

Hypnotically Facilitated Exposure Response Prevention Therapy for an OIF Veteran with OCD

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Abstract

The highly stressful conditions of a war zone may exacerbate or trigger a wide variety of symptoms including Obsessive Compulsive Disorder (OCD) once a service member returns home. Service members and new veterans of the Iraq and Afghanistan wars present to treatment with multiple psychosocial concerns and co-morbid psychiatric conditions. Evidence-based treatments including exposure based therapies are commonly recommended for use with returning veterans. Although studies support the efficacy of Exposure Response Prevention (ERP) therapy for treating OCD, eligibility for these studies limits participation to subjects who self-report a well-defined, circumscribed complaint. This approach is not typical of clinic clients who, more often than not, report multiple psychological issues. The following individual case study demonstrates how integrating hypnosis facilitated the cognitive-behavioral ERP therapy and treatment for a patient suffering from OCD.

Keywords: Hypnosis, obsessive compulsive disorder, exposure response prevention therapy, combat veterans, Operation Iraqi Freedom.

Introduction: OCD and Combat Veterans?

Psychiatric presentations among combat veterans are the second most common medical conditions currently seen at VA Medical Centers (Kang, 2009). Operational deployments to combat zones are associated with a variety of mental health, social, and occupational effects (Prigerson, Maciejewski, & Rosenheck, 2002). Studies to date suggest that 10-18% of combat troops serving in OIF (Operation Iraqi Freedom) or OEF (Operation Enduring Freedom) have probable Post-traumatic Stress Disorder (PTSD) following operational deployments (Litz & Schlenger, 2009). Although PTSD is heralded as one of the “signature wounds” of current U.S. military operations, a range of mental health conditions are also represented in our returning veterans including, but not limited to, depression, anxiety, and substance use disorders (Litz & Schlenger, 2009).

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Obsessive-Compulsive Disorder (OCD) is a chronic and debilitating anxiety disorder with an estimated lifetime prevalence of 2-3% in the general U.S. population (Bebbington, 1998). OCD is often not considered a combat related injury. However, some studies suggest that the risk of OCD is elevated in veterans particularly among those exposed to high war zone stress (Helzer, Robins, & McEvoy, 1997; Jordan et al., 1991). Although empirical evidence is limited, clinical experience with OEF/OIF veterans suggests there is a PTSD-OCD dimension, similar to that observed in other anxiety disorders (Sasson et al., 2005; Tuerk, Grubaugh, Hamner, & Foa, 2009).

OCD and PTSD are associated with persistent, recurrent, intrusive, and unwelcome images, thoughts, or memories. However, in PTSD, the intrusive thoughts are often viewed by the individual as appropriate and related to experienced trauma. OCD is also characterized by compulsive checking, or repetitive behavioral or mental rituals performed in an attempt to control or reduce psychological distress (Abramowitz, 2006). Despite how OCD presents or its etiologic origin, it is one psychiatric condition that responds well to Cognitive Behavioral Therapy's (CBT's) Exposure and Response Prevention (ERP) technique. ERP consists of therapist guided, systematic, repeated, and prolonged confrontation of feared stimuli, along with abstinence from ritualistic or compulsive behavior. ERP is considered the treatment of choice, usually obtaining reductions in symptoms that exceed 50-60% on assessment instruments (Abramowitz, 2006).

Evidence-based treatments such as ERP are the preferred mode of intervention for PTSD and OCD within the VA medical system. However, despite equivocal support, the technique is not without its critics or limitations (Bonchek, 2009). According to one review, 25% of patients referred to ERP programs will not engage, 40 to 60% fail to improve sufficiently, and 30% will relapse after treatment (Frederick, 2007). Overall, some estimate that 50% of patients referred to ERP will be "non-engagers," dropouts, failures, and relapses (Abramowitz, 2006). It is possible that augmenting ERP with other therapeutic strategies such as hypnosis may address some of its limitations. Anecdotal evidence of clinical treatment with OIF veterans reporting OCD symptoms that were provoked or exacerbated by combat stress supports this hypothesis. Below is a detailed account of a case in which hypnosis and ERP were integrated.

Case History

Ms. Z was a 24-year-old, single, white, female U.S. Army Reservist who presented to an outpatient behavioral health clinic within a VA Medical Center requesting an evaluation for persistent, recurrent thoughts and impulses that she viewed as intrusive, sometimes senseless, and that interfered with her daily life. She had recently returned from an operational deployment in Iraq. She denied having these symptoms during her deployment. However, she reported the onset of some of her symptoms (e.g., counting and undoing rituals) long before she entered the military. Following her demobilization from Iraq her symptoms returned, leading to increased distress and difficulties in her professional and personal lives.

Ms. Z described elaborate hand washing rituals with dish soap and checking behavior (e.g., car doors, locks, environmental safety scans). She also explained that every time she entered her apartment she removed all of her clothes and placed them into a plastic bag to prevent "contamination" of her living space. She also reported ruminating thoughts related to her body and body image. Emotionally overwhelmed, she tearfully related, "I want to be freer in life and not to be scared to walk out of the door." Other complaints and symptoms included alcohol abuse, poor self-image, depression, and Irritable Bowel Syndrome (IBS). Ms. Z had sought help for her OCD symptoms three months earlier at her college counseling center. She dropped out of treatment after approximately six sessions. She was

adamant that she did not want to take medications and she feared her condition might affect her status with the military.

Ms. Z reported close family relationships with her mother, father, and two younger siblings. Her upbringing was strict with a high regard for conservative moral values. She explained that her mother, grandmother, brother, and sister had similar OCD symptoms. She recalled one common early memory that included a family outing to the local movie theatre that ended with her mother marching the family to the laundry room to remove all clothing for laundering.

During the first interview, Ms Z sat on the edge of her chair, tearful and tense, wearing her winter coat and gloves throughout the session. Over the first few sessions, The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) was administered to obtain a baseline measure of current symptoms, as well as clarification of the severity and persistence of symptoms. The Tellegen Absorption Scale (TAS) was also administered after Ms. Z described a few unusual experiences including tactile hallucinations and other abnormal physical sensations in reaction to saliva. For example, she reported she once heard a man expectorate while he was walking behind her. Although she was wearing a hooded jacket she was certain that she felt the “spit” running down the back of her neck. Another time, she reported her arms becoming so heavy that she perceived her knuckles to be practically “dragging against the ground.” She added that her hands became very warm and her vision tunneled. Ms. Z was diagnosed with OCD, Alcohol Abuse, Depressive Disorder NOS, and Rule Out Body Dysmorphic Disorder. At the time of the intake interviews, she was told about ERP therapy. She was also told that her strong hypnotic talent could facilitate the relief of her symptoms.

Description of Treatment

Ms. Z was seen for 26 sessions over a 5 month period during which hypnosis was used for 11 sessions. The remaining sessions were used for assessment, educational preparation for hypnosis and ERP, psycho-education regarding her body dysmorphia, addressing her problem of experiential avoidance, performing goal setting, motivational enhancement, and ERP. Sessions typically lasted 60 minutes; however, sessions that included behavioral exposure and hypnosis were extended to 90 minutes or more. Frequency of sessions was once per week, but increased to twice per week during the phase of treatment that included hypnosis and behavioral ERP. Hypnosis focused on goal orientation, enhancing the patient’s ability to form an alliance, symptom control, uncovering unconscious motivations and resources, emotional regulation via ego-strengthening and grounding interventions, the use of therapeutic metaphors for reframing, and self-hypnosis.

Hypnotherapy was first introduced in session 4. After a standard induction highlighting relaxation and comfort, Ms. Z was asked to recall the first time she became aware of her dissatisfaction with her body. Ms. Z recounted an adolescent experience when a boy, who she had asked to attend a dance, replied, “I don’t usually go out with girls your size” and commented on the width of her shoulders. Ms. Z had not remembered this experience prior to the suggestion to recall nor had she realized the powerful impact these words had on her self-image. She then participated in an ego-strengthening induction (adapted from Hadley & Staudacher, 1996): “Close your eyes and imagine writing the disparaging labels that people have given you on a blackboard. Now take an eraser and erase those labels from the board. Erase each one. As you wipe it away, accept the thought that this label no longer has any meaning for you . . .”

In a subsequent session, Ms. Z participated in another ego-state intervention that included “getting in touch” with the part of herself that was responsible for her body

dissatisfaction. It was suggested that she ask “the part of herself that disliked her body” what function these feelings served. Ms. Z concluded that her thoughts were “self-protective,” a fear-based reaction to her family’s history of obesity. Although she herself was not overweight, she saw herself as large and unattractive and assumed that others saw her body the same way. Ms. Z wanted to be attractive to others. It was suggested that she use her “creative self” to find alternative thoughts or behaviors that could protect her from her negative thoughts related to obesity. She shared two solutions: “develop a unique style that attracts the attention of others” and “avoid media exposure to images of thinness.” Ms. Z began reporting some improvement in her general mood functioning, self-acceptance, and positive expectations regarding treatment goals. She also started sharing many intimate internal experiences previously withheld from others.

In session 8, Ms. Z was trained to use positive guided imagery and self-hypnosis to induce relaxation and introduce positive, realistic, alternative thoughts, and positive self-talk. Some suggestions employed included: “the more you learn to cope in a relaxed easy manner, the more you will have a sense of confidence, and the more you have a sense of confidence, the more you will feel comfortable using the many coping strategies you have learned to meet challenges, overcome obstacles, and fulfill your goals. Starting now, more and more, you will realize that happiness and unhappiness are due to your own thoughts and how you think about situations. You will be able to shift your thoughts to the positive aspects, and look at the positive aspects in living. When you cannot change things, you will accept them calmly. You will realize that life is too precious, can be too wonderful to waste it being bothered by minor annoyances. You will be less worried about problems and dangers of the future that will likely never occur. You will let the worries go ... let them fade away ... fade away ... like clouds breaking up in the sky. And when you are at work, you’ll be able to focus on a task, and become absorbed, and involved at the task at hand. You’ll also be able to become absorbed and involved with the people around you. When you work, you’ll be able to work well and efficiently, able to concentrate, able to enjoy your work, able to enjoy everything you do, the people around you, and able to enjoy the food you eat, as you eat moderately with peace of mind.”

Ms. Z was also taught “sensory grounding techniques” to break up obsessive rumination and to bring her awareness into the now. She was taught to look around her environment and name five things that she could see, then listen to her immediate surrounding and name five sounds that she could hear, and then get a sense of five feelings or sensations that she could feel (e.g., weight of watch, tightness of shoes, texture of clothing, etc.) and name those. Afterward, she was then directed to see and name four more things, listen and name four more sounds, and sense or feel four more sensations. She was told to repeat this procedure until she reached one new visual item, one new sound, and one new feeling event. The use of self-hypnosis, facilitated by the use of audiotapes for home practice, was encouraged. Between sessions, Ms. Z reported success with using the grounding exercise to overcome irritation to a noise in her gym workout. She also reported that she was able to avoid obsessing about touching the lavatory door at lunch because she became absorbed in her work activity.

Teaching grounding and mindfulness techniques encouraged Ms. Z to turn her attention to the outside world and to shift away from the inner world of obsessive thoughts and negative feelings. She was instructed to try not to judge anything—just notice what “is.” One grounding exercise asked Ms. Z to notice her feet on the floor: Feel them literally grounded, connected to the floor. She was encouraged to wiggle her toes inside her shoes, and to dig her heels into the floor to ground even more and then shift her attention to her hands and palms pressing together. Another technique asked Ms. Z to think of a series of questions such as: What is her favorite color, animal, TV show, season, upbeat song, and favorite actor. Then she was asked imagine these things in her mind’s eye. Following these successes, the rationale and explanation for ERP was reintroduced in session 13. Ms. Z expressed anxiety about beginning the intervention. The suggestion to “allow yourself to get in touch with the part of you that wants a simpler, easier life” was provided to address internal conflict. Within a few minutes Ms. Z successfully participated in her first exposure exercise.

During session 14, Ms. Z related that she had initiated a significant change in her life by eliminating the use of dish soap as a part of her cleansing routine. It is important to note that the veteran made this change without any prompts from the therapist and reported that she experienced minimal anxiety or discomfort making this change. Ms. Z participated in a second exposure intervention during which she was asked to touch the doorknob and refrain from washing her hands for four hours. She expressed some reluctance to follow through with the request. However she responded well to Frederick’s scripted “Inner Strength” ego state intervention to improve anxiety management, self control, and inner peace.¹

The next target on Ms. Z’s fear hierarchy was “picking something off the floor.” Although it appeared that Ms. Z had been compliant in this exposure exercise, she admitted in the following session that she had not allowed her fingers to touch the floor. As the exposure exercise was repeated, Ms. Z complained of a burning sensation in her hand. In response, the therapist waved his hand over hers suggesting, “If you think about your hands feeling cold they will begin to feel cold.” She expressed shock and awe as she reported her hand feeling “chilled, almost frozen.” As in the previous session, she was encouraged to refrain from washing her hands for four hours.

In subsequent sessions, Ms. Z routinely expressed pessimism about being able to shed OCD symptoms. She frequently resisted exposure intervention but would eventually comply. In one of the decisive sessions of ERP near the end of treatment, Ms. Z participated in an exposure that included having the bottom of a shoe about 12 inches away from her face. She reported intolerable states of anxiety but completed the exposure for 45 minutes. Following the exposure, she participated in a hypnosis intervention (Zarren’s Marble Technique) that included the use of a transitional object to absorb stressful thoughts. At the end of the session, she reported she was comfortable with her progress and was ready to terminate soon. During the next two sessions we completed the final treatment targets. She completed all items on the fear hierarchy and expressed satisfaction with her level of symptom distress by session 26.

Four months after the end of therapy, Ms. Z called and requested an appointment. During the session, she reported that she recently began dating someone seriously, but was concerned that her OCD symptoms might be returning. Her concerns were based on her annoyance with her boyfriend's habit of placing his dirty gym bag on her clean bed linens. Acknowledgement that her annoyance was justified and reasonable helped Ms. Z realize that her symptoms continued to be well managed.

Results

Ms. Z obtained a 99th percentile on a pre-treatment measure—Tellegen Absorption Scale—suggesting high absorption ability and also a correlate of hypnotic ability and dissociative experiences. The raw data for the outcome measure at each assessment point are presented in Table 1. At session 6, Ms. Z's pre-treatment composite score of 24 on the Y-BOCS suggested severe obsessions and compulsion. At the conclusion of treatment this score dropped to 12, revealing some moderate pathological doubting and mild overvalued sense of responsibility, mild indecisiveness, mild avoidance symptoms with no functional impairment and much global improvement. She was also able to complete exposure at each level of her fear hierarchy with little subjective distress as indicated by Subjective Units of Distress Scale (SUDS). At the four month post-intervention follow-up assessment, she showed sub-clinical concerns with obsessions and compulsions, with a composite score of 6. Other benefits reported by Ms. Z included being able to participate in public speaking events with national and local news media, hosting a successful party in her apartment, significant decrease in IBS symptom distress, readiness to address alcohol abuse, and an improvement in self-confidence and self-image.

Discussion

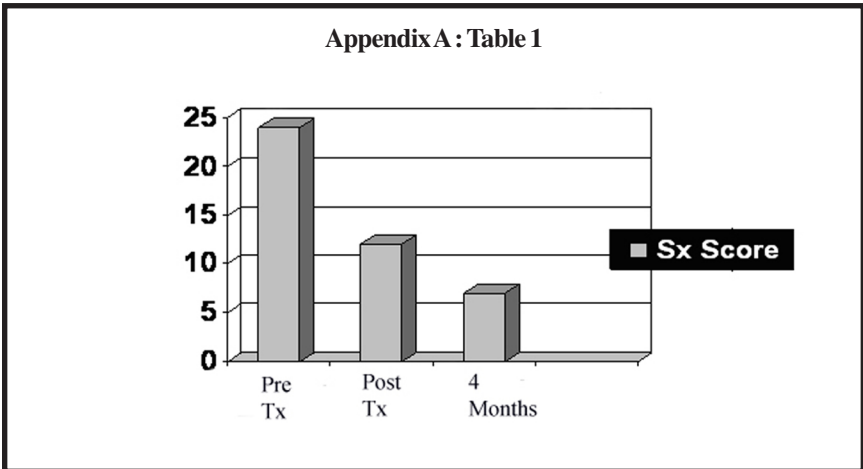
This case study illustrates the use of hypnosis as an adjunct therapy to ERP to facilitate treatment of OCD and other concerns. In this case, the young woman with “simple” OCD turned out to have co-morbid diagnoses of IBS, possible Body Dysmorphic Disorder, and Alcohol Abuse, as well as to be enmeshed in a ritualized, moralistic family and military culture in which her OCD was only one expression of her inhibitory coping style. Although the variety of interventions utilized make it difficult to pinpoint hypnosis as the decisive intervention, clinical data support that hypnosis facilitated treatment by deepening the therapeutic alliance, resolving preliminary concerns related to body image, facing fear, and assisting with decreasing anxiety, regulating affect regulation, and enhancing motivation. The latter point is particularly important, as Bonchek (2009) writes, “... patients with OCD seem to possess more flexibility and inner strength than they are given credit for in preventing compulsive responses” (p. 71). At several points throughout the therapy, Ms. Z took control of her treatment by identifying changes and targets for ERP that were not previously discussed. After the first ERP intervention she reported “giving up” the use of dish soap, a vital piece in her OCD rituals. Toward the end of treatment she brought up the idea of “cross contaminating” her apartment

by mixing clothing and items that were outside of her “safe and clean” apartment with items inside the apartment.

Although hypnosis has been found to be effective with thought suppression in people with high hypnotic ability (Bryant & Sindich, 2008), this treatment emphasized a mindfulness approach that taught Ms. Z to observe and experience her thoughts, memories, and reflections from a psychological distance and without judgment. A suggestion commonly given in both hypnotic and non-hypnotic interactions was, “Just because you think it doesn’t mean it is real.” This was quite a contrast from her upbringing and military culture which emphasized “perception is reality.” She was raised in a household that taught the individual’s need to resist “immoral” urges and overcome “sinful” thoughts with sheer willpower. Experiential avoidance like this has been correlated with ironic process (e.g., “Don’t think of a white bear”) resulting in an increase of “unwanted thoughts” (Wegner & Schneider, 2003). Therefore, the mindfulness approach confronted the experiential avoidance, allowing her to gain freedom from her thoughts and ultimately giving her control over her behaviors.

Another factor possibly contributing to the success of ERP for Ms. Z was her compulsive honesty and sense of duty. She generally felt “bad” or “guilty” when she cheated on her assignments and didn’t follow through with her verbal commitments. Her strong work ethic and honesty allowed her to “police” herself in the absence of a therapist between sessions.

In sum, this case is supportive of the use of hypnosis as an adjunct treatment to enhance the effectiveness of ERP. Although ERP is widely accepted and used, data suggest that it is ineffective with a significant subset of patients. Given that this is the treatment of choice for OCD, it is critical to consider adjunctive approaches that could enhance its efficacy. Interestingly, it may be that the particularities of the case, namely the combination of war zone stress and OCD, led to increased efficacy of the combined approaches. Thus, it will be important to further explore the potential of combined hypnosis and ERP in the treatment of PTSD-OCD.



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Author's Note

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