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THE USE OF HYPNOSIS TO HELP AN ANXIOUS STUDENT WITH A SOCIAL COMMUNICATION DISORDER TO ATTEND SCHOOL

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Abstract

This single-case study examines the efficacy of hypnosis as an anxiety management and confidence strengthening technique in the specific area of a social communication disorder of long duration and which had proved resistant to other therapeutic approaches. The anxiety of a 15-year-old student with a social communication disorder and inability to enter a classroom was measured before and after intervention, in addition to progress on personal targets and the effect of his difficulties on life at home. In hypnosis the student was taught anxiety management and self-hypnosis techniques and, with his mother, approaches to increase assertiveness. Anxiety decreased, and self-confidence, social communication and school attendance increased during and following the hypnosis intervention. Four sessions, including hypnosis and self-hypnosis, were delivered. Follow-up monitoring visits at one, three and six months provided evidence of maintenance or continued improvement in the post-intervention measures. In addition to the marked positive gains from pre- to post-intervention measures, both the client and his mother reported improvements in his emotional well-being and social inclusion. The significance of the results for the use of hypnosis as an adjunct to educational psychology is discussed.

Key words: anxiety, confidence, hypnosis, relaxation, school attendance, self-hypnosis, social communication

Introduction

The use of hypnosis in the treatment of anxiety is well documented. Indeed, the most frequently found disorders in the general population are anxiety disorders (Beletsis, 1989). Although most people experience anxiety and avoidance they are able to cope without much of a problem, though many people suffer acute episodes of anxiety (panic disorder) or chronic feelings of anxiety and worry (generalized anxiety disorder).

In the *Diagnostic and Statistical Manual of Mental Disorders IV* (DSM-IV) (American Psychological Association, 1987) specific anxiety disorders also include obsessive compulsive disorder, phobias and post-traumatic stress disorder, and anxiety is referred to as a symptom of most other disorders (Higgins, 1989). Anxiety may include a variety of physical symptoms, for example, heart racing, shaking, sweating, feeling hot, feeling of choking and also cognitive symptoms, including fear of losing control, fear of dying and fear of the worst happening.

When using hypnosis to reduce anxiety and stress Dowd, Friedberg and Golden (1987), Barnier, McConkey and O'Neill (1999) and Beletsis (1989) note the benefit of

hypnosis as a therapeutic tool for treating anxiety and its usefulness in facilitating relaxation. Hypnosis is not a therapy in itself but an adjunctive process observed to enhance various therapeutic approaches (Levitt, 1993; Kirsch, Montgomery and Sapirstein, 1995). Kirsch et al. (1995) found that hypnosis enhanced the efficacy of cognitive behavioural treatments for a wide variety of problems.

Hypnosis is a procedure where the therapist suggests to the subject that he or she experiences changes in perception, thoughts, behaviours and feelings (Kirsch et al., 1995). In self-hypnosis the subject induces, manages and directs his or her own experience (Barnier et al., 1999), which enables the subject to become actively involved in the programme of treatment and to develop a sense of mastery of self. Successful applications of self-hypnosis to treat anxiety have been recorded for both children (Eccles, Holton, La Baw and Tewell, 1975; Gardner, 1976) and also for adults (Apfel, Arns, Benson, Crassweller, Daniels, Frankel, Greenwood, Kotch, Nemiah, Rossner, Schniewind and Sifneos, 1978). Although one's attention is less focused in self-hypnosis (Boxer, Brown, Fromm, Hurt, Oberlander and Pfeifer, 1981), imagery is considered to be richer.

In the present case study, hypnosis included anxiety management, by introducing imagery through which the client could work at his own rate on areas giving rise to anxiety; relaxation, ego strengthening to help the client feel better about himself, together with training in self-hypnosis for the client. The latter involved the client in replicating for himself the process in hypnosis sessions with which he had already become familiar with initial instructions, prior to practice, being given to the client whilst still in hypnosis. Hypnosis and self-hypnosis were used to reduce anxiety, improve self-confidence and social interaction thus making it more likely that J, the subject, could feel more in control and be able to attend classes again and resume his education.

The client

J, a 15-year-old student, was referred by an outreach counsellor because the degree of anxiety he was experiencing was preventing him from entering a classroom or joining any lessons. J had a Statement of Special Educational Needs which included a social communication disorder very similar to Asperger syndrome. Although academically competent, attendance had broken down by half-term in the autumn.

J had reached the stage were he did not even want to go out and was totally obsessed with himself, but said he did not want to be like this. J was seemingly unable to recognize non-verbal signals and was fearful of who sat in front of him or behind him, dwelling upon what people said. J could take things literally and often did.

Several agencies were already involved in supporting J when he was referred, including a consultant psychiatrist, a clinical psychologist, his general practitioner, an outreach counsellor and the school Special Educational Needs Department. In addition he was also receiving medication (Cipramil and previously Seroxat and, before that, Prozac) for obsessive behaviour. J had experienced a complete breakdown in communication and in coping socially. For example, he would worry about small details and would ask, *'If someone says "Hello", what should I say? "Hello" or "Hello, how are you?" '*

The professionals appeared to conclude that J was too ill to be at school and that he would have to transfer from mainstream secondary school to a special small group provision. The outreach counsellor described J as shaking and twitching, and crying as he said to her, *'I'm so scared; it's being with people'*. The counsellor also noted that on

the few occasions when J had been able to get himself into school to the Special Educational Needs Department he would hide under the table to avoid being recognized by passers-by at lesson changeovers.

J's special educational needs included:

- School phobia.
- Emotional fragility.
- Poor social skills.
- Social communication difficulties.
- Difficulty with peer interactions.

His file notes revealed a school history of similar difficulties, even at age seven, including, 'an inability to follow class or group instructions/discussions, rocking movements, peculiar gestures, making faces and noises, not liking changes in routine or attention to himself, and an obsessive interest in consequences of naughty behaviour'.

At age 12, J had been described as, 'anxious and very tense, overwhelmed by the school size, unable to eat breakfast due to tension about school, and worrying about things which had not happened'. J was not observed to use social chat or small talk.

J's case, at the point of referral, appeared extremely challenging, entrenched, deteriorating and had considerable multidisciplinary involvement.

Therapeutic plan

The rationale for the intervention took note of the helplessness, lack of control, and despair and distress of the client which was preventing him from attending classes at school and from interacting with his peers. The aim was to teach him to relax and to regain control of his anxiety, rather than his anxiety controlling him, but not to eliminate feelings of anxiety. Being aware of feelings of anxiety is both natural and useful for an individual. The rationale was also to actively involve the client as much as possible in his treatment and recovery, so that success would enable him to be in a stronger position to address the issue of attending classes regularly and interacting with his peers again.

All sessions with J and his mother took place at home. The first session held at J's home included establishing baselines of J's anxiety, of his personal targets and of the effect the school difficulties were perceived both by J and by his mother to have upon home life.

Three sessions of hypnosis, the last including self-hypnosis, were followed by a session to repeat the baseline measures and monitor the self-hypnosis. Follow-up sessions took place at one, three and six months.

An audiotape was made of session one and left with J to listen to as near daily as possible. This was repeated for session two. Also, J and his mother were asked to note any small changes observed between the sessions, and discussions of these took place at the beginning of each session with J, as did discussion of his progress towards his personal targets.

Hypnosis intervention

At the first hypnosis session J chose as his special place a garden; this being a place where he would feel calm, peaceful and relaxed. J made himself comfortable on the settee and closed his eyes and an induction was delivered followed by progressive relaxation and experience of his special place. Ego strengthening using Stanton's 'snowball' imagery

(Hammond, 1990) and confidence building using Benson's 'biscuits' imagery, where the client makes biscuits to eat containing ingredients from positive elements of the client's life, were also included. A post-hypnotic suggestion was given to enable J to access the calm feelings of being in his special place immediately, when in a challenging situation, by rubbing his finger and thumb together.

At the second hypnosis session, induction and progressive relaxation was followed by the use of age progression where the client was taken forward in time to a point which he identified when he had achieved all of his objectives. There, the client was invited to watch a video of himself at this point in the future and to describe the evidence he observed in the video that showed he had achieved one or more of his objectives.

The third hypnosis session included age progression again, and in addition, instructions for self-hypnosis. This was followed by a self-hypnosis practice session by the client who was asked to practise self-hypnosis daily until the next session. Assertiveness techniques were also discussed at this session with both J and his mother.

The fourth session included a review of the client's self-hypnosis practice and post-intervention testing was carried out on all the measures. At each session the client completed the self-rating scales for his personal targets (see Figure 1).

Therapeutic outcome and conclusions

Results showing a reduction in anxiety are illustrated in Figure 2. It provides a comparison of pre- and post-intervention measures on the Beck Anxiety Inventory and shows a reduction for nine of the features of anxiety (see Appendix) with only one feature now in the 'Moderately anxious' range and remaining features of anxiety within the 'Mildly anxious' range. A numerical interpretation gives a score of 25 on 17/11/01 which had reduced to 16 by 11/12/01.

Results showing a continued reduction in anxiety are illustrated in Figure 3. This indicating that six months after the last hypnosis session J was still reducing his anxiety level which was now down to a score of 11.

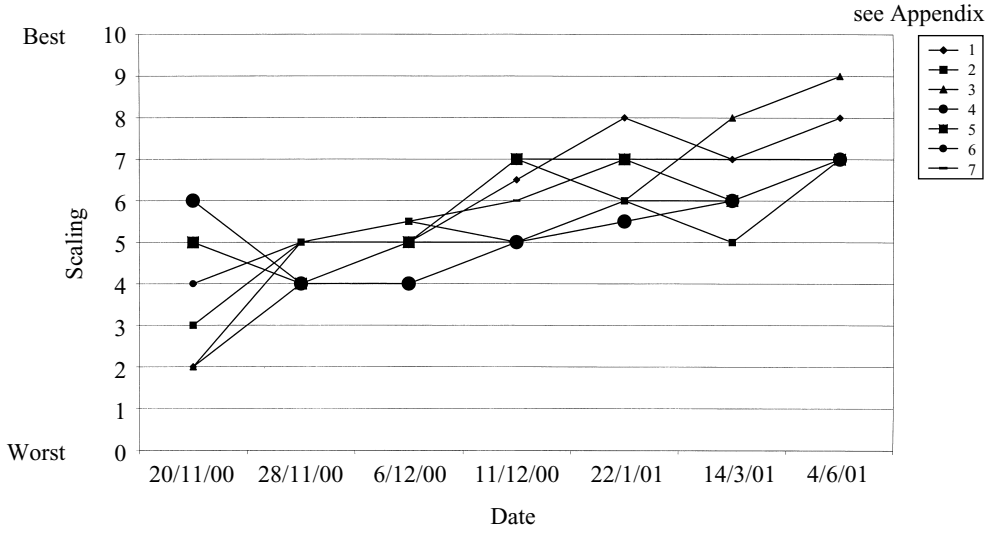

Figure 1. J's progress towards his personal targets.

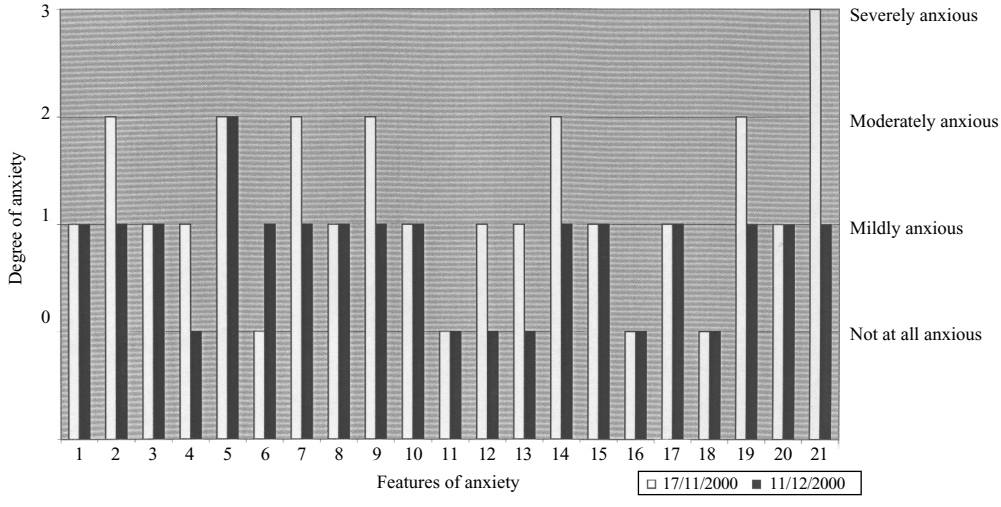

Figure 2. Comparison of J's anxiety scores before and after hypnosis.

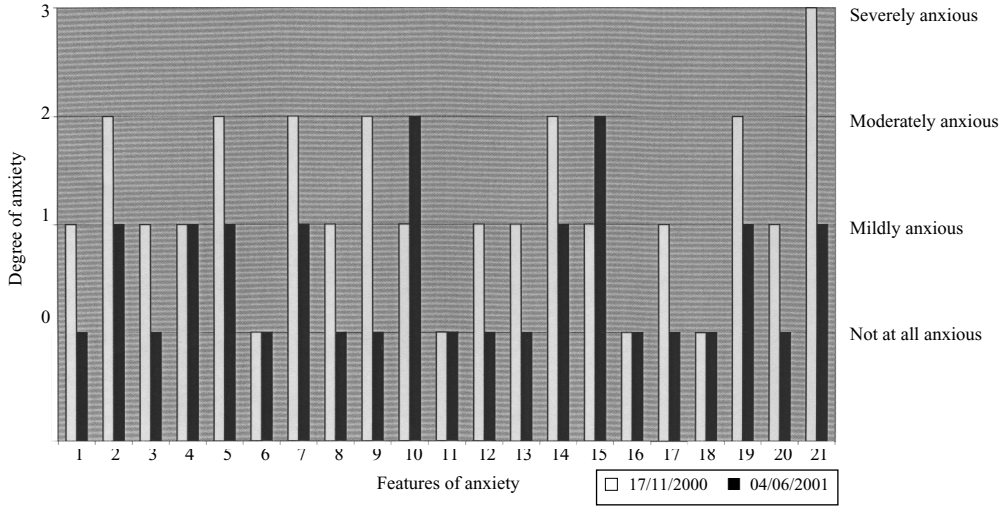

Figure 3. Comparison of J's pre-treatment and six-month follow-up anxiety scores.

J's personal targets included:

- Feeling OK about going into a room of people I may not know.
- Feeling I can get on with people.
- Feeling able to cope with name-calling.
- Recognizing exceptions to problem areas (challenges) in my life.
- Feeling I can do something about making things better for myself.
- Believing in myself.
- Feeling confident.

Monitoring of progress on the personal targets agreed at the initial session took place at each visit and has been illustrated in Figure 1. By use of a self-rating scale, from one to 10, with a score of 10 being the highest (best) rating possible, Figure 1 reveals that J made a steady improvement on all personal targets and maintained this through to the six-month follow-up.

A considerable reduction in the impact of J's difficulties on life at home from the initial visit to the six-month follow-up visit, for both J and his mother, is illustrated in Figure 4. This also shows that there were differences between J and his mother in their perceptions of the situation over this period of time, with J perceiving a steady, continuous improvement in home life, and his mother seeing the effect on home life initially becoming worse but then improving more rapidly than J perceived.

The hypnosis sessions and teaching of self-hypnosis, with the discussion about assertiveness, appeared to result in empowering both J and his mother and in J making substantial progress towards his personal targets, most of which involved J being able to cope socially.

The steps towards regaining control, which J began during the hypnosis intervention, continued under his self-hypnosis. During the intervention J began to improve his attendance at school dramatically. This continued to improve after the hypnosis sessions were completed and J was able to resume full-time education, to join in lessons and to re-engage socially with his peers. Unfortunately, no objective measure of self-esteem was taken but the self-hypnosis conducted by J, with the feedback to him of his progress on the various measures, was observed to have an empowering effect and appeared to raise J's self-esteem, which suggests that self-esteem is an important variable to consider measuring in future work.

Follow-up visits

Three follow-up visits were made, at one, three and six months, to check for maintenance of the initial changes recorded on the measures referred to earlier. At the one-month

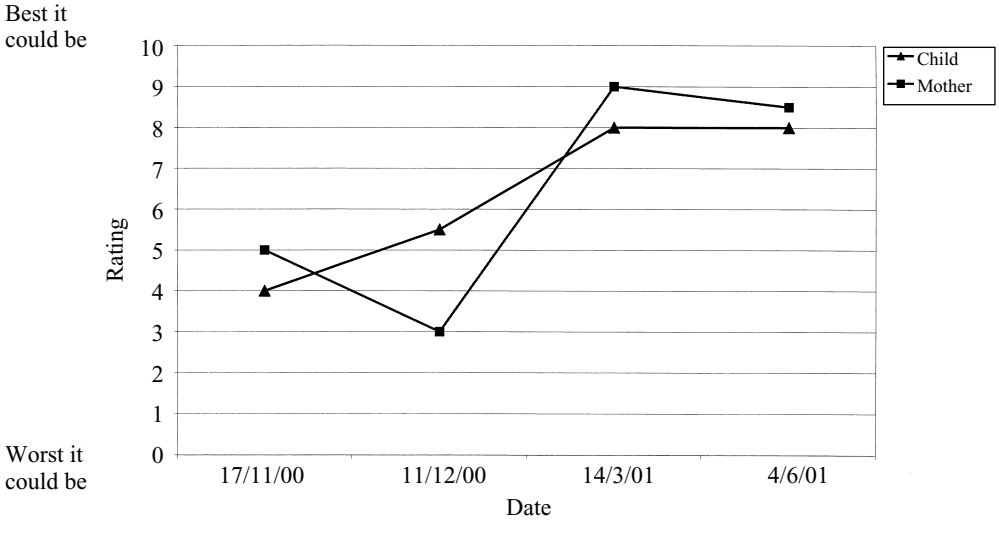

Figure 4. How home life has been affected.

follow-up visit J confirmed, *'I'm now in 17 hours out of 23 hours of lessons each week and I did PE on Thursday.'* while his mother remarked, *'After our assertiveness talk I started to let my son know how his behaviour made me feel — it helped him to talk more about it.'*

At the three-month follow-up J's mother observed, *'J has been doing his homework the past three weeks, he has never done this since starting at school until now. He went to a sleepover last week.'*

At the six-month follow-up, when asked what he would say to others thinking of trying self-hypnosis, J concluded, *'It's worked for me. It made me relax more. It made me calm down and with self-hypnosis you can change your own thoughts and take your mind off your problem.'*

A letter received sometime later from J's mother included the following and illustrates the impact of J's progress on life at home:

> I feel that we have been privileged to benefit from this service and now that we are six months down the road it seems unbelievable that this once tense and emotionally stressed boy, who couldn't cope in group situations is now much more relaxed and able to enter school and mingle with his peers and walk into town. Something we believed would be impossible … I am grateful to have my son back.

Although it is not possible to credit solely the use of hypnosis and self-hypnosis with all of the successful outcomes described here, not least in view of therapeutic approaches including medication, made before this intervention and continuing family and school support, it appears that hypnosis was the only new factor. The use of hypnosis as an adjunct to educational psychology appears to have achieved considerable benefit for the client, and for his mother, in spite of his life-long social communication disorder. Perhaps others involved in working with clients with a social communication disorder will be encouraged by this evidence to consider developing and applying hypnotic skills as an adjunct to their current professional skills.

Appendix

Beck Anxiety Inventory

Features of anxiety

1 Numbness or tingling.
2 Feeling hot.
3 Wobbliness in legs.
4 Unable to relax.
5 Fear of the worst happening.
6 Dizzy or lightheaded.
7 Heart pounding or racing.
8 Unsteady.
9 Terrified.
10 Nervous.
11 Feelings of choking.
12 Hands trembling.
13 Shaky.
14 Fear of losing control.

15 Difficulty breathing.
16 Fear of dying.
17 Scared.
18 Indigestion or discomfort in abdomen.
19 Faint.
20 Face flushed.
21 Sweating (not due to heat).

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