

---

## HYPNOTHERAPY FOR ANXIETY IN PRIVATE PRACTICE: SCL-90 RESULTS AND CASE DESCRIPTION

---

IRENE SHESTOPAL

### ABSTRACT

The author has used hypnosis for the treatment of GAD in her private outpatient clinic and monitored the efficiency of treatment by administering SCL-90 questionnaire. Twenty-seven patients completed the scales at their first treatment appointment; then they were offered a follow-up assessment a month later. The treatment method and one of the patient cases are described. Only twelve patients completed their first month of treatment; all of them had demonstrated an improvement. The results are statistically significant or highly significant in somatization, depression, anxiety and phobic anxiety symptom dimensions. The results are consistent with prior studies (Gould & Krynicki, 1989). Five patients had reported an improvement, but discontinued the treatment after three to four appointments. Ten patients dropped out after their first or second appointment. Possible reasons for patients dropping out of the therapy are discussed.

---

*Key words:* hypnosis, hypnotherapy, anxiety

### BACKGROUND

Anxiety is among the most common psychic disorders. Prevalence of anxiety disorders in the Norwegian population is around 15% (Knudsen & Mykletun, 2010). Among the best established treatments are cognitive-behavioural therapy and psychopharmacology with serotonin reuptake inhibitors. A review of meta-analyses on those treatments reveals that about a fifth of patients drop out prematurely, and a third of treatment completers are classified as non-responders (Taylor et al., 2012).

Prior studies confirm the efficacy of hypnosis and self-hypnosis in the treatment of anxiety, and this research is summarized below.

### *SELF-HYPNOSIS*

Self-hypnosis was shown to decrease baseline anxiety in healthy volunteers (VandeVusse et al., 2010), and the effect of it was similar to relaxation exercises and imaginary training (Gruzelier, 2002). O'Neill, Barnier and McConkey (1999) rated self-hypnosis as a more effective treatment than relaxation in their study of subjects with mild anxiety. Kohen colleagues (1984) give an account of a study of 505 children with diverse problems who were treated with self-hypnosis (relaxation and mental imagery). As many as 51% of these children achieved complete resolution of their problems and an additional 32% achieved a significant

improvement. In their subgroup, where anxiety was a main complaint, the figures were higher (58% and 42% respectively). Sakai (1997) had described the effect of autogenic training on anxiety disorders in a hospital setting. 51% of the patients were assessed as cured and 76% as having had successful treatment.

#### *DISTRESS RELATED TO MEDICAL PROCEDURES.*

Studies described patients having undergone open surgery with hypnosis, but those were special individuals described as 'hypnotic virtuosos' (Wain, 2004). Schnur and colleagues (2008) had conducted a meta-analysis of 26 trials based on 2,342 participants. Their conclusion supports the efficacy of hypnosis. Flory, Salazar and Lang (2007) summarized the benefits of hypnosis for distress management during medical procedures. The conclusion was that hypnosis was as effective as a tranquilizer in reducing pain and anxiety. Calipel and colleagues (2005) conducted a study, where hypnosis before surgery in children was compared to premedication with midazolam. The number of anxious children was significantly reduced in the hypnosis group, and the frequency of postoperative behaviour disorders on day one was also reduced by half. In addition, these children had shown more active participation in their treatment, faster recovery and a shorter hospital stay.

#### *HYPNOSIS IN CANCER PATIENTS*

Plaskota and colleagues (2012) conducted a study in a palliative care unit for cancer patients. The patients received four sessions with hypnosis and were also taught self-hypnosis. There was a significant reduction in anxiety, depression, symptom severity and sleep disturbance. Zeltzer and LeBaron (1982) compared hypnosis with non-hypnotic techniques in a study with paediatric cancer patients who had to undergo either bone marrow aspiration or lumbar puncture. Hypnosis reduced both pain and anxiety significantly more than other techniques.

#### *HYPNOSIS AND CBT*

Bryant and colleagues (2005) compared cognitive-behaviour therapy alone, in the treatment of acute stress disorder, to the combination of cognitive-behaviour therapy and hypnosis. Hypnosis was shown to give significant additional benefits.

#### *GENERALIZED ANXIETY*

In view of the clearly demonstrated benefits of using hypnosis in a variety of anxiety-provoking situations, it is surprising that the effect of hypnosis on generalized anxiety disorder seems to be insufficiently studied. This literature is limited to selected case studies which advocate the effectiveness of hypnosis in the treatment of anxiety and provide clinical illustrations, such as articles by Gilbertson and Kemp (1992) and Smith (1990). The author found no case-control studies, and only the article by Gould and Krynici (1989) included quantitative data. The patients in that study sought hypnotherapy for light to moderate stress, anxiety and depression. They exhibited a wide range of symptoms, which were quantified with the SCL-90 scale. After three treatments, there was a significant reduction of symptoms in all dimensions. Somatization was reduced by 49%, anxiety by 43% and depression by 38%.

## METHOD

The current study was conducted in the setting of a private psychiatric practice, where 27 patients diagnosed with general anxiety disorder (with panic disorder or without) were asked to complete a 90-item symptom checklist (the SCL-90 questionnaire, Derogatis et al., 1973) at their first appointment. All patients had presented anxiety as their main complaint. SCL-90 scales were re-administered approximately one month later, after approximately four treatments. All the patients had significant symptoms before treatment, with the anxiety score ranging between 1.1 and 4.0 (maximum SCL-90 subscale score is 4.0). The intervals between treatments varied from one to two weeks. The treatment sessions were 50–60 minutes long; 20–30 minutes of that time was reserved for the hypnosis, and the rest was used for collecting history and discussing current life issues.

The hypnotic method was permissive, with cognitive and behavioural elements. Imagery of a safe place and breathing exercises were used as an induction. The initial part of the hypnotic session was dedicated to achieving a relaxed, anxiety-free state. Then, a patient was asked to imagine herself or himself in a situation which would normally provoke an anxiety, for example riding a bus or conducting a lecture, but keeping the same calm feeling, which was achieved in the beginning. Breathing exercises and peaceful imagery were used repeatedly until the patient succeeded with that. Patients were often asked to find an optimal way of dealing with the situation as well and to imagine themselves implementing it.

Traumatic past events were approached in the same manner: the patient imagined that she or he remained calm in the traumatic situation and handled it in an optimal way. The thoughts and feelings arising in hypnosis were discussed concurrently.

In addition, all patients were taught a ten minutes self-hypnotic exercise, which they were instructed to complete twice a day. The exercise consisted of a verse about peace, together with peaceful imagery.

## RESULTS:

Twelve of the patients, six men and six women, completed the first month of treatment and could therefore be retested. All of the completers had shown improvement and, in some cases, the improvement was dramatic. The respective test results before and after the treatment are summarized in Tables 1 and 2.

Two men and tree women discontinued their treatment prematurely, before they filled out their second SCL test. They attended three to four treatment sessions and had reported some improvement during their treatment. These patients are not included in the statistical analysis. Ten patients, five men and five women, attended only one or two appointments. They are included in the statistical analysis as dropouts, and the results of the test they filled out at the first appointment are summarized in Table 3.

Dropouts were somewhat older, with the mean of 46 years (77–22 yrs), whereas the mean age of completers was 33.8 years (58–17 yrs).

Because there are ten symptom dimensions, there is a need for using Bonferroni correction. Only  $p < \alpha$  is considered significant, where  $\alpha = 0.05/10 = 0.005$ . As we can see, the completers had a tendency to a decrease in all symptom dimensions, but the change is significant or highly statistically significant only for somatization, depression, anxiety and phobic anxiety.

*Table 1. Completers at first appointment/initial values*

Patient	Som	ObC	Iterp	Depr	Anx	AngH	Phob	Paran	Psych	GSI	Age
1	1.1	1.2	3.0	2.2	1.6	1.2	2.0	1.0	1.0	1.4	28
2	0.8	0.8	0.6	1.3	1.1	0.0	0.4	0.0	0.4	0.7	58
3	1.5	2.7	1.1	1.6	1.9	0.8	0.7	1.8	0.3	1.4	21
4	2.3	1.0	0.7	1.7	3.3	0.8	1.0	0.7	1.2	1.4	28
5	2.2	2.8	2.2	2.7	2.7	0.5	1.7	1.2	1.1	2.0	45
6	2.1	2.5	1.7	1.7	2.8	0.7	2.1	1.8	0.9	1.8	17
7	3.8	3.9	4.0	3.6	4.0	3.2	4.0	3.8	2.9	3.7	22
8	2.4	0.7	0.6	1.8	3.1	0.7	1.4	1.3	1.8	1.7	33
9	2.5	3.0	2.6	2.6	1.4	0.3	0.4	0.6	0.7	1.9	41
10	1.4	0.6	0.1	0.5	1.4	0.2	0.0	0.0	0.6	0.6	44
11	2.0	1.9	2.4	2.5	3.2	1.0	3.0	1.7	0.6	2.1	40
12	1.5	1.5	1.4	2.2	1.1	0.3	1.0	1.2	0.2	1.2	29

Where *Som* is somatization dimension, *ObC* is obsessive-compulsive, *Iterp* is interpersonal sensitivity, *Depr* is depression, *Anx* is anxiety, *AngH* is anger-hostility, *Phob* is phobic anxiety *Paran* is paranoid ideation, *Psych* is psychoticism dimension and *GSI* stands for global severity index.

*Table 2. Completers after one month*

Patient	Som	ObC	Iterp	Depr	Anx	AngH	Phob	Paran	Psych	GSI
1	0.3	0.6	2.1	1.2	1.0	0.7	1.1	0.8	0.1	0.8
2	0.1	0.5	0.2	0.5	0.2	0.2	0.1	0.0	0.1	0.3
3	1.0	1.9	0.8	0.5	0.2	0.5	0.0	1.2	0.3	0.8
4	0.8	0.6	1.1	0.5	1.4	0.0	0.4	0.3	0.3	0.6
5	0.2	1.0	1.1	0.6	0.4	0.0	0.7	0.2	0.1	0.5
6	1.6	2.6	1.4	1.9	2.0	0.3	1.7	1.8	1.1	1.7
7	3.4	3.9	4.0	3.7	3.6	3.0	3.4	3.3	3.0	3.5
8	0.7	0.5	0.6	0.5	1.2	0.3	0.1	0.7	1.0	0.6
9	1.4	2.2	2.6	2.2	1.0	0.3	0.9	1.3	0.3	1.6
10	0.5	0.3	0.0	0.2	0.4	0.2	0.0	0.0	0.0	0.2
11	0.4	0.5	1.6	1.2	1.0	0.2	2.4	0.3	0.2	0.9
12	0.7	1.6	1.6	1.4	0.9	0.2	0.7	0.8	0.7	1.0

Where *Som* is somatization dimension, *ObC* is obsessive-compulsive, *Iterp* is interpersonal sensitivity, *Depr* is depression, *Anx* is anxiety, *AngH* is anger-hostility, *Phob* is phobic anxiety *Paran* is paranoid ideation, *Psych* is psychoticism dimension and *GSI* stands for global severity index

Table 3. Dropouts

Patient	Som	ObC	Iterp	Depr	Anx	AngH	Phob	Paran	Psych	GSI	Age
1	3.2	3.9	3.4	3.8	3.7	2.0	2.7	3.2	2.4	3.2	24
2	3.8	3.3	1.6	3.2	3.7	1.8	2.7	0.3	0.4	2.7	66
3	2.6	2.2	1.8	2.4	2.2	0.8	1.3	1.7	0.6	1.8	62
4	2.4	2.3	1.4	2.0	2.6	1.3	2.4	1.7	1.3	2.0	54
5	2.6	2.0	0.9	2.2	2.8	0.8	0.9	0.2	0.2	1.6	36
6	3.0	2.6	3.4	3.3	3.0	2.6	3.3	1.5	1.3	2.7	24
7	1.5	2.1	2.9	1.9	2.3	1.0	2.3	2.2	1.6	1.6	28
8	1.7	2.5	2.3	2.4	2.1	0.8	1.3	2.2	1.1	2.0	77
9	2.6	1.6	1.2	1.5	3.2	0.3	1.4	0.3	0.8	1.6	67
10	2.9	1.7	1.9	2.2	2.8	1.0	3.1	1.2	0.8	2.0	22

Where Som is somatization dimension, ObC is obsessive-compulsive, Iterp is interpersonal sensitivity, Depr is depression, Anx is anxiety, AngH is anger-hostility, Phob is phobic anxiety Paran is paranoid ideation, Psych is psychoticism dimension and GSI stands for global severity index

Table 4. Statistical analysis

	Som	ObC	Iterp	Depr	Anx	AngH	Phob	Paran	Psych	GSI
Mean1	1.97	1.88	1.7	2.03	2.3	0.81	1.48	1.26	0.98	1.66
SD1	0.79	1.08	1.17	0.79	1.00	0.83	1.17	1.01	0.75	0.8
Mean2	0.925	1.35	1.43	1.2	1.11	0.49	0.96	0.89	0.6	1.04
SD2	0.90	1.11	1.1	1.00	0.95	0.81	1.06	0.93	0.84	0.9
p1-2	0.00003	0.01	0.06	0.001	0.0002	0.005	0.003	0.03	0.023	0.0057
MeanD	2.63	2.42	2.08	2.57	2.84	1.24	2.14	1.45	1.05	2.12
SD D	0.68	0.71	0.9	0.73	0.57	0.69	0.85	0.98	0.64	0.56
p1-D	0.05	0.19	0.4	0.11	0.15	0.21	0.15	0.66	0.81	0.14

Mean1, Mean2, and MeanD are the respective means of the symptom dimensions in the completers before, after the treatment and in dropouts. SD1, SD2 and SD D are the respective standard deviations of the symptom dimensions in the completers before, after the treatment and in dropouts. The statistical significance of the change in symptoms in completers was estimated by comparing Mean1 and Mean2 and calculating the p value (p1-2) with the help of paired 2-tailed t-test for matched groups. The symptom dimensions in dropouts (MeanD) were compared with the symptoms, which completers had before the treatment (Mean1), and p value (p1-D) was calculated with 2-tailed t-test for groups with equal variance.

Dropouts had a tendency to score higher on all symptom dimensions, but the difference was not statistically significant.

#### CASE EXAMPLE (PATIENT NUMBER FIVE, COMPLETERS)

The patient was a housewife in her forties, who suffered from anxiety since her childhood. Her major complaints were anxiety and gambling. Her gambling involved both automatic slot machines and bingo. The patient had lost a considerable sum of money as a result of her addiction. She explained that gambling provided an escape from her negative thoughts.

The patient reported that she experienced depressive episodes and was prescribed venlafaxine. She described some decrease in her anxiety since the start of her medication. Still she was afraid of 'everything' and felt restless and anxious most of the day. At times, she had panic attacks. She was unable to travel by either boat or airplane.

In contrast, she had a satisfactory marriage, and it was her husband who drove her to my office for the first few appointments. Later, the patient arrived independently, by a bus.

At the first session the patient was taught self-hypnosis. Imagery of a peaceful place and breathing exercises had been used as an induction. She was asked to imagine herself at her home in the morning, and she reported feeling restless due to constant rumination about the way she would spend that day. Together, we created imaginings of a quiet morning, when the patient would feel good and use her time in a positive way.

At the second session, two weeks later, the patient reported that she had felt calm for the first few days after the first appointment. She still gambled, but somewhat less. She spent time worrying about her daughter, although she realized that her daughter's problems were minor. Moreover, she felt stressed about an approaching trip abroad that she felt obliged to undertake, to deal with an inheritance, following the death of a family member. During that hypnotic session, we created imagery of her remaining calm while her daughter was visiting recounting her problems. Also, we visualized packing a suitcase before the forthcoming trip.

At the third session, which was one week later, the patient reported having abstained from gambling. She stated that her husband commented on her having become less anxious. During that session, we worked mainly with the images of the places where she used to gamble. The patient imagined that she went by, but did not go in, and that she felt peaceful and satisfied doing so.

At the fourth session, the patient was re-tested. She reported that she herself was surprised to see the difference. She had abstained from gambling, and she spent less time ruminating about her addiction. At this session we concentrated on working with the images of her trip on an airplane.

The fifth session was supposed to be used for the last preparations for the trip, but the patient reported that she had relapsed into gambling. So, prior to hypnosis, we discussed her thoughts and hopes that create a drive for gambling, like the hope of getting back what she had lost before. The patient did not wish to work with the images of a flight any more—she felt confident that she could do it. We worked once again with the images of the places where she used to gamble and with the thoughts that these images invoked.

The patient contacted me again, seven weeks later, which was two weeks after she had returned from her trip abroad. She told me that she was somewhat anxious before she boarded

the plane on the way from Oslo, but experienced no anxiety at all on the way back. However, she continued gambling and was unhappy about it.

During that treatment session we discussed seeking employment, whether it would improve her quality of life and would make it less likely that she would fall back into the habit of gambling. She expressed negative thoughts about herself that hampered her in seeking employment. We worked again with images of places where she used to gamble, and with the symbolic actions of locking away in a secret room all her thoughts connected to gambling. During that appointment the patient was re-tested as well, and she scored somewhat higher than at her second test. Her depression score increased from 0.6 to 1.4 and anxiety from 0.4 to 0.7, but it was still significantly below the initial values.

After that session the patient visited my office twice more. She reported that she did not gamble any more. She reported sporadic anxiety, but significantly less acute than before the treatment. She continued with her psychopharmacological regimen, and we neither discussed medication nor tried to reduce it.

#### DISCUSSION:

This study confirms the assumption that hypnosis can be an effective treatment for generalized anxiety disorder. 63% of the patients, twelve completers and the five patients, who completed three to four treatment sessions, had reported a subjective improvement.

The range of improvements in completers, as demonstrated by SCL-90 test, is consistent with the findings of Gould and Krynicki, 1989. All the scores in every symptom dimensions had shown a decrease, but statistically significant or highly significant change was demonstrated only in somatization, depression, anxiety and phobic anxiety symptom dimensions. The greatest change occurred in the somatization. That could be due to the treatment procedure itself, with its extensive use of relaxation and breathing exercises.

It was unfortunate that ten of the patients dropped out after their first or second appointment. That high percentage of patients is not unusual for psychiatric practice. In a recent Danish study (Fenger et al., 2011) 27% of the patients referred for psychiatric treatment did not show up, while another 11.7% had dropped out. The dropouts were contacted by phone. The reasons for discontinuing ranged from availability of a public psychologist, emergency hospitalization, relocation and acute anxiety, preventing follow-up. The authors however suspect that some of those patients had an expectation of a magic instant cure and got disappointed when they did not experience that.

It is obvious that the subgroup of dropouts consisted of both non-responders and potential responders to the hypnotic treatment. Some of them could have experienced adverse effects after the treatment. It would have been useful to conduct a more extensive interview of dropouts, but even without such an interview the results of the hypnotic treatment are comparable to or better than those achieved by serotonin reuptake inhibitors.

## LITERATURE

- Bryant RA, Moulds ML, Guntrie RM, Noxon RD (2005). The additive benefit of hypnosis and cognitive-behavioural therapy in treating acute stress disorder. *Journal of Consulting and Clinical Psychology* 73(2): 334–340.
- Calipel S, Lucas-Polomeni MM, Wodey E, Ecoffey C (2005). Premedication in children: hypnosis versus midazolam. *Paediatric Anaesthesia* 15(4): 275–281.
- Derogatis LR, Lipman RS, Covi L (1973). SCL-90: An outpatient psychiatric rating scale—preliminary report. *Psychopharmacology Bulletin* 9: 13–28.
- Fenger M, Mortensen ML, Poulsen S, Lau M (2011). No-shows, drop-outs and completers in psychotherapeutic treatment: Demographic and clinical predictors in a large sample of non-psychotic patients. *Nordic Journal of Psychiatry*, 65(3): 183–191. DOI: 10.3109/08039488.2010.515687.
- Flory N, Salazar GM, Lang EV (2007). Hypnosis for acute distress management during medical procedures. *International Journal of Clinical and Experimental Hypnosis* 55(3): 303–317.
- Gilbertson AD, Kemp K (1992). Uses of hypnosis in treating anxiety state. *Psychiatric Medicine* 10(4): 13–20.
- Gould RC, Krynicki VE (1989). Comparative effectiveness of hypnotherapy on different psychological symptoms. *American Journal of Clinical Hypnosis* 32(2): 110–117.
- Gruzelier JH (2002). A review of the impact of hypnosis, relaxation, guided imagery and individual differences on aspects of immunity and health. *Stress* 5(2): 147–163.
- Knudsen AK, Mykletun A (2010). Det du trenger å vite om forekomst av psykiske lidelser [What you need to know about the prevalence of psychic disorders]. *Tidsskrift for Norsk Psykologforening* 47(4): 342–343.
- Kohen DP, Olness KN, Colwell SO, Heimel A (1984). The use of relaxation – mental imaginary (self-hypnosis) in the management of 505 pediatric behavioural encounters. *Developmental and Behavioral Pediatrics* 5(1): 21–25.
- O’Neil LM, Barnier AJ, McConkey K (1999). Treating anxiety with self-hypnosis and relaxation. *Contemporary Hypnosis* 10(2): 68–80.
- Plaskota M, et al (2012). A hypnotherapy intervention for the treatment of anxiety in patients with cancer receiving palliative care. *International Journal of Palliative Nursing* 18(2): 69–75.
- Sakai M (1997). Application of autogenic training for anxiety disorders: a clinical study in a psychiatric setting. *Fukuoka Igaku Zasshi* 88(3): 56–64.
- Schnur JB, Kafer I, Marcus C, Montgomery GH (2008). Hypnosis to manage a distress related to medical procedures: a meta-analysis. *Contemporary Hypnosis* 25(3–4): 114–128.
- Smith WH (1990). Hypnosis in the treatment of anxiety. *Bulletin of the Menninger Clinic* 54(2): 209–16.
- Taylor S, Abramowitz JS, McKay D (2012). Non-adherence and non-response in the treatment of anxiety disorder. *Journal of Anxiety Disorders* 26(5): 583–589. DOI: 10.1016/j.janxdis.2012.02.010.
- VandeVusse L, Hanson L, Berner MA, White Winters JM (2010). Impact of self-hypnosis in women on select physiologic and psychological parameters. *Journal of Obstetric, Gynecologic and Neonatal Nursing* 39(2): 159–168. DOI: 10.1111/j.1552-6909.2010.01103.x.



- Wain HJ (2004). Reflections on hypnotisability and its impact on successful surgical hypnosis: A sole anesthetic for septoplasty. *American Journal of Clinical Hypnosis* 46: 313–321.
- Zeltzer L, LeBaron S (1982). Hypnosis and nonhypnotic techniques for reduction of pain and anxiety during painful procedures in children and adolescents with cancer. *The Journal of Pediatrics* 101(6): 1032–1035.

Correspondence to: Irene Shestopal, Solskinnsveien 14, 0376 Oslo, Norway  
Email: Irene Shestopal (ishe@broadpark.no)  
Phone: +47 91 99 98 00