involved in comparison to the *in vivo* approach in the original form of fixed role therapy. The efficacy of the results of this patient's care brings to light the basic dilemma inherent in case studies: the question of what influenced the behavioral change. Iglesias and Iglesias (2014) have indicated that the lack of experimental conditions such as no control plus multiple methods utilized in case reports render reaching inferences regarding the active ingredients in the treatment a virtual impossibility. The result is that it cannot be determined by this case report the degree of efficacy that can be credited to self-hypnosis, to fixed role therapy, to Wolberg's (1996) theater technique, or to combinations of these elements. Iglesias and Iglesias (2014) have acknowledged the presence of methodological weaknesses and asserted that the objective of this case report was to introduce unusual conditions and offer treatment approaches worthy of empirical investigation. Furthermore, gains reported in this case report, must be understood within the limitations reported (Choy, Fyer, & Lipsitz, 2007) which suggest that relapse is a common phenomenon in the treatment of phobias. With regards to long-term outpatient treatment gains, Choy et al. (2007) added that the understanding was that gains are generally maintained for one year, but longer follow-up studies are needed to better understand and prevent relapse.

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