

Treating travel related phobias with hypnotherapy

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Hypnotic procedures have a long history. Induction techniques were used in treatment by the ancient Greeks. In modern medicine the ethical use of hypnotherapy was accepted by the BMA in 1954. The use of hypnosis to treat, facilitate treatment or as an adjunct to therapy is now firmly established and utilised by psychologists, GPs, and some nurses.

It is used in pain and stress reduction, anxiety and phobic states, and for deconditioning of unwanted habits and addictions. Post graduate medical education courses on hypnotic induction and therapy are popular and several universities have a curriculum leading to the award of a degree in the subject.

What is Hypnosis?

There is general agreement that hypnosis is an altered conscious state involving mechanisms of attention and habituation of whatever duration. The involvement of attention is the sine qua non of hypnosis differentiating it from other altered conscious states. A behavioural phenomenon, the state facilitates rapid learning, enhances memory and helps the mechanism of conditioning to be established more quickly than if the patient is not hypnotised¹. The importance of hypnosis in treatment lies in its ability to bypass critical faculties of the conscious mind.

Hypnotic induction

This is a process and not an end result and refers to the preparation of the subject to loosen their critical grasp on familiar reality and to accept uncritically other evidence or suggestion. The person's imagination is used to assist creation of the desired state. Although there is much in the literature about induction techniques the function of the induction procedure is merely to achieve this state and the means of its accomplishment is not of primary consideration. It can be achieved in moments and often very quickly, a major consideration for those using hypnosis in the primary care setting.

Some skilled practitioners consider hypnosis and induction as mere therapeutic tools and use them as many do a computer. They do not really understand its workings and do not really wish to, but they know the mechanism works and they use it. The cure of the patient is of more concern than the route to cure. Apprehension about the hazards of hypnotherapy in clinical professional use has not been justified.

Today, time is crucial in clinical management and family doctors and those working in the travel health field can only embark on procedures involving brief patient encounters. With carefully selected patients affected by clearly demarcated conditions the use of hypnosis is practical within this scene. It can be remarkably effective in conditions severely affecting a patient's physical and physiological status. It can prevent the acute case becoming chronic. In this instance its greatest value is in the psychological arena and can be used with simple cognitive behavioural techniques to bring quick cure. Simple phobias for instance can be remarkably disabling and yet can often be easily reversed with brief hypnotherapy. For the novice hypnotherapist a case involving a single phobic aversion such as an aircraft phobia – a common condition – can prove a good introductory approach. This particular fear can prevent patient and

family from embarking on international travel but it responds well to simple hypnotic techniques and need not be time consuming for the therapist :

Flying phobias are increasingly common, but with good management , disabling fear, disturbed conditioned responses and frantic avoidance behaviour can be replaced by rational activity.

Phobias

A phobia is characterized by:

- A degree of anxiety and fear out of all proportion to evoking situation
- Cannot be explained or reasoned away
- Beyond voluntary control
- Leads to avoidance

Surveys ^{2,3,4} in the United States, Marks (1969) and Burns³ in Britain, show that there is still a marked lack of empirically based information on the prevalence of specific phobias in adults in the general population. The majority of phobics appear to be women although it is recognised that women are more likely to report their fears than men. Wilson (1967) and Burns³ record that travel phobias represented 2.81 per cent of phobias reported by women in one survey. In a 10 per cent random sample of 7,074 patients in my own general practice⁶ based on a structured questionnaire listing 13 common fear-provoking objects or situations, 16 per cent admitted to having a phobia and 13 percent of this sub-group reported fear of flying with a female to male preponderance of 2:1. The increase in air travel over the last decade is likely to be associated in an increase in such phobias as more people are exposed to requirements and opportunities for flying.

Components occurring in phobic states

- Cognitive element – person is subjectively afraid
- Behavioural response – avoidance of feared situation
- Physiological manifestation – tachycardia; hyperventilation which often lead to:
- Social component – disruption of normal living

Hypnosis

The use of hypnosis for phobias⁶ borrows both from behaviour modification and desensitization but therapy is facilitated by induction of a trance state.

Given time before the need to travel, behaviour modification is widely used in clinics to treat phobics⁵. The principal is to expose the patient to the situation which causes distress until he gets used to it and attempts are then made to extinguish the fear by relating it to a pattern of response which provokes no anxiety. The problem behaviour needs detailed study in order to arrive at a hypothesis about its genesis and identify appropriate intervention.

Behaviour modification(BMT) in therapy

BMT is based upon the conditioning and learning experiments of Pavlov and Skinner and their extension by Wolpe and Lazarus, Behavioural medicine at present does not focus upon patient's verbal reports and free associations but rather direct observation

and quantification of the patient's overt behaviour in real life situations. Many of these techniques are practicable in hypnotherapy and some, such as desensitisation and flooding, seem to be enhanced and the treatment period abbreviated by the use of hypnosis.

The techniques of behaviour modification

Behaviour therapy is directive and is aimed at manipulating the forces of behaviour to change disturbing emotional reactions to provocative situations. Procedures involved are:

Systematic Desensitisation:

Desensitisation is achieved by a rapid repetition of the stimulus and/or the response, with or without reinforcement.

Extinction usually of old responses by omitting either reinforcement or the original unconditioned stimulus that followed the eliciting stimulus or the instrumental responses.

Negative reinforcement. This is done by subjecting the patient to an aversive stimulus whenever he makes an undesirable response.

Counter-conditioning is achieved by affiliating a different and opposing response with the conditioned stimulus, followed by a direct reinforcement of the opposing response.

Desensitisation ⁴ consists of two features:

- **muscle relaxation and reduction of anxiety**
- **the construction of a graded hierarchy of aversive stimuli** from information provided by the patient.

Such a hierarchy for a flying phobia would consist of arrival at the airport, proceeding to the departure lounge, walking on to the plane, experiencing take-off and landing. The hierarchy can be presented to the patient, either in imagery or in reality, and film and tape recordings can be used effectively in desensitisation. Treatment can be assisted by vicarious or participant modelling. Here the therapist approaches the feared object or situation and demonstrates his confident response to it before asking the patient to do likewise. This procedure has three functions; the model encourages new patterns of behaviour to be adopted, unnecessary responses are inhibited or disinhibited and the expression of already established responses can be facilitated. Desensitisation works well with social and specific phobias and British Airways and several universities and hospitals have run courses for phobic travellers with

success. These often culminate in a short flight round the local town to demonstrate to the sufferer that the phobia has been extinguished. The disadvantage is that the process is time-consuming and often requires many sessions. Desensitisation can be carried out, however, with minimal therapist contact using tape recordings and book instruction on relaxation and desensitization procedures.

Flooding

Another technique, called flooding or implosion can be used to treat the phobic. If desensitization is like wading slowly in to a swimming pool at the shallow end, flooding is equivalent to jumping in at the deep end. Flooding is based on experimental evidence that conditioned fear responses dissipate when animals are prevented from running away from fear provoking situations. It is a prolonged exposure to the phobic situation with exposure usually initiated by flooding in fantasy with people imagining themselves in the frightening situation for one to two hours. The basic principal is to encourage the patient to face his fears rather than to avoid them. Flooding can be used very effectively with hypnosis which is possibly the most reliable method for removing the phobia when time before travel is at a premium.

Self Hypnosis

Teaching the patient auto-hypnosis, whereby at a coded signal he can recreate the relaxed state acquired at earlier sessions, decreases the risk of dependence and diminishes the time required for therapy. Graded desensitisation and flooding are both practicable within the trance states and visual imagery and vicarious modelling can also be utilised. A modified flooding technique is used and it is very effective for specific phobias such as flying.

One of my patients, who had patiently built up his business, had a unique opportunity presented to his firm for advancement and profit in the Far East, but he had long had a phobia for air travel. Unable to resist the opportunity for expansion he made his plans, bought his tickets, and the day before departure succumbed to panic and terror at the thought of many hours incarcerated in an aircraft. In the surgery he was in a state of agitation but refused to consider a drug prescription as he wished to be mentally fit for tough business negotiations upon arrival in Hong Kong.

He accepted the offer of hypnotherapy with alacrity and, providing to be good subject, was quickly in a trance and relaxed. Soon he was able to create a visual image of himself boarding and sitting in the aeroplane and, with continued suggestion of calmness, muscle and mind relaxation and freedom from tension, he was able to fantasise himself through a prolonged exposure to the feared situation. Given post-hypnotic suggestions that he would remain calm throughout the flight, and that the standard pre-take off and recorded music would relax him, he went off to make a successful return flight and business deal.

Even when the jet-liner was buffeted badly by turbulence and suddenly dropped 500 feet, with the dramatic appearance of personal passenger oxygen masks from their overhead stowage, he was able to keep calm. Now after a decade and many air trips he remains undisturbed by his once disabling phobia.

Gentle words, quiet words are after all the most powerful words. They are more convincing, more compelling, more prevailing and successful; a patient wrote these to

me on return from her first successful air trip after years of phobic avoidance. However the removal of psychosomatic symptoms before the patient is ready, and has built up more socially satisfactory defences, can precipitate more serious difficulties and therapists have to keep this in mind. It seems likely, however, that desensitisation can be carried out with little therapist contact using tape recordings to carry out relaxation and desensitisation procedures, and these are certainly a useful adjuvant in desensitisation and hypnotherapy. Book and computer instruction courses offering graded and detailed programmes of relaxation and exposure are available, and have proved of value to many phobics.

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