

FEAR OF INJECTIONS: THE VALUE OF HYPNOSIS IN FACILITATING CLINICAL TREATMENT

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Abstract

Three examples of the use of hypnosis in counselling show the variable effects of experiences in the creation of fear, anxiety and disabling phobia. Therapy may be directed to an apparently single cause of a few weeks' duration, or to a many-layered complex of over 40 years' existence. The processes of resolution may be jointly agreed by client and counsellor or else no clear path to improvement may be identified. The present paper describes three patients with different problems who had high levels of fear or anxiety about receiving injections in botulinum toxin clinics. Individual differences in causes, history and personality made an integrated approach the logical choice. Successful outcomes showed that hypnosis, adaptedly adjoined with mainly behavioural and cognitive methods of counselling, can be of very great assistance in enabling patients to receive injections essential to treatment, and can usefully be made part of multidisciplinary team provision.

Key words: botulinum toxin therapy, hypnosis, injection anxiety, needles, phobia

Introduction

In *The Treatment of Anxiety Disorders*, Andrews, Crino, Hunt, Lampe and Page (1994) say, 'The major features of a phobia are (1) a stimulus-bound fear reaction that is (2) distressing to the point of causing emotional, social or occupational disruption, (3) recognised as excessive or unreasonable, and (4) leads to avoidance upon exposure to the feared stimulus'. This sentence blends the two symptom lists offered by the DSM-IV (American Psychiatric Association, 1994) and the ICD-10 (WHO, 1990) systems of classifying anxieties. Agoraphobia is used as the pure type of the species, with other phobias labelled as 'specific'. Only a moderate number of symptoms need to be present for a phobia to merit a specific label.

We may at first believe that there is a unitary condition called 'needle phobia'. However, what we meet in clinical practice are individual people's conditions, difficult to post into one pigeon hole, and needing a flexible choice of therapeutic approach.

In his review, Marks (1988) used the label 'blood-injury phobia', narrowing down from the earlier, broader concept of 'multilation' which had covered all fears associated with clinical places, personnel and procedures, blood, wounds and pain (Marks, 1988). Marks also repeated that individuals with blood-injury phobias differed from those with other phobias in that exposure to the feared stimulus was likely to cause a drop in blood pressure, and perhaps a faint.

In the last two decades, research into needle phobia has identified a fair degree of co-morbidity (Neale, Walters, Eaves, Kessler, Heath and Kendler, 1994), a likely genetic component derived from twin studies (Neale et al., 1994), and a possibility that it may be considered as a distinct category of phobia (Hamilton, 1995). People with injection phobias have been divided into, first, the majority vasovagal type (Graham, Kabler and Lunsford, 1961) who show fear and avoidance and passivity when injected, and second, the resistant type who show equal fear and avoidance, but who offer strong resistance with no vasovagal reaction when injected (Trijsburg, Jelicic, van der Broek, Plekker, Verheji and Passchier, 1996).

Dental anxiety and phobia is psychological complex by comparison, with a recent Dutch study concluding that people with dental and injection phobias should be considered as distinct (De Jongh, Bongaarts, Vermeule, Visser, De Vos and Makkes, 1998).

Treatment

Behavioural methods, promoted since the 1950s (Wolpe, 1958) for their success in treating phobias, now have the addition of cognitive-behavioural methods to produce success rates of 70% to 85% (Roth and Fonagy, 1996). The effective methods are rapid or graded exposure, modelling, cognitive restructuring and applied relaxation. A recent British text on phobias and their treatment (Davey, 1997) does not mention hypnosis, not even as an adjunct (cf. Gibson and Heap, 1991; Heap and Dryden, 1991).

Here, three cases have been chosen to demonstrate the range of hypnosis use to be found in outpatient practice. The first case was unclear in presentation, aetiology and diagnosis, and proceeded at a very slow pace. The second case was fairly representative of the needle anxiety literature, and involved a combined therapy approach. The third was a very brief, almost emergency use of hypnosis to enable a surgical procedure to be performed. These three cases represent a range of situations in which hypnosis procedures were of essential value to patients attending treatment clinics.

Case 1

J first sought counselling in October 1995 for depression. She was retired and receiving medication for anxiety, depression, cardiovascular problems, hypothyroidism and for schizophrenia with auditory hallucinations. She had had an operation 16 years previously to remove the clot causing a left-sided stroke, and operations more recently on both eyes for glaucoma. She was extremely uncommunicative about her feelings.

To strengthen J's autonomy, a broadly client-centred counselling approach was adopted. J asked about 'the hypnotherapy' and responded quickly to the first induction comprising suggestions of focusing on her own breathing, of relaxing and enjoying the mental peace and quiet.

Over the next three months, during hypnosis but not afterwards, J was free of the typical pain caused by the stroke, and extended and flexed her left thumb and fingers, which otherwise assumed the shape of a loose fist. J also talked about her needle anxieties and of having avoided dentists for maybe 40 years. She requested hypnotherapy once for this, which was provided in the form of suggestions of confidence and comfort while at the dentist's.

During the summer, J talked about intrusive disturbing memories of the glaucoma operations, but without hypervigilance or raised startle response. She described frightening imagery about dentistry, and mentioned permanent discomfort in her left lower jaw. She also gave a blood sample calmly for the first time. By September, J had visited a dentist for a check-up and was surprised to see that the dentist was young. She then stopped attending for counselling.

Nine months later, now in residential accommodation after another stroke, J mentioned a follow-up visit to the psychiatrist who enquired if she was still 'hearing the voices'. J was asked to describe them. She explained that they were the ophthalmic surgeon and his nurse, during the glaucoma operations. I sent the psychiatrist her account, offering a possible post-trauma interpretation of her symptoms. She was then again absent for eight months until March 1998, when the psychiatrist agreed she might be suffering from post-traumatic stress or pseudo-hallucinations.

Without using hypnosis, J was invited to describe and make a detailed mental video recording of these operations in order to create some distance from them. Her principle intrusive memories were of the music played during the operation, seeing the needle approaching her right eye and 'sometimes it's as if it's gone in and come out again', a slitting of the right eyeball, then the use of a large needle, and finally experiencing her left eyeball fall out on her cheek.

The many-layered nature of J's needle phobia was by now apparent. She was too weary and distracted by pain to make the mental film, and memories of her latest fall kept intruding. She was still free of pain during hypnosis, and now admitted to having been frightened by the fall. Over two months, memories of it receded.

J was seen less often in 1998. In September, she casually mentioned that she had had two fillings whilst being free of anxiety. Hypnosis for dental anxiety had been requested only once, 34 months previously. J now dated the start of this anxiety to her junior schooldays. In the following months, references to the glaucoma operations slipped unnoticed from the conversation. Discomfort and nursing home life became its main topics.

It seemed that after 40 years the original fertile ground for needle phobia was now clearing. A year after the psychiatrist had agreed to a post-trauma interpretation of J's 'voices', the anti-psychotic medication was discontinued.

Case 2

T was in her thirties, married, with one teenage daughter. She was very articulate and worked in a caring profession. She had blepharospasm (spasms of the eyelids) and was monitored regularly for several hormonal irregularities. T was seen seven times. Her phobic response showed very strong resistance.

Referred to the botulinum clinic for injections in the muscles around the eyes, T had reacted to the first attempted injection by fighting vigorously against the nurse practitioner and then running out in tears through the waiting room. After discussion with the counselling assistant, she decided to try hypnotherapy with me because she was highly motivated to receive the injections.

Three years previously, T had fallen and torn tissues in the left knee. Eighteen months later she had keyhole surgery in the knee, which revealed degeneration in the connective tissues. At our first meeting, T repeatedly used the word 'terrifying'. 'It's just injections,' she said. T had the same fear about dentists, but added that she was all right as a child. Her trouble with injections started at the age of 16 with hospital

treatment for her left knee. At the Dental Hospital, they had tried breathing exercises with her, to no effect.

We talked about hypnosis, and then T was directed to pay attention to her breathing whilst her mind began to quieten. It was suggested that her breathing would become slower and deeper, as if the body were asleep, although T would remain quite awake. As I counted from one to ten, T would slowly feel herself becoming a spectator on her physical system as it became increasingly peaceful.

It was then suggested that T was looking down a peaceful corridor where, 14 years ago, there were images of herself giving birth, and then, further down, at 16 years old, where she was having surgical work on her knee. Finally, even further down the corridor, young T was having dental treatment in peace. I then suggested that a bridge of connection would be made with that young T, and that all the qualities she desired would pass over it into the present.

After returning to alertness slowly, on a count of ten to one, T said, 'I feel particularly clear-headed,' and added that everything was 'in focus'. She felt stronger, but still had a little apprehension, which she rated at about 20%.

I then accompanied T to the treatment room for the injections, where she, the nurse practitioner and I discussed her progress. T accepted a number of injections with about 20% apprehension.

A month later, at the second session, hypnosis was used to prepare T for future repeat injections. I suggested that relaxation would be invisibly linked to her very first thought about injections, about going to the clinic, and so on, up to sitting in the treatment chair. The suggestion was given that the confidence of young T would spread out to all situations involving needles, present, past and future. T was more responsive to hypnosis this time.

Seven and 11 weeks later, sessions three and four were spent in counselling, concerning the matter of T's very low self-esteem. Session four was to be followed by injections, after T had estimated herself as now 85% ready for them. She then missed her own appointment time for the injections and had to wait about 25 minutes, becoming somewhat tense, and I was too busy to stay with her. She was later heard laughing with the nurse practitioner in the treatment room.

Two months later, at the next session, T felt that she was 'calm' with 'no worries'. She was sleeping well, and had managed to come to the hospital free of panicky feelings. She was now in training, with a better job which involved meeting members of the public.

At our final meeting, in May 1999, T talked about her new employment and her family, and the subject of injections was never mentioned once.

Case 3

S was 30 when I saw him in 1997. Although over six feet in height, his head was pulled onto his chest, his shoulders retracted and his spine curved with the stomach protruding. He was anxious about his health and depressed about the future. His diagnosis was schizophrenia and drug-induced anterocollis (that is, head pulled forward), a form of tardive dystonia.

S had had bouts of paranoid thinking without hallucinations from age 16 to 20. The tardive dystonia had begun when S was 18, and had remitted only once for some months in 1996. In 1997, he attended the botulinum clinic for examination and later for injections.

I first met S briefly by chance and gave him my telephone number. In seven months we had six telephone conversations, about medication side-effects, his former love of sports and his desire for a normal life. I did not take any formal case history.

One afternoon, S phoned in great distress, saying, 'I'm terrified'. He had an appointment the following day for an injection through the rear wall of the oesophagus into a muscle which in spasm was pulling his head down. Some weeks before, on his previous visit, the surgeon had explained the procedure to S. Now, thinking about this injection, he could see and hear in his imagination the needle banging against the spine, loudly. The seeds of a needle phobia seemed to be present, caused by instruction, the least common pathway (Öst, 1991). What has been called 'misconception correction' was needed.

I told S that his image of metal hitting hard bone was impossible, because bones had a coating resembling tyre rubber. I asked him to repeat his mental video deliberately with that new information incorporated, and to breathe slowly and deeply if he became tense. I guaranteed that I would see him for an hour before his injection the following day, and that we would use hypnotherapy.

The following afternoon, S was brought in and sat with his unusual posture in a semi-reclined chair. The horrible mental video had somewhat quietened and he had managed some sleep. I explained the induction of hypnosis, basing it largely on attention to breathing. With this method, S relaxed very quickly, his cheeks became pale, and his body straightened out naturally. Within a minute he was looking 'normal'.

After deepening, S's hypnotic state associated with counting from one to ten. I suggested an invisible zone of safety around him. In this way he would remain relaxed. After the reverse count from ten to one, bringing peace and relaxation back through every number, S regained normal alertness, remaining very peaceful, and then stood up to his full height. I walked with him to the surgeon's treatment room and handed him over to the clinic nurse, who was amazed to see him 'looking normal'.

She later reported that S had been calm throughout the whole rather difficult procedure. It was not clear how the injection could otherwise have been carried out if his head had remained pulled down onto his chest.

Another visit to the hospital allowed a session of hypnosis, focusing on his safe place in memory, and on relaxation to the muscles down the neck and spine, which helped to relieve backache permanently.

In the autumn, S had had a repeat injection through the back of the throat without any anxieties. A change of medication in December, to the anti-psychotic sertindol, had later cleared the movement disorder, by April the injections had been discontinued, and S has now been classified as 'cured'.

Concluding remarks

The first case met the DSM-IV criteria for needle phobia (American Psychiatric Association, 1994; Cooper, 1999). A childhood fear of dental surgery (Öst, 1991) was followed by a lifetime of avoidance, accompanied by blood disorders, a brain operation and operations for glaucoma. This case, onion-like, had layer upon layer of fear and avoidances of which several involved needles. It is hypothesized that repeated hypnosis was essential for recovery by producing a pain-free and thereby distraction-free state in which J could make safe contact with suppressed traumatic memories. This would facilitate fragmented but repeated exposure to them, leading to a reduc-

tion in fear and anxiety, and to the ability to obtain necessary treatment. J's fears may have been functionally dependent, in that reduction of one led to a weakening of the others (Rachman and Lopatka, 1984).

The second case met the criteria for injection phobia, again starting with a childhood fear of dental surgery, reinforced in adolescence and adult life by surgery for recurrent damage to a knee. Relaxation, time regression and ego-strengthening during hypnosis, reframing of past experiences and imaginal exposure through alert discussion reduced anxiety enough for T to receive her desired injections.

In the third case, the cause of the phobic state was the patient's catastrophic construal of the surgeon's description of an injection procedure. Restructuring S's understanding was necessary for change, but not sufficient. Applied relaxation (cf. Öst, Lindahl, Sterner and Jerremalm, 1984) through hypnosis hurriedly enabled the performance of an unusual injection.

High anxiety and avoidant behaviour before a feared event gives these three cases something in common. Not much else does. The use of the term 'phobia' across all of these does not entail a common therapeutic approach. Human individuality argues for a client-centred philosophy, which requires the flexibility of a multimodal or integrated approach. Hypnosis was indispensable with J and S, and much faster than most other published methods with T.

This reduced disruption to patients' lives advocates the availability of hypnosis procedures in multidisciplinary clinic teams of this sort.

References

- American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition). Washington, DC: American Psychiatric Association.
- Andrews G, Crino R, Hunt C, Lampe L, Page A (1994) *The Treatment of Anxiety Disorders*. Cambridge: Cambridge University Press.
- Cooper JE (ed) (1999) *Pocket Guide to the ICD-10 Classification of Mental and Behavioural Disorders*. Edinburgh: Churchill Livingstone/WHO.
- Davey GCL (ed) (1997) *Phobias. A Handbook of Theory, Research and Treatment*. London: Wiley.
- De Jongh A, Bongaarts G, Vermeule I, Visser K, De Vos P, Makkes P (1998) Blood-injury — injection phobia and dental phobia. *Behaviour Research and Therapy* 36: 971–92.
- Gibson HB, Heap M (1991) *Hypnosis in Therapy*. London: Lawrence Erlbaum.
- Graham DT, Kabler JD, Lunsford L (1961) Vasovagal fainting: a diphasic response. *Psychosomatic Medicine* 23: 493–507.
- Hamilton JG (1995) Needle phobia: a neglected diagnosis. *Journal of Family Practice* 41: 169–75.
- Heap M, Dryden W (eds) (1991) *Hypnotherapy: A Handbook*. Milton Keynes: Open University Press.
- Marks I (1988) Blood-injury phobia: a review. *American Journal of Psychiatry* 145: 1207–13.
- Neale MC, Walters EE, Eaves LJ, Kessler RC, Heath AC, Kendler KS (1994) Genetics of blood-injury fears and phobias: a population-based twin study. *American Journal of Medical Genetics* 54: 326–34.
- Öst L-G (1991) Acquisition of blood and injection phobia and anxiety response patterns in clinical patients. *Behaviour Research Therapy* 29: 323–32.
- Öst L-G, Lindahl I-L, Sterner U, Jerremalm A (1984) Exposure *in vivo* versus applied relaxation in the treatment of blood phobia. *Behaviour Research Therapy* 22: 205–16.
- Rachman S, Lopatka C (1986) A simple method for determining the functional independence of two or more fears — IV. *Behaviour Research Therapy* 24: 661–4.

- Roth A, Fonagy P (1996) What Works for Whom? A Critical Review of Psychotherapy Research. London: Guilford Press.
- Trijsburg RW, Jelicic M, van den Broek WW, Plekker EEM, Verheij R, Passchier J (1996) Exposure and participant modelling in a case of injection phobia. *Psychotherapy and Psychosomatics* 65: 57–61.
- Wolpe J (1958) *Psychotherapy by Reciprocal Inhibition*. Stanford, CT: Stanford University Press.

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