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Awake-Alert Hypnosis in the Treatment of Panic Disorder: A Case Report

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An individual developed a lifestyle-limiting case of Panic Disorder that threatened to interfere with her *raison d'etre:* To participate in the exclusive lifestyle of her community. The panic episodes started to cripple her social calendar and as the "season" came into full swing her coveted role of chairwoman of various philanthropic functions came into peril. A variant of awake-alert hypnosis had to be created for this case. Hypnosis consisting of eye closure with relaxation was out of the question. The authors created an induction technique and specific suggestions based on the Waterford glassware, as focal point, with the purpose of not only inducing awake-alert hypnosis but also of executing a series of specific strategies, tailored to abort the incipient panic episodes.

Keywords: Awake-alert hypnosis, panic disorder

Panic Disorder has been described as perhaps the most terrifying of all psychiatric symptoms (Maxmen, 1986). Suddenly and devoid of any logical reason, panic attacks inundate the unsuspecting victim with overwhelming ominous thoughts. Moreover, these episodes are accompanied by a constellation of horrific sensations that create fears of going mad or of actively dying. Complicating the picture is the slippage of controls that the individual has always taken for granted. The loss of control at times escalates into a sense that one is losing consciousness (Beck & Emery, 1985). The striking characteristic of a panic attack is the overwhelming and paralyzing experience

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of being engulfed by anxiety (Barlow, 1993). The individual's reasoning powers are categorically suppressed by the anxiety and the accompanying cognitive ideations of doom, destruction, and imminent death (Burns & Beck, 1978). A host of physiological correlates are present during an episode and they conspire to convince the victim that he must fight for his own life. Profuse sweating, peculiar sensations in the extremities, hyperventilation, chest pains, nausea, paresthesias, chills or hot flashes, and feeling dizzy or faint constitute the constellation of physiological symptomatology that make panic attacks such a devastating experience (American Psychiatric Association, 1994). Most episodes have duration of 3 to 10 minutes and rarely more than 30 minutes.

Panic attacks can present in a host of Anxiety Disorders including Panic Disorder, Social Phobia, Simple Phobia, and Posttraumatic Stress Disorder. The DSM IV (American Psychiatric Association, 1994) further classified Panic Disorder to be with or without Agoraphobia and adds that for Agoraphobia to be present, the individual has to report anxiety in places or situations from which escape might be difficult or in which help may not be available in the event of having unexpected panic attack symptoms (American Psychiatric Association, 1994).

Hypnotherapy of Anxiety Disorders

Because hypnosis exploits the intimate connection between mind and body (Rossi & Cheek, 1988) and provides relief through improved self-regulation (Kirsch, Capafons, Cardeña, & Amigó, 1999), it holds utility in the treatment of the anxiety disorders. Moreover, as it beneficially affects the control of cognitions (Zarren & Eimer, 2001) and enhances the experience of self-mastery (Dowd, 2002), hypnosis has been deemed an efficacious treatment for the management of Anxiety Disorders (Smith, 1990).

Hypnosis has been employed in the treatment of Panic Disorder in different ways, depending on the theoretical orientation of the hypnotherapist. The combination of hypnosis and behavioristic principles and strategies was documented in a study of the efficacy of biofeedback-aided hypnotherapy for intractable phobic anxiety (Somer, 1995). McNeal (2001) reported on the role of hypnosis aided with EMDR in the efficacious treatment of phobias. A dynamically oriented hypnotic approach for the therapy of anxiety reactions was developed by Spiegel and Spiegel (1978). Their approach stressed the importance of helping the patient understand the historical origin of the anxiety condition.

Hypnosis is recognized as a potent anti-anxiety intervention, which can be incorporated into a variety of theoretical systems and models of therapy. Its efficacy and role in enhancing the successful treatment of anxiety disorders has been endorsed for a variety of orientations including the psychodynamic, interpersonal, cognitive, or behavioral (Gilbertson & Kemp, 1992; Miller, 1986). Additionally, the role of hypnosis in treating anxiety conditions from a co-morbid pharmacological/hypnosis perspective was investigated in a study of the efficacy of alprazolam (Xanax) and hypnosis with a college-aged population (Nishith, Barabasz, Barabasz, & Warner, 1999). Their findings supported the use of hypnosis as a substitute for sedative drug use.

Awake-Alert Hypnosis

Despite the fact that relaxation-oriented inductions hold the greatest popularity and are the most widely used form of trance induction, hypnosis is not equivalent to

relaxation nor is relaxation a required characteristic (Alarcon, Capafons, Bayot, & Cardeña, 1999). The notion that a relaxation-based induction could be counterproductive in conditions where cognitive alertness was desirable was suggested by Oeting (1964). Gibbons (1974) created an approach that emphasized suggestions of alertness which he coined "hyperempiria" and which he described as a "new altered state of consciousness." The evidence which clearly demonstrated that relaxation based techniques are not essential to hypnosis is summarized by Cardeña, Alarcón, Capafons, and Bayot (1998) and by Wark (1998).

The field of alert-hypnosis is predominantly represented by studies that establish an operational distinction between two strategies or different approaches: Awake-alert hypnotic techniques and active-alert hypnotic techniques. The research and applications of the awake-alert strategies are synonymous with the work of Cardeña et al., (1998). Capafons (1999) is also a major contributor to the awake-alert literature. Representatives of the awake-alert school of non-relaxation-based hypnosis (Cardeña et al., 1998) recognize that their approach is based on the contributions of three conceptual systems. Gibbons (1974) is credited for his hyperemperic procedure; Bányai and Hilgard (1976) are recognized for their general approach; and the contribution of emotional self-regulation therapy (Capafons & Amigó, 1995) is also acknowledged. Basically, the hypnotic induction in this system is presented to the individual as a method to achieve mental activation, with simultaneous activation and calm but free of anxiety (Alarcón et al., 1999). A transcription of a representative induction, in its entirety, can be found in Cardeña, et al. (1998).

The active-alert techniques also enjoy substantive representation (Bányai & Hilgard, 1976; Bányai, Zseni & Túry, 1993). This procedure entails the use of controlled and steady resistance while pedaling a bicycle. As the individual pedals, suggestions are provided to enhance the active-alert induction of hypnosis. Bányai, et al. (1993) provided an example, described in detail, of the active-alert induction.

Methods of alert trance or active hypnosis, rather than relaxation and drowsy hypnosis, have been employed and documented in clinical situations. Alert-trance methods have been adapted to athletic performance enhancement with weight lifters (Howard & Reardon, 1986).

Case Report

The patient was a 72-year-old widowed heiress who lived in Florida during the winter months. Her *raison d'etre* revolved around the exclusive social life of her affluent community: dinner engagements, the philanthropic balls, and the various and sundry social engagements attended by the celebrities and aristocrats. During her youth this patient abused alcohol and barbiturates, medically prescribed, to manage social and public speaking phobias. This abusive pattern of relying on alcohol and barbiturates damaged the lining of this patient's intestinal tract and created a chronic case of diverticulitis. This presented an obstacle whenever this patient required medications as most medications triggered acute episodes of diverticulitis.

At the present time, she was not particularly bothered by thoughts of ridicule and public failure. She enjoyed the spotlight and the adulation and attention that her role created. She could recognize the role that her physical attributes played in her social success. A radiantly attractive lady all of her life, she had become noticeably aged by the passage of time. She was cognizant of her narcissistic features and knew

that loss of appeal was a significant blow to her vanity and ego.

The panic episodes were characterized by an accelerated heart rate, shortness of breath, chest pain, fears of losing control and being detected, and sweating; they fit the criteria for Panic Disorder as described in the DSM IV (American Psychiatric Association, 1994).

She was tried on several SSRIs plus a benzodiazepine but the medications had to be discontinued because they irritated her intestinal lining and exacerbated the patient's diverticulitis. At this point the patient accepted her psychiatrist's referral for hypnosis.

First phase of treatment

The first step in her hypnotherapy was to inform this patient that this modality was most efficacious in aborting incipient panic attacks when employed at the earliest phase of the episode. This task was facilitated by introducing the "intensity thermometer," a 0-10 subjective intensity scale where 0 symbolizes the absence of panic and 10 is the worst imaginable. She was then instructed to break down a typical panic attack and give a detailed description of every level on the intensity thermometer. She was asked to define and describe, phenomenologically, each level in terms of the three following inquiries: 1) Describe how you react physiologically at each level; 2) Describe your behaviors or what you are doing at each level; and 3) Describe the dialogue and ideas that go through your mind at each level.

Second phase of treatment

An eye-fixation induction was employed for the induction of orthodox hypnosis and direct suggestions under hypnosis were provided that she will become immediately cognizant of incipient panic episodes at the earliest onset or level. It was reiterated under hypnosis that to the degree that she employed hypnosis at the earliest level of the panic episode, to that degree she would be successful in aborting the episode.

Third phase of treatment

Training in awake-alert hypnosis was approached from an eye-fixation, eye-closure, orthodox induction. After inducing hypnosis by employing an eye-fixation and eye-closure induction, the patient was gradually conditioned to open her eyes, while remaining in a hypnotic state. The fractionation method (Kroger, 1963) was adapted and successfully employed to teach this patient to enter into an awake-alert hypnotic state with eyes open and devoid of body relaxation; instead the patient was conditioned to engender a disconnected and "woodsy" feeling all over her body.

The fractionation method involved the following steps: a) induction of orthodox hypnosis using eye fixation and eye closure; b) suggestions that from the neck up her hypnotic state would evolve into an awake-alert trance allowing her eyes to be open and to be able to speak while the rest of her body remained in traditional relaxed hypnosis; c) broadening the area of the body, from the head to her waist, which was to enter awake-alert hypnosis. Suggestions were provided that instead of being in a state of relaxation, her body was becoming "woodsy" and would feel as if an anesthetic agent had been injected yet it could be active and move about as necessary; and d) the final step instructed the patient to be able to induce awake-alert hypnosis over her entire body. From this point on, hypnosis was induced in the awake-alert fashion.

Fourth phase of treatment

Starting at this phase of treatment, awake-alert hypnosis was induced at all sessions using the alert-awake method. The following step involved conditioning the patient under awake-alert hypnosis to the suggestions in the following "Waterford script" for aborting panic attacks.

> You are now in a state of hypnosis with your eyes open. You are familiar with this experience, as you have practiced its induction many times. You know that it is a unique type of hypnosis that allows your eyes to remain open, for you to be alert and be able to converse and to move about freely. You also know that it makes your body numb, as if you had taken an injection of an anesthetic. It makes your body feel numb and "woodsy," yet you are free to move about unimpeded. As you continue staring at the Waterford, a sense of security comes over you. Somehow it feels like you and the Waterford are blending, joining forces. The Waterford is the finest of its kind and this element of grandeur makes it a symbol of success, power, elegance and impeccable taste. Without a doubt, only the most socially upward mobile, the intellectually elite and the aristocratic are entitled to enjoy the splendor and beauty of such a treasure. These individuals do indeed possess certain qualities that distinguish them from the general public: They are individuals that understand duress and know how to overcome it; this is why they belong to the ranks of the successful. They are endowed with a self-corrective mechanism in their personalities that make them impervious to defeat. They are resilient and momentary pain and duress makes them stronger. These realizations make you feel safe and offer you comfort. They offer you strength, confidence and security.
>
> As you already know, at the slightest hint of discomfort, you are to immerse yourself in the splendor of the Waterford and transport yourself within the safe heaven that it is prepared to offer you. The intricate labyrinths perceived within the deepness and richness of the glass offer the perfect haven and sanctuary for you to feel protected. It is indeed an impenetrable fortress all around you. The greater the discomfort, the deeper within the Waterford that you retreat. The numbness and "woodsy" feeling that you have throughout your body serve as a reminder that you won't feel any pain. As the Waterford transmits peace, serenity and safety to you, your entire being registers the benefits. Your heart rate accordingly normalizes…your respirations slow down…your stomach unwinds and feels comfortable again…at this point, you consult your intensity thermometer to determine when its acceptable to disengage from the Waterford.

Formulation

The panic attacks symbolized the terror behind the prospect of losing her social position, standing and the coveted role of chairwoman at various philanthropic functions. This patient was able to recognize that in reality her social life was all she

had. This explained the recalcitrance and intensity of the panic attacks. The decision to employ an intervention that strengthened the patient's fantasy of entitlement and specialness, the apparent source of the presenting problem, was based on one conclusion. This individual's personality organization indeed presented characteristics typically associated with adjustment difficulties including self-admiration, a sense of entitlement, and self-centeredness. However, upon further examination, her history indicated that it was not necessarily maladaptive. This conclusion, in turn, was based on two pivotal circumstances. The first concerns individuals engaged in occupations or avocations in which chasing the spotlight and thriving on the adulation of others are not only appropriate and adaptive but a sine qua non for success (Weiner, 1998). This lady's accomplishment in her avocation depends on attracting the attention of others; thereby being noticed is essential for success. The second circumstance that limits the maladaptive effect of this patient's narcissistic orientation involves the fact that she is best described by Weiner's (1998) definition of a "nice narcissist." Weiner (1998) noted that despite their self-centeredness these people are able to show considerable genuine interest in others. In most cases their primary concerns lie with their own priorities, but they are able to enjoy being around others, can be entertaining and ingratiating even though it is mostly as a means of ensuring an appreciative audience that will gratify their needs for attention and admiration (Weiner, 1998). Millon & Davis (1996) described this personality type as "healthy narcissist" and, in addition to the usual characteristics of the personality type, these writers indicated, that these individuals can demonstrate "interpersonal empathy, interest in the ideas and feelings of others, and willingness to acknowledge one's personal role in problematic interpersonal relationships" (p. 408). These writers deem this personality organization as not maladaptive.

Results

Data collected at the start of therapy demonstrated the panic episodes to present with a frequency of approximately three times a week. The patient was having the episodes equally during lunch engagements as well as during dinner parties. The level of intensity was typically reaching levels 6-7 (as measured by the intensity thermometer); at this point she was forced to leave with the excuse that "she wasn't feeling well." After four weeks of three-times-a- week 30-minute visits, the following results were documented: a) the frequency of the episodes was unchanged; she continued to have approximately three episodes a week; and b) the intensity level of the episodes was markedly suppressed. The patient became able to thwart the development of incipient episodes by applying the hypnotic procedure in the early phases (levels 1-3) of the panic process. She was followed up with weekly 30- minute visits, for reinforcement, for 2 additional months. She was seen the following "season" for follow-up and the picture was virtually the same. She continued to manage incipient episodes with the same hypnotic technique.

Discussion

The Waterford technique is an anecdotal example of the efficacy and importance of utilization and individualization of ego-strengthening suggestions (Frederick & McNeal, 1999; Phillips & Frederick, 1992; McNeal & Frederick, 1993). The Waterford

technique was designed to address the idiosyncratic psychodynamics underlying the panic attacks: The decline of physical attributes and the inherent threat that this represented to this patient's healthy narcissistic personality. The Waterford technique relied on indirect means to imbue this patient's fragile ego with individualized ego-strengthening suggestions that incorporated the same grandiose attributes that the patient ascribed to Waterford glassware. The Waterford technique transfused her ego with indirect suggestions of being elegant, refined, and of possessing discriminating taste, sophistication, prestige, and elitist status. Suggestions of resilience, strength, comfort, and security were also included. These ego-strengthening efforts were intended to improve the patient's self esteem by helping to get in touch with inner resources and to develop "Inner Strength" (Frederick & McNeal, 1993; McNeal & Frederick, 1993).

The Waterford technique also provided this patient a place of refuge or sanctuary where she could retreat and find safety (Finkelstein, 1990). The suggestions of anesthetic-like sensations or a "woodsy" feeling all over her body offered the patient contradictory and mutually exclusive physical sensations to those that accompanied her subjective experience of panic.

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