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THE PLACE OF HYPNOSIS IN PSYCHIATRY: ITS APPLICATIONS IN TREATING ANXIETY DISORDERS AND SLEEP DISTURBANCES

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"I do not generally view hypnosis as the therapeutic agent, but rather as the catalyst for communicating therapeutic ideas or facilitating therapeutic experiences."

This is the view of Yapko (1993), which endorses our view of the role of hypnosis in the treatment of emotional disorders. Hypnotherapy can be used extensively for a wide range of conditions in the field of psychiatry: It is valuable for the treatment of anxiety disorders, sleep disturbances, eating disorders, depression, psychosexual disorders, addictions, and particularly, in the treatment of phobic disorders (Waxman, 1980). Hypnotherapy is advantageous, as it allows patients to face their fears in a relaxed and safe environment; in hypnotherapy, patients are able to explore problem areas together with the therapist (Kraft, 2000). The purpose of this article is to focus on the treatment of anxiety disorders, including obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD), and a range of sleep disturbances.

ANXIETY DISORDERS

Anxiety disorders, according to DSM-IV (American Psychiatric Association, 1994), may be considered under the following six major categories:

1. Panic disorder (with and without agoraphobia),
2. Specific phobia (replacing simple phobia),

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3. Social phobia,
4. Obsessive-compulsive disorder,
5. Generalised anxiety disorder, and
6. Post-traumatic stress disorder.

These disorders will be elaborated now and the role of hypnosis in their treatment considered.

Panic Disorder (With or Without Agoraphobia)

Patients suffering from panic disorder, with or without agoraphobia, experience high levels of anxiety associated with a "fear of fear," loss of control, a fear of dying, and a dread that they might go mad (Evans & Coman, 2003). These patients describe a wide variety of symptoms which include chest pain, hyperventilation and parasthesia, faintness, dizziness, and in some cases, depersonalisation.

Hypnotherapy is valuable when treating this disorder, as patients can be encouraged firstly to experience a safe place where they are free from anxiety, and where they feel secure (Callow, 2003). The safe place can either be an imaginary situation or a real one; and it can be a scene from the past, present, or future. Although beach settings are frequently chosen by patients, there is a wide range of possible scenes and, invariably, patients visualise being on their own.

Once the patient is comfortable and relaxed in the safe place, one can explore situations which give rise to panic. When the anxiety level starts to cause distress, the patient is returned to the safe place.

Patients who suffer from agoraphobia have complex disturbances in which control is a central feature (Salzman, 1982). It is not possible to treat agoraphobic patients using a simple behavioural approach with hypnotherapy. The therapist must focus on, and gradually introduce the patients to, the concept that the family dynamics must be changed in order for them to recover from the agoraphobia. This involves the use of psychoanalytically oriented psychotherapy, which should be used in conjunction with the hypnotherapy (Kraft, 1976). It is frequently found that the agoraphobia is a function of the whole family dynamics and that high levels of hostility exist in the family.

The hypnotherapy concentrates on the behavioural therapy which, in turn, focuses on increasing the patients' mobility — that is to say, the distance that they are able to move from their home. It is extremely important that patients

actually go into the outside world; this, in turn, gives rise to insights into the nature of the disorder. In hypnosis, systematic desensitisation is employed; at first, patients visualise walking a few steps to the pillar box and then to the local shops and, later on, they are encouraged to drive their car. The whole process of mobilising agoraphobic patients is an extremely difficult one and requires a great deal of patience. The desensitisation can be carried out in the hypnotherapy or, alternatively, patients may prefer to be accompanied by the therapist — on walks, going into department stores using the lifts and escalators, using trains and buses — and this process is referred to as in vivo desensitisation (Kraft, 1975).

Specific Phobias

A specific phobia is applied to any circumscribed fear reaction which is capable of causing severe distress and avoidance behaviour. Most commonly, people are afraid of animals — dogs, cats, snakes (Horowitz, 1970), spiders, dead birds (Van der Hart, 1981), and mice. Other specific phobias include fear of heights, enclosed spaces, injections (Kraft, 1984), heat (Kraft & Al-Issa,1965), flying and driving phobia (Kraft & Kraft, 2004). In all of these specific phobias, the patient is asked to imagine the feared situation in the form of a graded stimulus hierarchy, starting from relatively simple situations to the most complicated; in addition, the patient must experience the feared situation outside the consulting room.

Patients suffering from arachnophobia should be encouraged initially to look at diagrams of spiders in a children's book; once this has been achieved, the next stage is to look at photographs of real spiders, and then to handle toy spiders of varying sizes, followed by the handling of real dead spiders. The final stage is to handle (non-venomous) live spiders. Ideally, patients should be able to cope with a spider running over their hands; but, frequently, patients will terminate the therapy before this stage has been reached.

Social Phobias

Patients who suffer from social phobia develop a variety of symptoms in social situations. They experience a feeling of distress when being faced with certain social situations and this can often lead to complete avoidance. Often, the patients suffer from blushing, trembling, tachycardia, and excessive sweating. Symptoms frequently arise in adolescence, but they can often be traced back to childhood events where the patients have experienced feelings

of embarrassment either in the classroom situation or at home. Some patients develop such a severe amount of sweating that they can literally wring out their clothing after being in a social situation — this is referred to as hyperhidrosis (Kraft, 1985). Young people often find that alcohol is an effective way of counteracting social anxiety and it may become increasingly tempting for them to use this as a form of self-medication; in fact, it has been the first author's experience that social anxiety is invariably the underlying cause of excessive alcohol intake (Kraft, 1971).

Systematic desensitisation is an excellent method of treating patients with social phobias. At first, patients are encouraged to imagine relatively simple social situations; they then move on to more difficult scenarios which become increasingly more challenging. Again, if the patients show any distress during the hypnosis, they are immediately returned to the safe place. Interestingly, they are frequently surprised that symptoms, which have proved crippling over many years, can be resolved in this way.

Whether the predominant symptom of the social phobia is apprehension, trembling, blushing, or excessive sweating, the treatment approach is very similar. The emphasis, in all cases, is to reduce the anxiety in social situations: This allows the patients to have greater freedom of movement, generally more self-esteem, and the confidence to interact with other people. During the treatment, patients frequently become aware of the underlying psychodynamic factors which gave rise to the symptoms (Wachtel, 1987).

Performance anxiety is a sub-group of social phobia in which patients have a marked and persistent fear of one or more social or "performance" situations; this often occurs when patients are exposed to unfamiliar people, or when they are subjected to scrutiny by others (DSM-IV, 1994). While the most common form of performance anxiety is public speaking, there are many other areas; these include actors who are frightened that they might forget their lines, musicians who are afraid of making mistakes, and athletes who worry about being beaten in contests (Lazarus & Abramovitz, 2004).

Lazarus and Abramovitz (2004) give a detailed account of a 30-year-old violinist (first violinist) who led a prestigious orchestra and, having enjoyed a promising career, developed a crippling performance anxiety which could well have put an end to his career. In the early stages of therapy, systematic desensitisation was used as the sole treatment strategy. Little progress was made in the therapy, until he was encouraged to bring his violin into the consulting room. The therapist asked him to play a series of pieces, starting with the easiest and working to the most difficult, while the patient chose appropriate

pieces forming a graded hierarchy. A turning point in the therapy occurred when he played the first violin part to a record of Mozart's *Linz Symphony*. After 20 sessions, he made a complete recovery and this was maintained. This case underlines the importance of incorporating live performance into the treatment session. Patients who are afraid of public speaking are encouraged to rehearse the speech in the treatment session, first in hypnosis and then without the use of hypnosis. Singers who are frightened of performing in public are encouraged to bring in *Minus One* tapes so that they can sing along with the recording — again this is done first with the assistance of hypnosis, and then, subsequently, without the use of hypnosis.

Obsessive-Compulsive Disorder

An extensive search carried out by the Royal Society of Medicine has shown that there are very few papers written on the use of hypnotherapy for the treatment of obsessive-compulsive disorder (OCD), although there are a few case reports.

OCD is characterised by uncontrollable, intrusive thoughts and actions that, as far as the patients are concerned, can only be alleviated by patterns of rigid and ceremonial behaviour (DSM-IV). One of the important features of this disorder is that patients are well aware that these thoughts and actions are irrational, but feel that they are unable to resist them. It can take the form of excessive ruminations or compulsive behaviour which may include continuous hand washing, checking of locks, gas taps, water taps and plugs; all of these may be associated with highly complex rituals. Patients are often obsessively anxious about dirt, contamination, flooding, germs, or a fear of real or imagined traumas (DSM-IV). If the patients are interrupted while carrying out a ritual, or if they make a mistake, then the whole sequence has to be repeated once more from the beginning.

If the main symptom of OCD consists of obsessive rumination, a technique which is extremely helpful is one of "thought-stopping." Here, the patient is encouraged in the hypnotherapy session to focus on the obsessional thought; next, the therapist forcibly says the word, "stop." At this point, the patient is encouraged deliberately to think of something else, thus interrupting the obsessive pathway. This technique was used in the case of a 12-year-old boy who had repetitive matricidal thoughts (Kellerman, 1981). Over a period of 10 weeks, the patient made a complete recovery after receiving six treatment sessions.

A 32-year-old married woman was plagued by obsessive sexual thoughts about Jesus and the Virgin Mary: At church, she was unable to concentrate properly on the service because these intrusions. The treatment strategy here was to rehearse the whole church service without any sexual overtones, and this was achieved in hypnosis (Kraft & Kraft, 2005). After 21 hypnosis sessions, she told me that she was able to attend church services without any intrusion of a sexual nature.

An interesting approach to the treatment of OCD is a technique referred to as "split-screen imagery." This was illustrated by a single case study of a disturbed 18-year-old girl who feared that she might use a knife in order to kill her parents. In hypnosis, the patient was asked to divide a screen into two halves: On the one side, she was encouraged to visualise a knife, and on the other half of the screen she was asked to imagine flowers. The rationale of the treatment was that the flowers should neutralise the harmful thoughts that she had in relation to the knife. It has been established that nature scenes are particularly helpful in this respect, because they are capable of evoking nourishing associations and are able to reduce feelings of isolation and loneliness (Ahsen, 1977). In this way, she felt that she had control over the sharp instrument and could choose what to do with it. This form of treatment is particularly helpful for younger patients who watch a great deal of television (Taylor, 1985).

Another technique which has been used successfully in the treatment of OCD involves flooding the patient with situations which are regarded by the patient as being contaminated. An example of this technique is that of a 47-year-old housewife who was plagued by contamination fears to the extent that she had to wash her hands 250 times a day, and had to clean her house almost constantly (Scrignar, 1981). The only time when she felt relatively calm was when she was lying in bed wearing a freshly laundered night-dress. In hypnosis, the therapist instructed her to touch all the objects which she felt were contaminated, and she was told that no harm would come to her. Although the patient was very distressed during the course of the sessions, she made a successful recovery and maintained her improvement for two years.

General Anxiety Disorder

Patients who have been diagnosed as having generalised anxiety disorder complain about a variety of symptoms which include an excessive worry about a whole range of events in their lives, often coupled with feelings of fatigue, lack of concentration, and a general sense of weariness. Frequently,

these patients show anticipatory anxiety in relation to a wide variety of life events and often they go to their general practitioners to obtain tranquilisers such as Diazepam or antidepressant drugs such as Fluoxetine. The problem arises when the general practitioner either refuses to continue prescribing these drugs or when the patients decide to stop taking the medication.

Patients with generalised anxiety disorder may benefit considerably from hypnotherapy: The treatment can involve focusing on specific anxiety-provoking situations, free association, or a combination of these two approaches. The great advantage of self-hypnosis is that it gives the patients a feeling that they are in control of the problem, rather than being at the mercy of their symptoms.

Post-Traumatic Stress Disorder (PTSD)

This term was introduced into the psychiatric literature in 1980. Previously, there had been several other terms used, such as traumatic syndrome (Seguin, 1890), shellshock, gross stress reaction, and combat neurosis (Kennedy & Duff, 2001). *The Diagnostic and Statistical Manual of Mental Disorders* (APA, 1994) defines PTSD as a collection of symptoms which develop after exposure to a traumatic event that "involves actual or threatened death or serious injury, or other threat to one's physical integrity." PTSD may occur following combat (Brende, 1985), rape (Spiegel, 1989), child abuse, domestic violence, accidents (Mutter, 1987), terrorism, disaster (De Silva, 1999), and torture. The symptom complex of PTSD may include a number of these features: intrusive imagery associated with flashbacks, nightmares, a heightened arousal and startle response, phobic avoidance of situations reminiscent of the original trauma, and in some cases, emotional numbness and fugue states (Degun-Mather, 2001).

It is widely recognised that patients who suffer from PTSD show high hypnotisability and there are many studies which support this finding (Evans & Coman, 2003; Hollander & Bender, 2001).

The aim of hypnotherapy is to ensure that patients re-experience all the components of the original traumatic incident. This may be achieved by ensuring that the patients feel totally secure in the treatment situation in their safe place. Although some patients find it difficult to understand why the therapy should involve returning to the original trauma, it is central to the recovery process. At the end of each session, the therapist must ensure that the patient's anxiety level is relatively low, so that the patient's fear, connected with the original trauma, is reduced (Evans & Coman, 2003).

SLEEP DISORDERS

According to the *International Classification of Sleep Disorders* (ICSD, revised; American Sleep Disorders Association, 1997), sleeping disorders can be divided into four categories: (a) dyssomnias; (b) parasomnias; (c) sleep disorders associated with mental, neurological, or other medical disorders; and (d) proposed sleep disorders.

The term dyssomnia refers to any condition which involves either difficulty in initiating or maintaining sleep, or excessive sleeping (ICSD, 1997). According to the ICSD, there are 88 sleep disorders in all, and in this article a number of these will be reviewed. The term "insomnia" has now been replaced with the term "dyssomnia" as insomnia literally means "no sleep," which is a rare phenomenon (Becker, 1993). Dyssomnias are divided into three main categories: (a) intrinsic sleep disorders, which originate within the body, such as idiopathic insomnia, narcolepsy, obstructive sleep apnoea syndrome, and restless legs syndrome; (b) extrinsic sleep disorders, which originate outside the body, such as altitude sleep disorder or alcohol-dependent sleep disorder; and (c) circadian-rhythm sleep disorders which include shift work sleep disorder and time zone change (jet lag) syndrome.

Parasomnias are conditions which are primarily associated with arousal, partial arousal and sleep-stage transition which interfere with sleep (ICSD, 1997). These are divided into four main groups: (a) arousal disorders, which include sleepwalking (somnambulism) and night terrors; (b) sleep-wake transition disorders, for example, sleep talking and nocturnal cramps, (c) parasomnias usually associated with REM sleep, such as nightmares, sleep paralysis; and, finally, (d) "other parasomnias" which include sleep bruxism and enuresis.

Where the sleep disorder is associated with major psychiatric illness or neurological disorders, the primary focus of attention must be directed first and foremost to the underlying condition. If the sleep disturbance persists after the underlying condition has been satisfactorily treated, then hypnotherapy may be considered to correct the sleep disturbance.

Proposed sleep disorders are disorders which had not been classified until the 2005 edition of the *International Classification of Sleep Disorders*. These include sleep-related laryngospasm, terrifying hypnagogic hallucinations, sleep hyperhidrosis, and menstrual associated sleep disorder.

The Use of Hypnotherapy in the Treatment of Initiating or Maintaining Sleep/Dyssomnias

In the younger age group, the problem is usually one of difficulty getting off to sleep (onset insomnia), whereas, in the over 50 age group, the most frequent problems are interrupted sleep and early morning awakenings (Kales & Kales, 1984). In order to qualify as a sleep disorder, the patient must experience difficulties for a minimum of three nights per week, continuing for more than one month.

Nielson (1990) describes two male patients with whom he uses an integrative approach combining psychodynamic principles with the use of hypnotherapy. The first patient, aged 30, had onset insomnia, while the second, aged 40, suffered from early morning awakenings. The treatment approach was similar in both cases, in that it combined brief psycho-dynamically oriented psychotherapy with hypnotherapy. The aim of the psychotherapy was to focus attention on the emotional factors which were responsible for the sleep problem, whereas the hypnotherapy was directed towards helping them get to sleep. In the hypnotherapy, these patients were encouraged to visualise scenes which were pleasant and comfortable; and, during the hypnosis, they were told that they would be able to conjure up these scenes whenever they chose to do so. The therapist encouraged them to practise self-hypnosis twice a day, especially at bed-time. Both patients found that not only had their target symptoms (the sleep disorders) improved, but also there was a marked change in their general well-being; they were less irritable, more relaxed, and were able to enjoy their leisure activities.

Scholz and Ott (2000) examined the efficacy of hypnotherapeutic audiotapes with 21 subjects who had suffered from chronic insomnia for several years. They prepared lengthy audiotapes in which they made indirect suggestions of relaxation and sleep. The researchers introduced two main characters: One was referred to as the "protagonist" and the other the "antagonist." The message was that the person who was able to achieve relaxation and sleep adequately (the protagonist) was also able to perform more competently in his daily life; the second person (the antagonist), who had difficulty sleeping, found that he was lethargic during the day and performed his daily tasks less adequately. The patients were required to listen to these lengthy and repetitive tapes in order to induce sleep.

Another technique used in hypnotherapy involves the patient drawing an imaginary circle on the blackboard and inserting the number 100. Next,

the patient is instructed to imagine the words DEEP SLEEP, erasing the number 100 and replacing it with the number 99. This process is repeated by subtracting one number, one at a time, until the patient is asleep (Bauer and McCanne, 1980; Becker, 1993). In the two cases described, both patients found that this was an extremely effective method of achieving sleep; and, at one year follow-up, their improvement was maintained.

Narcoleptic Tetrad

Narcolepsy is a disorder which is characterised by repeated episodes of sleep and overwhelming urges to lapse into sleep during the day. Sleep periods often last less than one hour; the patient feels refreshed on waking, only to lapse into further sleep two or three hours later. Interestingly, it has been established that narcoleptic patients move directly into REM sleep without entering the previous stages of sleep (Maron, Rechtschaffen, & Wolpert, 1964). Often, these periods of sleep occur in circumstances where there is no active participation, such as attending a lecture, listening to music, watching a play, or travelling on a train; but they may also occur while driving, eating, or when holding an active conversation. It is frequently found that patients who suffer from narcolepsy may have one or other of the following conditions: cataplexy, sleep paralysis, and/or hypnagogic hallucinations. This is often referred to as the narcoleptic tetrad.

Cataplexy, a characteristic and unique feature of narcolepsy, involves the rapid loss of bilateral muscle tone in response to high states of emotion — particularly laughter and elation — but may also be precipitated by anger. The frequency of cataplectic attacks increases with sleep deprivation. In cataplexy, the episodes are often brief — ranging from 1 to 10 seconds — although episodes can last up to one minute (Price, 1987): During a cataplectic attack, the patient remains conscious and the loss of muscle tone varies from a slight weakness or head droop to complete postural collapse.

Sleep paralysis, which is a frequent concomitant of narcolepsy, is a frightening experience in which the patient is unable to move all muscle groups and is unable to speak; in some cases, patients fear that they are unable to breathe (ICSD, 1997). In addition, the intensity of this experience may be increased by vivid hypnagogic hallucinations.

Schneck (1980) reports the successful treatment of a 40-year-old lady who had frequent episodes of uncontrolled sleep. In the first phase of the hypnotherapy, the patient was given suggestions of wakefulness and alertness at times when the she felt irresistible urges to go to sleep during the day. As this

was only partially successful, the therapist gave her post-hypnotic suggestions that when she was feeling drowsy, she should deliberately touch one hand with the other, and this would anchor her ability to remain awake.

Price (1987) described a 45-year-old male patient who had had a 32-year history of narcolepsy and cataplexy. He was particularly sensitive to praise, and sought treatment after he had been promoted at work. He would experience a number of cataplectic episodes during treatment sessions when discussing emotional themes relating to his wife. During the hypnosis sessions, the patient was given metaphors which were centred on past experiences of overcoming problems, acquiring new skills, and his inherent ability to perform tasks automatically. As this patient was particularly sensitive to being complimented at work, and this was responsible for the cataplectic attacks, these themes were introduced into the treatment program: in hypnosis, the patient rehearsed being given a compliment for a project in which he had had a considerable involvement. He was also encouraged to use self-hypnosis to rehearse situations which would have normally triggered cataplectic attacks. At the end treatment, this patient was able to control his cataplectic attacks and, at a 10-month follow-up, he was given a promotion to general manager at work. He was also able to communicate much more freely with his wife, to express anger and other feelings towards her without this precipitating cataplexy.

Nardi (1981) described two patients, the first being a 25-year-old woman whose attacks of sleep paralysis began shortly after her marriage. At these times, she feared that she was dead or that others might assume that she had died. These episodes of sleep paralysis occurred about once a month. In the hypnotherapy, it was suggested to her that, even though she was very relaxed, she could still control her arm to raise it. It was then suggested to her that she could exercise a similar control during sleep paralysis, and that she should relax and enjoy the experience. The therapist explained that there was a link between hypnosis and her sleep paralysis; the patient was also taught self-hypnosis and was asked to "count herself out" and to use this technique when she had an attack. A follow-up 14 months later showed that she was no longer distressed by the sleep paralysis and that she could either wake herself up or be relaxed enough to go back to sleep.

The second patient, a 30-year-old woman, had suffered from sleep paralysis and hypnagogic hallucinations since the age of six. A similar treatment approach was used as in the first case; and, after the combined use of hypnotherapy and self-hypnosis, she felt able to handle these experiences, dismissing them as "interesting" and "non-threatening."

Somnambulism

Sleepwalking occurs more frequently in children, but may also be seen in adults (Hurwitz, Mahawald, Schenck, Schluter, & Bundlie, 1991). It has been found that adults suffering from sleepwalking are often unable to deal with their own aggression (Klackenberg, 1982). Although most sleepwalkers merely sit up in bed, walk briefly, or carry out some repetitive activity only to return to bed, there are some patients who carry out more complex movements such as cooking a meal or even driving a car. These episodes are more frightening for the sufferer, who would then tend to seek treatment (Gutnik & Reid, 1982). It tends to occur in the first third of the night and it is associated with an abrupt arousal in either stages 3 or 4 of non-rapid eye movement sleep (nREM) or slow wave sleep (SWS). At these times, the patient will show purposeful movements, walking out of the room or even out of the house. Reid, Ahmed, and Levie (1981) describe a treatment approach which was found useful for somnambulistic subjects. They were given two direct suggestions, the first that, like hypnosis, sleepwalking occurs in a trance-like state and, secondly, that they could utilise this state at night, so that whenever their feet touch the ground they would immediately wake up.

Hurwitz et al. (1991) described a technique for treating sleepwalking in which the patients imagined a screen where they were lying comfortably in bed, sleeping peacefully. In the consulting room, an audiotape was prepared so that the patients could practise self-hypnosis at home. The therapists also gave post-hypnotic suggestions that the patients should be safe during the night and that movement would be minimal. They used this technique for adult sufferers of sleepwalking and night terror disorder. The patients received between one and six sessions. The authors reported that, out of the 17 patients who had only one treatment session, 11 patients had immediate success, whereas the remaining six did not improve and stopped the hypnosis treatment.

Night Terrors

Night terrors — also known as sleep terrors — tend to occur in children aged 4 to 12, but can also be seen in adults, particularly between the ages of 20 and 30, with a male preponderance. Night terrors, like somnambulism, begin with an abrupt arousal in stage 3 or stage 4 sleep (nREM/SWS). They are characterised by a scream at the outset, associated with a number of autonomic disturbances, including tachycardia, rapid breathing (tachypnoea), mydriasis, flushing of the skin, combined with heightened fear responses. Patients will

often sit up in bed or leave the bedroom; and, if awakened, they are frequently confused and disorientated. In most patients, there is amnesia for the whole event, and it is for this reason that patients tend to be referred for treatment by other family members or partners.

In children suffering from night terrors, the favoured method of induction is to ask the patient to describe their favourite story, which may then be embellished in their fantasy. Kohen, Mahowald, and Rosen (1992) reported four children, aged between 8 and 13, all of whom suffered from sleep arousal disorders. These authors also found it helpful when treating children to compare the brain to the computer and likened the night terror to a "bad habit" which could be "reprogrammed." It was found that the children were fascinated with this concept and were interested to learn how to undo this "habit." At follow-ups 6 to 18 months later, it was found that all these children made a complete recovery.

Kraft (1986) reported a single case study of a 22-year-old single male who had been suffering from night terrors for four years. His father reported that at night his son would suddenly scream out, "Go away," and he would be found huddled in a corner of the hall in a state of sheer terror. The patient had no memory of these attacks and thus it was important to re-activate the contents of these episodes during the hypnotherapy. It was established that the terror was associated with a gang of boys attacking him, and the aim of therapy was to use a re-framing technique to change the outcome of this sequence of events. As soon as he had changed the outcome of the chase, so that he was in the winning position, his fear was eliminated, and a 6-month follow-up showed that there was no recurrence of these night terrors. An alternative treatment approach was used by Kennedy (2002), who suggested that his patient, a 37-year-old female whose night terror consisted of her being chased by a man in a theme park, should imagine a television screen where she would be able to have complete control and where she would be able to change the ending.

Obstructive Sleep Apnoea Syndrome

Patients who suffer from obstructive sleep apnoea syndrome (OSAS) have repeated episodes of upper airway obstruction: During sleep, patients typically gasp or snore loudly and this alternates with periods of silence lasting between 20 to 30 seconds (ICSD, 1997). These periods of apnoea cause arterial desaturation which, in turn, lead to psychological impairment during the daytime. In addition, OSAS can lead to an increase in accidents during the

day, underperformance, heart rhythm abnormalities, coronary heart disease, and cerebrovascular accidents. Whenever heavy breathing at night is associated with daytime somnolence, the diagnosis of OSAS should be considered (Kraft, 2003). Factors which contribute towards OSAS are obesity, alcohol intake, smoking, and the use of hypnotics at night (Krieger, 1996). While snoring is a constant feature of OSAS, many patients snore without having the condition (Stores, 2003).

Finking (2000) describes the use of a tennis ball which is placed in the pyjamas of the patient suffering from OSAS, and this is designed to prevent the patient lying on his back. It was shown that this was an effective form of treatment. Several authors have referred to the use of a nasal continuous positive airway pressure device (nCPAP), but this is a cumbersome device which does not in any way correct the snoring or the OSAS and many patients object to wearing this apparatus at night.

Hypnotherapy has the great advantage in that no mechanical devices are required, and a useful approach is to concentrate on weight reduction. In the case report of Kraft (2003), a 53-year-old married man requested that he be given the direct suggestion that, when snoring at night, he would automatically turn onto his side. This suggestion, in fact, was taken up, and his wife commented that the snoring had decreased, even though she was unaware that he was receiving treatment for this condition. Later in the therapy, he was advised to lose some weight and, after losing 6.3 kilograms and having had 10 treatment sessions, the snoring symptom was completely eliminated.

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