
COUNTERACTING RESISTANCE IN AGORAPHOBIA USING HYPNOSIS

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ABSTRACT

Agoraphobia is an extremely complex disorder to treat in clinical practice (Chambless, 1982a; Kaplan & Sadock, 1991) and patients are often resistant to therapy (Fava et al., 1997; Kellerman, 2010). Resistance takes on many forms including refusing to visit the practitioner in the first place, confrontation, symptom substitution, over-reliance on a 'safe person' (Carter & Schultz, 1998), focusing on and increasing the intensity of psychosomatic manifestations, refusing actively to participate during treatment, intellectualization, somatization and, in many instances, the family can take an active role in perpetuating the condition. The following paper focuses on the treatment of agoraphobia and, specifically, on how hypnosis is employed in order to counteract resistance, thus reducing negative transference and providing the patient with the coping skills to become independent in the outside world. The efficacy of the additional use of *in vivo* desensitization, Ericksonian strategies, and 'rationale therapy' (Clarke & Jackson, 1983) is discussed.

Key words: agoraphobia, resistance, psychosomatic manifestation, safe person/safe partner

INTRODUCTION

According to DSM-IV (American Psychiatric Association, 1994), agoraphobia is characterized by anxiety and/or panic situations outside the comfort of the home or 'safe zone' (Chambless, 1982a; McCabe, 2010). Many agoraphobics fear situations in which they feel that they are unable to escape (Harris, 1991), and in which there is no one to help if they were to have an unexpected or situationally induced panic attack. A common element in agoraphobia is the fear of losing control (Chambless, 1982b; Salzman, 1982; Basoglu et al., 1992). In many cases, agoraphobia begins with a phobic response to one stimulus—for example, driving (Collins, 1996) or crossing a bridge (Tilton, 1983)—and this develops into full-blown agoraphobia. As the condition worsens, individuals experience a great deal of anticipatory fear (Burns, 1982; Stafrace, 1994) and many worry that they will have a panic attack. This phenomenon has been described as the 'fear of the fear' (Harris, 1991; Hoffart et al., 1992; Evans & Coman, 2003; Kraft & Kraft, 2005, 2006). Agoraphobic patients typically fear one or more of the following situations: being alone and outside the house, queuing, being in a crowd, standing on a bridge, travelling on public transport, going shopping, walking amongst tall buildings, meeting friends, and some even fear different types of weather.

Agoraphobia is often perpetuated by family behaviour and, in many instances, members of the immediate family—particularly partners and parental figures—help to maintain phobic anxiety (Arnou et al., 1985; Oatley & Hodgson, 1987). Some patients come to rely on these 'safe partners' (Kraft, 2011) and, as a result, this decreases independence which in turn affects overall quality of life (Leon et al., 1995). Agoraphobia is associated with a huge

amount of avoidance behaviour: individuals tend to avoid situations because of a marked fear that they might have a panic attack; indeed, many sufferers fear they will lose control and will embarrass themselves in these situations. These panic attacks are accompanied by some of the following concomitant symptoms:

1. Dizziness
2. Palpitations
3. Trembling or shaking
4. Chest pain/tightness of chest
5. Fear of losing control
6. Fear of dying
7. Fear of going mad
8. Nausea
9. Choking sensations
10. Abdominal pain
11. Shortness of breath
12. Hyperhidrosis
13. Paraesthesia
14. Hot flushes
15. Feelings of depersonalization and/or derealization

A number of studies have shown that agoraphobia responds well to behaviour therapy: successful results have been reported using systematic desensitization (Kraft, 1967; Wolpe, 1973), flooding (Johnston et al., 1976), *in vivo* exposure therapy (Emmelkamp, 1980; Andrews, 1990; Fava et al., 1997, 2001), and group exposure (Teasdale et al., 1977). Further, behavioural techniques—particularly *in vivo* exposure therapy—have been employed successfully in conjunction with hypnosis (Jackson & Elton, 1985; Schmidt, 1985; Milne, 1988; Harris, 1991; Mellinger 1992; Roddick, 1992; Stafrace, 1994; Collins, 1996).

Due to the fact that the source of agoraphobia is complex (Kaplan & Sadock, 1991) and inextricably interconnected with the family situation (Stafrace, 1994; Kraft, 2011), it is difficult to treat (Mathews et al., 1981; Chambless, 1982b; Hobbs, 1982); thus, therapy often tends to be lengthy (Milne, 1988). The source of this condition centres on complex and/or disturbing relationships with—normally over-powering—parental figures (Craske, 1999), and the parent's persistently damaging behaviour reduces patients' independence, causing them to be resistant in treatment. In addition, Hafner (1977) and Hand and Lamontague (1976) have stressed how important it is to investigate the relationship between patients and partners or spouses, as this, if not entirely responsible for the problem, can quite often have a deleterious effect on the patient's mobility and overall sense of well-being.

A number of therapists have reported resistance in agoraphobic patients and have suggested possible interventions using cognitive-behavioural therapy (CBT) (Mavissakalian et al., 1983; Beck & Emery, 1985; Marchione et al., 1987; Taylor 2000) and psychotherapy (Bassler & Hoffmann, 1994; Shilkret, 2002; Winter & Metcalfe, 2008; Kellerman, 2010). The following report, however, focuses on the treatment of agoraphobia using a combination of approaches with hypnosis and how, specifically, hypnosis has been employed to counteract resistance—unconscious or otherwise—in patients' behaviour as well as in the behaviour

of members of the family. Cognitive-behavioural techniques and the use of 'rationale therapy' (Clarke & Jackson, 1983) are also considered.

REFUSING TO VISIT THE THERAPIST AND THE ROLE OF HOME VISITS AND TELEPHONE SESSIONS IN TREATMENT

Agoraphobics, due to the nature of their condition, are sometimes unable to go to the consulting room for treatment. If the patient is unable to see the therapist, even with the help of a 'safe person', a home visit is probably the only option. Schmidt (1985), in the treatment of a 28-year-old female, decided to arrange telephone sessions to deal with this problem, but this was done after he had made a house call and once he had established a treatment programme. The programme consisted of systematic desensitization in hypnosis using a graded hierarchy of her own invention. The therapist provided the patient with weekly tapes to this end and, over a period of six months, the tapes gradually moved her closer towards being able to visit the shopping mall on her own.

Schmidt did find that there was some resistance at the house call: the patient insisted that her neighbour was present during the session. It is often the case that agoraphobic patients have one or more 'safe people' who stay with them in the house, help them with shopping, and do other jobs for them. These individuals, often with the best intentions, help to perpetuate or even worsen the condition. Sometimes this safe person is a spouse or loved one, and this, as we will see later, can have more serious effects in perpetuating the agoraphobia. Schmidt dealt with this intrusion by ignoring it and by teaching the patient autogenic training (Jencks, 1973; Wallnöfer, 1980) so that she could practise this in the comfort of her own home (and on her own). They jointly devised a treatment plan that consisted of using a combination of tapes which, employing guided imagery, would gradually desensitize her to what she perceived to be threatening public places. They also decided that she should follow up each new scenario with a telephone appointment; the purpose of these sessions was to reinforce her progress, providing her with more control over the pace of the therapy. They also gave her the opportunity to explore the meaning of her thoughts as triggered by the exercises on tape. Teaching her autogenic training (self-hypnosis) right from the start, and organizing one-to-one telephone sessions, helped to make sure that her safe person would not interfere with her progress.

Collins (1996) reported the successful treatment of man who had been suffering from agoraphobia for six years due to the collapse of his business. The patient, referred to as Roger, had been experiencing panic attacks while driving and this had gradually worsened so that he was unable to leave the residential estate in which he lived—he was also unable to go anywhere on foot and could not tolerate being a passenger on public transport or in anybody else's car. Interestingly, the family were dubious about the selectiveness of his condition, particularly as he very much enjoyed his domestic role and was able to drive his own car. Roger resisted treatment at the hospital, refusing to attend the appointment; it was then that the psychologist arranged for a home visit.

At the first appointment, Collins explained the rationale of treatment and reinforced the fact that Roger would be in control of both his therapy and the speed at which it progressed—this comment served the purpose of ensuring his active involvement in the process. He was also taught self-hypnosis. Collins arranged weekly visits and Roger made significant progress using hypnosis and by working through the Subjective Units of Disturbance Scale (SUDS) (Wolpe, 1969). He was told that *in vivo* desensitization would not be

employed until he was able to reduce his levels of anxiety during these visualizations to a 3 (on a scale where 0 = no anxiety and 10 = maximum anxiety).

Roger made significant improvement, meticulously recording his levels of anxiety for each potentially anxiety-provoking visualization; however, further resistance occurred after six weeks of treatment. He had reduced his anxiety to a zero in all the scenarios, but had found that he was unable to drive on a particular road—the same road in which his business had failed—and this represented for him an insurmountable psychological barrier in his treatment. However, the therapist helped Roger gradually to be able to move towards this final goal: first, he was instructed to drive closer and closer to the road; secondly, to sit in his car alongside the road; and, thirdly, to do this while employing visualization techniques and coping strategies. In the sessions that followed, both he and the therapist were able to chain the small segments of the road together so that he could build up an image in his mind of a complete journey using this specific road.

RESISTANCE WITHIN THE FAMILY CONTEXT

Often resistance can come from members of the immediate family and this is particularly difficult to deal with when it is a spouse or partner. Jackson and Elton (1985) reported a case of a 41-year-old married woman who had been suffering from agoraphobia for many years and had controlled her condition with medication including amitriptyline, clorazepate, and chlordiazepoxide. While this had the effect of reducing her overall anxiety, it did not reduce her avoidance behaviour or lessen the frequency of her panic attacks. After four weeks of intensive *in vivo* exposure, with some initial success, her train phobia remained at an 8 on the 0–8 Main Phobia 1 Rating Scale, as derived from the Fear Schedule (FSS) (Hafner & Marks, 1976; Marks, 1987). The patient complained that she was still experiencing a great deal of anticipatory anxiety and had had multiple panic attacks on trains; it was then decided that hypnosis should be used as an adjunct to therapy.

Using age regression, it was revealed that, at the age of 8, she was publicly humiliated, undressed, and fondled by her mother's male friends at a party. At this point, she abreacted, screaming at her mother. She claimed that she projected the abuser's faces onto strange men on trains. Following this important session, she began to use trains more freely.

However, after approximately two months of treatment, as the patient was making significant improvement, her husband began to become increasingly introspective and, as a result, her supportive mechanism was taken away. In addition, he increased his alcohol intake, demanded to do the shopping for her, and underplayed her treatment gains. In order to counteract this problem, she was encouraged, during the hypnosis, to express her anger about her husband's behaviour. The therapy then focused on her working through her feelings of guilt about continuing *in vivo* exposure therapy—this was done both in the hypnosis and in the psychodynamic psychotherapy. This combined approach made it possible for her to continue her *in vivo* work, and also to make a complete recovery.

PHYSICAL MANIFESTATIONS

Patients suffering from agoraphobia frequently report that their anticipatory anxiety leads to a panic attack, and this often means that they avoid any situation that may precipitate this chain of events. Stafrace (1994) reported the case of a man, Peter, who had been suffering from agoraphobia as well as a constant fear that he was on the verge of having a

heart attack—indeed, he experienced many of the associative features of a myocardial infarction, including palpitations, shortness of breath, chest pains, dizziness, perioral numbness, and tingling sensations in his fingers. Having excluded any cardiac or other organic causes for these manifestations, he was referred for assessment. Stafrace used the first two sessions to take a history, to plan the treatment together, and to educate his patient about his condition—a process described by Clarke and Jackson (1983) as 'rationale therapy'.

However, Peter still believed that his 'symptoms' were a result of some sort of heart disease. The therapist reassured him that none of the cardiac investigations supported this and designed a treatment strategy using CBT, hypnosis, and a starting dose of Imipramine 25 mg, gradually increasing to 150–200 mg over a three-week period. The CBT component to the therapy consisted of exposure therapy, initially *in vitro* and moving on towards *in vivo*, and the keeping of a diary which would record his feelings of anxiety on a scale of 0–10. He was also asked to record any physical sensations and negative cognitions associated with each attack and to reframe these negative thoughts in order to reduce his anxiety in each feared situation. However, Peter still believed that he was experiencing angina-type symptoms. Scafrace suggested to him that his palpitations were due to his selective attention to, and heightened awareness of, his heart rate: he taught Peter ideomotor signalling (Waxman, 1989), and asked him to focus on his heart rate and to signal when occasionally it would miss a beat. Following this, Scafrace used special place imagery, followed by suggestions of calmness and tranquillity, to encourage him to experience the imagined scene without any negative connotations—and, specifically, without palpitations. Importantly, Scafrace did not use direct suggestions to eliminate the symptoms so as not to challenge Peter's sense of self-control; instead he used ego strengthening and symptom relief in order to provide the patient with a feeling of self-control and confidence (Yapko, 1984; Waxman, 1989). After this session, although more exploratory work needed to be done, he was able to recognize that the palpitations were a manifestation of anticipatory anxiety and was able to stop these ruminations from developing into a full blown panic attack.

RESISTANCE TO HYPNOTHERAPY

Some agoraphobics are resistant to hypnotherapy altogether (Chase, 1991). During the induction, the body begins to experience a number of physiological changes as well as changes in perception which can, in the first instance, be frightening. For example, some individuals may even anticipate that these changes could precipitate a panic attack. Hobbs (1982) pointed out that it is important to combine suggestions of relaxation with positive reinforcement, but that agoraphobics' obsessional and introspective ideation will often block the induction process. She therefore recommended that, for the first two to three sessions, patients should be educated about the physiological changes that occur during hypnosis (see for example, Crasilneck & Hall, 1959; Clarke & Jackson, 1983), using diagrams and a specially prepared audio tape which should be used at home. In the case report, Hobbs explained that, apart from normalizing hypnosis as a perfectly safe and natural process, the tapes helped the patient to feel more comfortable with the therapist's voice. Gradually, Hobbs added to these tapes suggestions of relaxation using guided imagery. She pointed out that deepeners could be incorporated as the therapy progressed; she also stressed that, by using audio tapes at home, the patient was able to exercise more control over the treatment and that this would reduce resistance. Indeed, it has been found that after the initial education, and once trust had been established between therapist and

patient, agoraphobics often become excellent hypnotic subjects and are able to respond and effect change using guided imagery and coping strategies (Mellinger, 1992).

It is important to note here that Hobbs gradually introduced hypnosis to the patient. Indeed, some therapists reframe the term 'hypnosis' and slowly introduce altered states of awareness in the form of 'hypno-relaxation'—a process similar to meditation (Milne, 1988). Another example of this gradual process is provided by Roddick (1992) who also spent three or four sessions building rapport and helping his patients to get used to being able to relax in his presence before introducing hypnosis. He recognized that agoraphobics tend to suffer from a lack of confidence which slowly becomes worse as the phobia develops. He suggested that this lack of confidence causes patients to be unable to relax sufficiently during sessions, and that hypnotic inductions are not entirely effective until they feel they can trust the therapist. The treatment programme consisted of the stages as shown below, and this was demonstrated in a single case study (Roddick, 1992). Note that the client here had a particular aversion to being driven in a car and that these principles can be adapted to suit the needs of the patient.

1. Relaxing in the presence of the therapist; case history (approx. 4 sessions)
- 2.a) Hypnosis is introduced using progressive muscle relaxation (PMR) induction
 - b) Experiencing special place imagery—desert island beach
 - c) Addressing the unconscious mind by focusing on (i) the importance of practising relaxation, (ii) being able to travel in a car, and (iii) being able to eat and drink 'as well as ever'
- 3.a) Direct suggestions of bringing the three parts together
 - b) Ideomotor signalling used to ascertain whether the strategy has worked and was acceptable
 - c) Reintegration of unconscious mind and conscious mind on the desert island beach
- 4.a) 'Throwing out' of negative thoughts
 - b) Direct suggestions that the skills that the patient has learnt in the special place can be utilized at any time.

After eight sessions of using this technique, the patient was able to drive herself to the clinic and continued to make further progress thereafter.

On occasions during hypnosis, patients resist direct suggestions and the guided imagery that is introduced, and this can cause significant problems for clinicians. In his model for treating agoraphobia using hypnosis—'subliminal therapy' and paradoxical intention—Yager (1988) pointed out that negative comments about a feared situation can be utilized in treatment. In his approach, he recommended that patients be first introduced to hypnosis by experiencing an early, pleasant memory, followed by the teaching of self-hypnosis. He then would ask patients to read his approach to subliminal therapy (Yager, 1984) which, it was hoped, would educate them about how to use the unconscious mind to facilitate positive change. Yager pointed out that paradoxical intention (Raskin & Klein, 1976; Lankton & Zeig, 1989; Zeig, 2008) can also be employed in order to counteract any anticipatory fear of, and resistance to, clinical hypnosis—he would suggest to patients that they should welcome the fear and that, paradoxically, this fear would lose its strength and meaning. In addition, he advised that the 'intentional effort' exerted by the patient at this time would help him or her to gain more control over the response (Michelson & Ascher, 1984). In ad-

dition, he advised that if patients express that they are worried they are going to faint or sweat profusely during *in vitro* desensitization, humour can be employed in order to contradict this fear. Comments such as, 'I'll show the world that I'm the best fainter anywhere', or 'I only sweated out a quart before, but now I'm going to pour out at least ten quarts' have been used effectively (Frankl, 1973; Yager, 1988).

The growing popularity of stage hypnosis in the media has produced a huge amount of fear about hypnosis in general. This has had several effects. A positive effect is that hypnosis has been brought into the limelight and many potential patients are aware of the immense power of hypnosis in the hands of a fully qualified clinician (Calvert, 2007). However, poor education and misunderstanding of the difference between clinical hypnosis and stage hypnosis, on occasions, may cause immense fear and resistance during treatment. An example of this can be found in the case study of a female agoraphobic patient who had been unable to travel abroad for a significant amount of time (Harris, 1991). Having been resistant to various other forms of treatment including neurolinguistic programming (NLP) and insight-orientated psychotherapy, it was decided that hypnosis be employed in order to help her to gain control of her behaviour. Aware of her scepticism of hypnosis and its efficacy, the therapist, like Hobbs (1982), began by re-educating her about its effects in clinical practice—specifically focusing on the control that would be given to her during the process. She was taught progressive muscle relaxation, involving the gradual tensing and releasing of muscle groups (Susskind, 1970); however, she harboured a number of myths about hypnosis and stage hypnosis and worried that, contrary to what she had just been taught, her therapist would have control over her.

Thus, as a result, Harris had to move very slowly, using PMR and ego strengthening until the patient had more confidence in her. Only after this confidence had been built was the therapist able to move on to employing systematic desensitization *in vitro*: Harris combined this with the use of positive imagery, self-efficacy training, and suggestions which reinforced her ability to cope with stress and tension. She also used the direct suggestion: 'Your body knows what to do'. The patient reiterated this positive statement post-hypnosis, intimating that she was beginning to feel that she had control of the situation. Harris commented that this was a pivotal point in the therapy in that it increased her confidence and her ability to cope in stressful situations. After ten weeks of hypnosis and *in vivo* desensitization, she was able to travel abroad successfully and said that she was symptom free.

Tilton (1983) reported the case of an agoraphobic man who had resisted hypnotic intervention by falling asleep during the process—this was evidenced by snoring, 'hypnic jerks' (head bobbing), and his refusal to respond. The therapist dealt with this by using arm catalepsy and by frequently asking him to respond verbally. It was revealed that the patient's agoraphobia began with his anxiety of specific bridges, and this developed into severe agoraphobia, a fear of all bridges, aeroplanes, highways, and open spaces. The patient asked to be treated intermittently (and, therefore, slowly), and required two years of treatment which consisted of systematic desensitization, age regression, NLP, and Ericksonian techniques in hypnosis. Thus, the patient felt that he had control over the pace of the therapy and, as a result, his panic attacks reduced significantly and he overcame many of his phobias.

Tilton experienced a second resistance from this patient during the course of treatment. Approximately one month before a holiday with his family, the patient stated that he was extremely anxious about this trip because it involved crossing various bridges and flying on

an aeroplane. The therapist gave him ego strengthening, used systematic desensitization, and encouraged him to practise visualizing enjoying various situations on the proposed trip. In the final session before the holiday, he reported that he was concerned about three situations—particularly a proposed fishing trip—and he displayed a huge amount of resistance, refusing to visualize these scenarios in the hypnosis. Tilton re-hypnotized the patient and, using pseudo-orientation, transported him to a time shortly after what he described as a successful trip away. He asked the patient about these three specific situations, but unfortunately he responded that he had not done any of them. The therapist cleverly, using an authoritative and sincere tone, expressed surprise and told the patient that he had already enjoyed doing all these activities; furthermore, and without pausing, he described a made-up story about one of these activities in great detail. He repeated these stories until the patient became somewhat confused. Tilton explained that, as the patient trusted him, he was placed in a double bind: if he believed his therapist, it meant that he had done these activities and had subsequently forgotten about them, but if he didn't believe him, it meant that his therapist was lying. Finally, he acknowledged the fact that he had done these activities, accepted the successful outcome of the ensuing holiday, and, as a result, was able to enjoy his vacation with his family the following week.

RESISTANCE TO *IN VIVO* THERAPY

Mellinger (1992) reported a case of a woman suffering from agoraphobia with panic attacks. The first eight weeks of treatment consisted of case history taking and a heuristic explanation of her phobic anxiety, the latter of which was subsequently used as a base of her cognitive-behavioural treatment. She then began a programme of *in vivo* desensitization. She decided that her first *in vivo* task would be to travel, at midnight, to the local shopping mall with her husband; however, although she used relaxation techniques to prepare herself for this task, she exercised a huge amount of resistance and, as she began to think more negatively about the situation, her anxiety increased and she abandoned her shopping and rushed home to safety.

The therapist, in the following session, decided to postpone the *in vivo* work and to use hypnosis in order to enhance her coping strategies. Mellinger used a permissive induction and employed an anchoring technique which consisted of her touching her fingertips to her solar plexus; this helped her to breathe more slowly and evenly and to relax. Further, during the hypnosis, she was encouraged to watch a pleasant scene on a television screen and was invited to adjust the volume, the brightness, and the focus controls (Clarke & Jackson, 1983); this enabled her, in subsequent sessions, to reduce the intensity of affect. She was also given the opportunity to practise shopping *in vitro* and this reduced her anxiety further. Six weeks after her initial panic and considerable resistance, she was able to resume her *in vivo* work, and made considerable progress.

RESISTANCE TO PSYCHOTHERAPY

It is always important as a therapist to consider any secondary gains a patient may have for remaining phobic, such as not having to go to work, having a safe person to do the shopping, and gaining constant sympathy and protection from loved ones. Gruenewald (1971) reported a case of a woman with severe agoraphobia who had a huge amount of support from her husband. On the surface, and perhaps with the best of intentions, he provided her

with continued care and support; nevertheless, he was partly responsible for maintaining and perpetuating her condition. Interestingly, when her husband's health worsened, and consequently his ability to protect and take care of her lessened, she had fewer secondary gains from her condition and thus had a renewed motivation for treatment.

In the first session, both therapist and client agreed that they should embark on a treatment strategy consisting of psychodynamic psychotherapy and systematic desensitization (*in vitro*); they also set a time limit of between three to six months. Gruenewald also pointed out that her active cooperation was required throughout the treatment. The patient was then encouraged to express her opinions about hypnosis and, during this process, she displayed a huge amount of resistance and ambivalence towards her therapist through her body language and in her choice of answers to questions. She also deliberately remained silent for long periods of time. Furthermore, she pointed out that she had already taken part in a stage hypnosis show and had been unable to be hypnotized; she told her therapist that she felt it was therefore unlikely that she would be able to experience hypnosis in the consulting room.

It was evident that the patient was trying to manipulate and undermine her therapist. Gruenewald dealt with this by ignoring these demands and authoritatively invited her to lie down on the couch in order to experience 'a new kind of relaxation'. After the deepener, she spontaneously abreacted and her therapist followed this up with suggestions of soothing relaxation, reintegration, and advice about future hypnosis sessions. This had an immediate effect on her and she left the consulting room in amazement. In the following sessions, hypnosis was employed to strengthen the patient's coping strategies and to increase her understanding of previous traumas.

Later in treatment, Gruenewald experienced more resistance from this patient. Although she was able to experience progressive muscle relaxation and ego strengthening, whenever her active participation was required, she refused to cooperate. She was not prepared to visualize any of the anxiety-provoking situations—even the first on her hierarchical list—and refused to communicate using ideomotor signalling. In addition, she did not carry out any of the self-hypnosis tasks at home. She also developed a new psychosomatic symptom—sciatic pain. Her therapist coped with these resistances by pointing out to her in hypnosis that she did not have to acquire a new symptom in order to recover from the old one, but that she could consult a physician about her problem. The thought of having to pay a private doctor an extortionate amount of money was enough to remove this 'symptom substitution'. The patient did finally improve significantly a year later, although she continued to test her therapist throughout treatment.

Huang (2008) commented that some of his patients—many of them Chinese—felt ashamed about their anxieties and were often reluctant to explore, or begin to come to terms with, their emotional problems. In many cases, their resistance manifested itself through intellectualizations or somatization (Cheung et al.; 2005; Huang, 2008). He recommended that, for some patients, it was important to use hypnosis as an adjunct to the treatment strategy in order to facilitate more significant progress (Kirsch et al., 1995; Schoenberger, 2000), and that, because there might be additional resistance to hypnotherapy, it should be used flexibly and informally—that is to say, without a marked or traditional induction. Alternatively, if formal hypnosis is used, it should be accompanied by a clear explanation of the process in order to eliminate any unnecessary anticipatory fear.

In the treatment of a female college student, aged 29, he found that, during the initial psychotherapy, she was unable to concentrate and was both ashamed and reluctant to reveal any of the possible causes for her condition. Huang dealt with this by reframing hypnosis as a 'special operation' which would help her to become 'mentally relaxed'; in the hypnosis, she felt comfortable enough to recall an episode six months previously in which she was knocked down by a car. The driver was drunk and, although he helped her to the side of the road, appeared threatening, and this had caused her to panic. She was then invited to re-experience this event in a calm fashion in order to reduce and then remove her feelings of panic. This session was an important turning point in the therapy and, after eight sessions, she was able to travel freely without symptoms.

COMMENT

However complex the combination of inner conflicts is in producing the phobic displacement, the protective mechanism of agoraphobia is at the core of this condition (Katan, 1951; Gruenewald, 1971; Mahoney, 2000). This report has shown that hypnosis is a highly effective adjunct to psychodynamic psychotherapy (Kirsch et al., 1995). It helps to reduce the risk of negative transference which might be detrimental to the patient, certainly in the early stages of therapy (Gruenewald, 1971); it provides the patient with the space to come to terms with inner conflicts and any feelings of guilt (Huang, 2008); it allows individuals to practise a series of gradually anxiety-provoking situations (Jackson & Elton, 1985); and it helps to build up their coping strategies to be utilized *in vivo* (Mellinger, 1992).

Agoraphobia is a frustrating disorder to treat because many individuals fear or feel guilty about being independent, and their phobic anxiety perpetuates their dependence on significant others or parental figures (Goldstein & Chambless, 1978; Shilkret, 2002). In therapy, patients often display resistance by unconsciously testing their therapist in the transference: this is done by inviting the therapist to act like the severe, punishing parent or, alternatively, by acting like the parent and treating the therapist as the child. However, the unconscious desire is that the therapist will not re-enact these damaging behaviours and will provide the client with a safe environment in which to practise more independent behaviour. It is important here that hypnosis is used in order to create a positive transference which shows the therapist to be a competent, authoritative, and caring figure, providing the patient with the coping mechanisms necessary later to become more independent (Hadley & Staudacher, 1989). Indeed, it has been demonstrated that teaching coping skills in many areas of psychiatry, including agoraphobia, has improved the efficacy of the systematic desensitization (Meichenbaum, 1972; Tilton, 1983; Golden, 2007). The most important feature of this is providing the patients with control of their own therapy—for, if they are not in control in the consulting room, they will not be able to take control of their lives. For this reason, it is vital for them to go at their own pace. The author also recommends providing agoraphobic patients with a thorough understanding of their condition and the physiological changes that take place during a panic attack—that is to say, panic attacks are often a result of a misinterpretation, and exaggeration of, certain bodily sensations (Clark, 1986; Marks, 1987).

A positive transference having taken place, and rapport having been built, there is less likely to be resistance, and thus more significant progress can be made in the hypnosis and in the psychodynamic psychotherapy. It is here, in this safe but unrestricted environment, that patients are able to use these coping strategies so that they can move systematically

further away from home. And, with the help of ego strengthening and positive suggestions, they can become more confident and independent outside the consulting room. This independence can then be increased by the use of *in vivo* desensitization and continued psychotherapeutic support.

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