Exploring the Efficacy of Hypnosis as a Complementary Therapy for Anxiety Disorders

Aurelia-Daniela STĂNCIULESCU ✉
ORCID: https://orcid.org/0000-0002-2887-6720
Spiru Haret University, Romania

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Abstract:

Unfortunately, anxiety has become a subject of increasing interest in the contemporary period due to the effects of the global coronavirus pandemic, as well as conflicts such as the Ukraine-Russia and Israel-Palestine conflicts, which have affected humanity economically and emotionally. Additionally, climate change, with its accompanying effects such as global warming, earthquakes, and floods, is further contributing to the rise in diagnosed cases of anxiety worldwide. In this troubling social context, the focus on anxiety disorders appears more necessary than ever. While the use of hypnosis in anxiety cases is not a new topic, it deserves greater attention due to scientific studies demonstrating its quick benefits in some cases. Furthermore, it is widely agreed that hypnosis yields unquestionable results when combined with other classical psychological therapies, particularly in more complicated cases.

Keywords: hypnotherapy, anxiety disorders, DSM-V, hypnosis therapy.

Introduction

Anxiety is often described as a sense of threat of imminent danger, which causes a permanent state of tension, restlessness, tension and insecurity. The human brain has a natural tendency to regard an uncertain situation as a danger until it is made clear about it. Anxiety appears as a result of insufficient information and the absence of landmarks regarding a situation, which leads to the inability to control it (Lăzărescu & Bărănescu, 2011). A first approach to anxiety disorders places anxiety in conceptual relation to fear, because confused states of anxiety might be mistakenly identified with the feeling of fear. However, if anxiety is a negative emotion without a concise object, fear is a negative emotion in relation to an objective stimulus or situation, which warns us of a real external danger (Romilă, 2004). In other words, fear expresses a normal emotion, while anxiety refers to an unjustified emotion regarding the inability to cope with the major demands of life. "In terms of psychopathological phenomena,

anxiety refers to anxiety disorders and fear explicitly refers to phobia. Fear has always been considered a normal reaction of the body to danger, reasoning that without it, the human species would have disappeared long ago. Fear urges caution in approaching unclear situations and protects the individual from adverse environmental conditions" (Preda, 2013).

Anxiety is a multidimensional construct, involving cognitive, affective, physiological and behavioral parts, such as: subjective feelings (tension, worry, nervousness, etc.), somatic symptoms (headaches, sweating, palpitations, tachycardia, gastric discomfort, etc.), as well as specific behavioral reactions (Zeidner & Matthews, 2011). Anxiety does not necessarily mean excessive worry as inner turmoil can be perfectly normal. It can be a healthy attitude, if it prepares or adapts the body for an action against a possible danger. In fact, anxiety has a positive component when it is short-lived and becomes dangerous to health if it is permanent and has no object. Thus, anxiety becomes abnormal when it disrupts everyday life, limiting individual actions to a permanent search for avoidance strategies. Healthy anxiety consists of worry or vigilance that helps us cope with different or difficult challenges, while unhealthy anxiety is an emotional response to some danger perceived as real because of a very low probability of occurrence (for example, fear of flying, that the plane might crash, although plane crashes are quite rare).

Anxiety arises because we do not realize the importance of a subject that has been bothering us for a very long time and that we do not decide to face. Anxiety is therefore the way in which our body sends us signals that inform us of the danger we neglect. According to the Ellis (2009), the main source of anxiety consists in the precarious crossing of crisis states specific to each stage of development. Specific symptoms of anxiety vary from person to person, depending on the level of anxiety. Thus, mild, moderate, and medium levels of anxiety can be beneficial for increasing one's performance. Even higher levels are considered normal under certain conditions (such as school competitions). When it comes to a fear without an object, however, we are talking about anxiety disorder - it can be about a situation in which either there is no obvious danger, or the danger is much too small to justify such a fear (Ellis, 2009).

Anxiety disorders reflect an affective state characterized by a feeling of insecurity, an intense and unjustified fear of the presence of a real danger. In most cases vague, diffuse or intense fear is accompanied by autonomic symptoms such as migraines, sweating, palpitations, chest tightness and restlessness. Unfortunately, anxiety also affects thinking, perception and learning. It also has negative effects on the process of attentional selectivity, as a person experiencing anxiety disorders tends to exaggerate the importance of certain things in order to justify their anxiety in a situation that causes them fear.

Therefore, anxious symptoms reside in the occurrence of realistic (normal anxiety) or unrealistic (anxiety disorder) feelings, physical reactions and/or thoughts related to a threat or danger. The disorders are common, affecting the global population. People who suffer from anxiety say that their problems are physical in nature, not realizing that they are actually dealing with an anxiety disorder. When anxiety takes on much larger dimensions, we speak of anguish (a word derived from the Danish Angest), which is a state of uneasiness, disturbance or exacerbated worry (sometimes of a pathological type). Although anguish is an emotional experience of the same nature as anxiety, it is much more intense, manifesting in addition with sensations of suffocation, knot in the stomach, sweating and rapid pulse.

Classification of Anxiety Disorders According to DSM-V

Anxiety is therefore a subjective sensation that can range from a non-specific and diffuse state to panic attacks, i.e., to a psychopathological manifestation that occurs suddenly, in the form of intense fear or terror, beyond the limit of a person's endurance. A panic attack is a crisis situation that appears for no apparent reason and, by its intensity, is associated with the feeling of imminent death. Panic attacks are so frightening that even the thought of their occurrence can induce an anxious anticipation of new attacks. From a subjective point of view, the person in question feels the panic syndrome as a great danger, with strong vegetative manifestations, so that he experiences the feeling of imminent death or is tried by other unpleasant biological phenomena, such as hyperventilation, apnea, etc. Anxiety disorders consist of "abnormal" or unrealistic anxiety combined with persistent distress or impaired functioning.

The prevalence of anxiety disorders is relatively high. According to the American Psychiatric Association, the estimated annual percentage of US adults with various anxiety disorders is: specific phobia: 8% - 12% (US); social anxiety disorder: 7% (US); panic disorder: 2% - 3% (US); agoraphobia: 1-1.7% (adolescents and adults; worldwide); generalized anxiety disorder: 0.9% (adolescents)” 2.9% (adults); separation anxiety disorder: 4% (children); 1.6% (adolescents); 0.9%-1.9% (adults); selective mutism: 0.03-1.9% (USA, Europe, Israel). In general, women have higher prevalence rates in all anxiety disorders compared to men.

Over time, the classification of anxiety disorders has not changed much, but DSM-V focused on “providing a more sophisticated scientific approach to the possible etiology and pathogenesis of these disorders. Several international conferences were held between 2003 and 2008 to sharpen the natural points of separation of diagnostic groups under the rubric of "anxiety disorders". Indeed, four separate international meetings have been devoted to these potential groupings” (Kupfer, 2015).

DSM-V changed the previous classifications by reorganizing the chapter structure so that the disorders within each chapter are addressed from the perspective of lifespan and specifier use. Thus, DSM-V considered that post-traumatic stress disorder should be integrated into a separate chapter from the previous classification. DSM-V aimed to convey more information about symptoms and more accurately capture the psychiatric morbidity of disorders and the severity of their specific conditions. Also, the electronic version of the DSM-V offers greater flexibility in its use and the rating scales (Kupfer, 2015). The Diagnostic and Statistical Manual of Mental Disorders DSM-V (2013) classifies anxiety disorders as follows (Diagnostic and Statistical Manual of Mental Disorders. 5th Ed. DSM-V):

- Separation anxiety disorder (SepAD);
- Selective muteness (SM);
- Specific phobias;
- Social anxiety disorder (social phobia);
- Panic disorder TP;
- Panic attack (specifier);
- Agoraphobia;
- Generalized anxiety disorder GAD;
- Substance/medication-induced anxiety disorder;
- Anxiety disorder due to another medical condition.

The anxiety disorders chapter in DSM-V pays more attention to how anxiety disorders develop, based on the usual age of onset, and extends their duration to 6 months for all ages, including specific phobia and social anxiety disorder. Panic attacks are considered a specifier applicable to all DSM-V disorders, not just anxiety disorders. Panic disorder and agoraphobia are treated under separate criteria. At the same time, the criteria for separation anxiety disorder were reformulated to more adequately represent the expression of separation anxiety symptoms in adulthood (the new diagnostic criteria do not specify that the onset must be before the age of 18). The space devoted to each disorder has been enhanced with sections such as their development and course, risk and prognostic factors, and associated biological information. The reformulation of anxiety disorders in DSM-V may lead to greater accuracy in a variety of ways. Epidemiological studies can identify better separation of disorders as well as overlap between disorders. Translational research efforts and the discovery of biological markers in subgroup diagnoses and predictors of treatment can be more easily mapped onto this updated formulation. Chapter structure and individual disorders may be more easily associated with genetic and other biological factors. An example of this strategy is placing anxiety disorders between the chapters on depression and obsessive-compulsive disorders. The new anxiety disorder specifiers on the DSM-V may help achieve a greater degree of precision in treatment interventions. As noted earlier, the panic attack specifier in the anxiety chapter can be used with any disorder because there is considerable evidence that the presence of panic attacks can affect treatment response. Interestingly, both bipolar and depressive disorders can be accompanied by an anxious distress specifier. Anxious distress has been noted as a prominent feature of both bipolar disorder and major depressive disorder in both primary care and specialist mental health settings. Perhaps most importantly, high levels of anxiety were associated with a higher risk of suicide, a longer duration of illness, and a greater likelihood of non-response to treatment. As a result, it is clinically useful to accurately specify the presence and level of severity of anxiety distress for treatment planning and monitoring treatment response (Kupfer, 2015).

Compared to DSM-IV, DSM-V includes 2 new types of anxiety disorder, separation anxiety disorder and selective mutism, which were placed in DSM-IV among childhood-onset disorders. In other previous classifications it appears as an anxiety disorder and hypochondria (fear of having or contracting a serious illness), but in DSM-V the diagnosis of hypochondria was replaced by two new diagnostic entities: somatic symptom disorder (SSD) and anxiety disorder illness anxiety (IAD). Both diagnoses share high health anxiety as a common criterion, but additional somatic symptoms are only required for SSD but not for IAD. Hypochondria is a fear of illness lasting more than 6 months, manifesting as a pathological fear or belief of suffering from a serious illness (cancer, AIDS, tumors, etc.), although it does not actually exist. This fear causes the hypochondriac to make frequent visits to all kinds of doctors, and the fact that the test results confirm the absence of the disease only increases the anxiety. The person affected by this disorder lives in a constant state of anxiety, which affects their daily existence. The causes of the disease are hypersensitivity, the presence of a traumatic event during childhood, as well as the need for attention. Thus, hypochondria is a somatoform disorder, although anxiety is still a central element of the disorder. Hypnotherapy is an effective form of treatment for this disorder, as it stimulates the emergence of positive cognitive, emotional and behavioral associations. Hypnotic suggestions can correct cognitive distortions and lead to behavioral pattern change. As with other anxiety disorders, hypnotherapy can be used in combination with other complementary therapies.

Meanwhile, the DSM 5–TR also appeared in March 2022, including a new form of anxiety disorder, i.e., prolonged grief disorder, i.e., the grief one registers for the loss of a loved one. The condition refers to people who have suffered from the death of a loved one more than 12 months ago - 6 months for children - and cannot overcome the pain leading to symptoms that negatively affect their daily existence. According to the DSM 5–TR, one in 10 adults is at risk of developing this disorder after the loss of a loved one.

DSM-V no longer includes post-traumatic stress disorder (PTSD) or acute stress disorder in the chapter dedicated to anxiety disorders. This is treated separately, in a new chapter called "Traumatic and Stress Disorders", segmented as follows:

- Reactive attachment disorder;
- Disinhibited social engagement disorder;
- Post traumatic stress;
- Acute stress disorder;
- Adjustment disorders.

But in the previous classification, DSM-IV, post-traumatic stress was one of the anxiety disorders, given that anxiety is a decisive factor in the diagnosis of this disorder.

Anxiety from the Hypnotherapeutic Perspective

As in any therapy, in hypnotherapy careful anamnesis and the building of a solid therapeutic relationship lay the foundations of the therapeutic process. As Corydon Hammond points out, “despite the fact that hypnosis is often helpful in the treatment of anxiety and phobic disorders, careful assessment and treatment are still essential (Crasilneck, 1980). In the treatment of panic disorders, the generally accepted view is that hypnotic interventions should be used in conjunction with more traditional psychotherapeutic and medical interventions, such as medication, in vivo desensitization, cognitive behavioral therapy, bibliotherapy, etc., on a case-by-case basis. - from case to case. Hypnosis has scientifically proven results in treating anxiety disorder, because it addresses the subconscious mind, where most behaviors and attitudes come from, including obsessive-compulsive ones. However, many psychologists believe that hypnotherapy can only bring benefits when combined with other complementary therapies. For example, a treatment regimen for obsessive-compulsive disorder may include, but is not limited to, cognitive-behavioral therapy by exposing and preventing the client's response to obsessions, drug treatment, and hypnosis therapy. Hypnosis therapy reduces or even eliminates anxiety, and in the absence of an anxious background, obsessive-compulsive disorder cannot manifest itself. To remove the causes of anxiety associated with obsessive-compulsive disorder, the therapist can use progressive relaxation techniques and trance suggestions to identify the causes of obsessions and dissociate the client from these obsessions.

Cognitive factors constitute an important etiological component of anxious and phobic responses. One of the most used therapies in this direction is cognitive-behavioral psychotherapy, which focuses on progressive awareness of cognitions (internal thoughts), introducing some learning techniques to restructure unnecessary thoughts. The subject thus learns to use strategies such as positive self-talk and thought stopping, aiming for self-control and mastery of problematic behaviors (Frew & Spiegler, 2013).

Empirical research indicates that hypnosis can enhance the effectiveness of cognitive-behavioral therapy, being a useful tool in the treatment of anxiety disorders. As early as 1995, Kirsch and colleagues published the findings of a large study that explored the benefits of integrating clinical hypnosis into a standard cognitive-behavioral therapy protocol. After a twenty-year review, researchers concluded that clinical hypnosis enhances the effectiveness of cognitive-behavioral therapy (Ramondo, et al., 2021).

Bryant, Harvey, Dang, Sackville & Basten's (1998) study of acute stress disorder compared hypnosis therapy as an adjunct to cognitive behavioral therapy with cognitive behavioral therapy alone and supportive counseling. At the end of treatment, the best of three interventions for reexperiencing symptoms was the one that included hypnosis. In another study of cognitive-behavioral intervention for public speaking anxiety supplemented with hypnosis, it was observed that anxiety decreased faster in participants treated with hypnosis than in those treated with cognitive-behavioral therapy alone (Schoenberger, 2000). Other studies led Alladin to conclude that clinical hypnosis and cognitive behavioral therapy go perfectly together, like yin and yang. Thus, Alladin said, both use relaxation and imagery. Being eclectic, both are easy to integrate into a range of counseling techniques. Also, both aim at reframing and understanding, with CBT focusing on cognitive restructuring and clinical hypnosis on unconscious processing at a much deeper level (Alladin, 2012). Another study evaluated the impact of hypnotherapy in alleviating anxiety symptoms in 50 participants in Delhi, and the results led the researchers involved to conclude that hypnotherapy significantly alleviated anxiety symptoms (Dwivedi & Kotnala, 2014).

Hypnosis can be used in many ways. There are trances by which the therapist can regress patients to experiences immediately preceding the moment when they began to feel anxious (Crasilneck & Hall, 1985). This can help identify anxiety-provoking situations, but also help build an internal dialogue and imagery that provides answers to problematic situations. Age regression to periods prior to the development of the phobia, when the patient has successfully coped with situations, can therefore be very effective within a solid therapeutic relationship (Logsdon, 1960). If it is found that the traumatic event is associated with phobic reactions, during age regression one can resort to the abreaction of negative feelings associated with the experience. When a phobic response or generalized anxiety is caused by more than conditioning or irrational cognitions, unconscious exploration through ideomotor cueing or hypnoprojective techniques can successfully identify past conflicts or experiences that lie beyond the conscious. Any cognitive therapy interventions that are used on a conscious level can be hypnotically reinforced. For example, in the case of low self-esteem, ego strengthening methods can be used, through one of the cognitive reframing methods. Rational-emotive therapy suggestions can be offered to anxious patients to get them to modify their underlying assumptions and internal dialogue.

Hypnotherapy in Panic Disorders

First, the therapist must teach the client to use self-hypnosis and relaxation whenever he is experiencing panic states, as it helps him gain control over the symptoms and consequently reduce their intensity. Panic attacks appear out of the blue, anywhere, anytime, in the form of extremely strong anxiety symptoms, where the client must learn to self-reduce the underlying anxiety level and control the acute episodes through self-hypnosis and relaxation.

The therapist also has the role of making the client aware of the fact that anxiety symptoms can be controlled, replacing thoughts that signal the onset of misfortune with ones that support the fact that these symptoms can pass. The client must be aware that regardless of the degree of panic attacks, they are not life-threatening. Finally, when the client has become accustomed to the techniques of relaxation, breathing and self-control, the therapist can move on to gradually expose him to the symptoms of anxiety, through the technique of hyperventilation (forced breathing). This stage of therapy leads the client to strengthen his belief that he can control, both cognitively and behaviorally, his anxiety states. (Holdevici, 2015).

Hypnotherapy for Agoraphobia

In the case of agoraphobia, whether or not it is accompanied by panic attacks, hypnosis therapy aims to gradually expose the client to the situations he fears and the symptoms that trigger his anxious states. The irrational fear felt by the agoraphobic client when in open, crowded spaces or away from home can be controlled by learning relaxation, self-hypnosis and breath control techniques. The therapist will teach the client to develop their inner speech, towards realizing the absence of a real threat to the experience, which they can actually avoid, and accepting the symptoms that cause their anxiety. Through hypnosis the client learns to gain self-control over the physiological sensations and catastrophic thoughts specific to anxiety and to dissociate from its symptoms by using a "trigger" (e.g.: *Whenever you are afraid, you will press the thumb of the left hand into right palm*).

Hypnotherapy in Generalized Anxiety Disorder (GAD)

Generalized anxiety therapy aims to reduce the level of underlying anxiety and change the thoughts that activate the anxious response. As in the case of panic disorder, a significant role is played by positive suggestions administered in trance, with the help of which the client's anxious beliefs are restructured. Of particular importance is age regression, with the help of which childhood traumas can be identified and eliminated. Progressive relaxation and self-hypnosis help the client control their thoughts and physiological reactions to anxiety.

Hypnotherapy for Specific and Social Phobias

Unlike panic disorder, phobias appear as a result of a psychological stress factor. Phobias are those intense and disproportionate fears of situations that for most people are not a problem. The challenge of irrational fear is to clear up the confusion between possibility and probability. There is a big difference between anticipatory anxiety of probable or improbable events and phobia, that is, between useful, protective fear and useless, maladaptive fear. Usually, the anxious response occurs in anticipation of the event, which may be a phobia of getting in an elevator or going on a plane, eating or giving a public speech. In the case of phobias, the anxiety response is based on fear. In other words, the phobia materializes that fear. The therapeutic strategy involves instructing trance patients to imagine that they are literally somewhere else, away from the feared stimulus, thus dissociating themselves from the anxiety-producing experience. Positive thinking or ego strengthening techniques help the patient to improve the symptoms. The researchers explored the relationship between trance ability and the genesis of phobic behaviors and found that patients with phobias had higher scores on suggestibility scales. Induction produces relaxation in patients with phobias, so the therapist can easily administer suggestions to reduce emotional and physical reactions. Age

regression can lead the patient to the time of the trauma to surface traumatic past memories and restructure them, with the help of guided imagery. For certain phobias, hypnosis can also address anxious responses using Watkins' affective bridge technique or progressive relaxation along with systematic desensitization.

In order to desensitize, before inducing hypnosis, the therapist can propose to the patient to create a hierarchy of situations that progressively approach the real phobic situation, so that the first situation is the least anxious, then somewhat more anxious and then strongly anxious. Let's take the example of a client who suffers from agoraphobia. The first step to desensitisation may be to visualize reading a supermarket leaflet (mildly anxious), then observe yourself thinking about going to the supermarket (moderately anxious), then going to the supermarket (highly anxious). Gradually, the therapist can guide the client to visualize shelves loaded with goodies of the client's liking in the supermarket. As the scenes are imagined, the therapist can elicit signals from the client by raising a finger if the client is feeling anxious. At that point, the therapist asks him not to imagine the scene, but another scene, this time neutral. The anxiety response decreases as the person goes deeper into the trance before re-imagining the anxiety-provoking scene. In this way, in vitro desensitization occurs gradually. This technique should be followed by in vivo techniques (e.g., going to the supermarket using self-hypnosis, see also Hammond, 1990). Some specialists believe that in the treatment of phobias, hypnosis can be used as a complementary method for other therapies, such as cognitive-behavioral therapy, etc. Thus, "the efficiency of using hypnosis in the therapy of phobias is based on high suggestibility," the vividness of visual representations, the ability to focus attention, as well as on the flexibility of cognitive strategies" (Holdevici, 2015).

Hypnotherapy and Separation Anxiety Disorder (SepAD)

Separation anxiety refers to excessive stress related to separation from home or an important attachment figure. Children with separation anxiety disorder may feel excessive worry about the possible loss of a major attachment figure through illness, injury, death, or any other harm. Those children may feel excessive worry about an unpleasant event, such as abduction or accident. There are children who cling excessively to their parents and refuse to sleep alone. Because they have a persistent fear of separation, they may also require someone to be with them when they go to another room, even if it is in their own home. Symptoms are specific to childhood, but can also be present in adulthood. We can talk about separation anxiety disorder when the fear is persistent and lasts at least 4 weeks in children and adolescents and usually 6 months or more in adults (DSM-V). Hypnotherapy can help clients with separation anxiety disorder using a few simple techniques. For example, for children about to go to school, phone hypnosis on the way to school can serve to relieve anxieties and phobias, gradually allowing these children to enjoy what school is all about. In therapy, during the face-to-face session, the therapist may use stories, metaphors, positive suggestions, relaxing music. Also, guided visualizations can allow the client to gain a sense of security and self-confidence.

Hypnotherapy and selective muteness (SM)

Selective mutism can affect children of all ages, usually starting at age 4 or 5. Children with selective mutism do not speak in contexts that are unfamiliar to them or in which oral communication is expected or required (for example, at school or kindergarten). Such a disorder interferes with the child's normal activities and can have long-term disabling

consequences if left untreated, being associated with anxious states. The results of some scientific research suggest that cognitive-behavioral interventions (20-24 sessions) would be the best therapeutic option (Cavarra et al., 2016). But other studies have concluded that Ericksonian Hypnotherapy leads to remission of the disorder and improvement of the client's general condition in only 5 sessions, a much shorter time frame than what is reported in the current literature.

Conclusions

Hypnosis is not a myth, but a natural phenomenon that has been observed and used since ancient times. Nowadays, the effectiveness of hypnosis has been validated by specialists and authorized institutes, such as BMA (British Medical Association), APA (American Psychological Association) or NIH (National Institute of Health, USA). Extensive scientific research has shown that hypnosis therapy is a valuable clinical tool in the treatment of many psychological problems, including anxiety disorders. If when we talk about treating anxiety disorders, we often hear that cognitive-behavioral therapy would have a much better yield than other therapies, empirical research indicates that hypnosis can increase the effectiveness of cognitive-behavioral therapy, being a very helpful tool.

In fact, cognitive behavioral therapy focuses on progressive awareness of cognitions (internal thoughts), introducing learning techniques to restructure unhelpful thoughts, while hypnosis helps to integrate the restructured thoughts by appealing to the subconscious. Therefore, thypnosis is a tool by which dimensions of experience are systematically amplified, then associated in ways useful to the client (Hilgard & Hilgard, 2013). In other words, “it is a window into the mind of the brain, helping patients better manage stress, pain, habits, dissociative symptoms and psychosomatic problems. It also provides psychotherapists with clinically useful information about the patient's cognitive and relational style, providing a means of selecting treatment approaches based on patient characteristics” (Himanshi & Pradeep, 2020).

Hypnotherapy always uses suggestions to induce trance, quiet the conscious mind and access the resources of the subconscious. The process of trance induction and deepening generally relieves anxiety, as numerous studies in the field have reported. In a general therapeutic context, we can use both direct and indirect suggestions, but in the treatment of anxiety disorders direct suggestions have been shown to be ineffective. However, there are other suggestive hypnotic techniques that can work well. For example, temporal dissociation techniques can lead the patient to a sense of tranquility with the help of age regression, or to visualize more peaceful scenes with the help of age progression. Progressive relaxation with the help of indirect suggestions also produces anxiety reduction. The use of deep meditative trance, based mainly on nonverbal methods, offers another option for managing anxiety.

All of these techniques used in the studies discussed in this article allow us to conclude that hypnosis has the ability to help subjects control their physical reaction to anxiety-provoking stimuli by dissociating the somatic response from psychological distress.

In conclusion, hypnosis is a modality of communication with therapeutic value in the context of the therapist-client relationship, which allows for a multitude of choices as to where and how to intervene in the client's problems.

Credit Authorship Contribution Statement:

Stănciulescu, A-D is responsible for drafting the manuscript and revising it critically for important intellectual content. Her contribution ensured the study's rigor and relevance, making her the sole author of this work.

Conflict of Interest Statement

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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