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Cognitive Hypnotherapy and EMDR: Two Effective Psychodynamic Therapies for the Rapid Reduction of Cognitive Anxiety

Elizabeth Brooker

Abstract

In the main research into cognitive anxiety has focused on the conscious mind. The aim of this chapter is to review two psychodynamic psychotherapies, cognitive hypnotherapy (CH) and eye movement desensitisation and reprocessing (EMDR). Both therapies focus on implicit or unconscious processes for the rapid relief of cognitive anxiety. The objective is to give credence to CH and EMDR both in the scientific and medical domains. The philosophy is concerned with changing negative cognitions and dysfunctional feelings through a process of desensitisation and reprocessing, utilising positive imagery. CH and EMDR were investigated in an intervention study with advanced pianists ($n = 46$). Participants were of mixed gender aged 18–26 and were randomly assigned to a therapy or control group. The therapy groups received two therapies of either CH or EMDR during a two week period between two concerts. Quantitative data were collected through the Spielberger State-Trait Anxiety Inventory. Results showed that both therapy groups (but not the control) experienced a significant reduction in state anxiety post-therapy and trait anxiety decreased significantly below baseline levels in the EMDR group. This chapter further reviews research into CH and EMDR documented through a case study allowing for qualitative assessment of the therapies where two sessions only were required to effect positive change.

Keywords: cognitive anxiety, implicit processes, explicit processes, CH, EMDR, psychodynamic therapy

1. Introduction

Cognitive anxiety is a widespread problem. It exerts a negative effect on human behaviour with individuals experiencing a gamut of mental, emotional and physical feelings. It has psychological and physiological effects which can be devastating. A plethora of research documents the outcomes of complementary therapies for the reduction of cognitive anxiety; however in the main the therapies focus on the conscious mind (explicit processes that are in conscious awareness) and these therapies can be both time consuming and costly. Both CH and EMDR focus on

implicit or unconscious processes (thoughts and actions no longer consciously perceived) as well as explicit processes. By this means the therapies target the root cause of the condition which allows for rapid alleviation of anxiety and effects long-lasting change. EMDR and CH, both hypnotically-based therapies, offer positive healing in a short space of time in comparison with other psychotherapies. As a therapeutic treatment each focuses on implicit processes and addresses the contemporary stimuli that might independently trigger the person's fear. Each offers relief of symptoms for small or 't' trauma; however EMDR is also used as a leading therapy for significant trauma, for subjects deemed to have experienced life-threatening situations.

The chapter first discusses cognitive anxiety looking at both trait and state anxiety, how anxiety arises and manifests itself before looking at the complexity and components of this debilitating condition. The cognitive/emotional connection is discussed and the role and importance of implicit memories, thoughts and emotions in the exacerbation and maintenance of cognitive anxiety. The use of alternative therapies for the reduction of cognitive anxiety is reviewed looking at their effectiveness and outcomes and the number of sessions required to effect positive change.

To enable the reader to understand the genesis and development of CH an overview of hypnosis is given followed by a synopsis of cognitive behaviour therapy (CBT). The assimilation of the two therapies has become known as CH and the rationale for this integration is discussed. The background, techniques and procedures of CH are outlined and current research critiqued where CH has been the intervention for a variety of dysfunctional conditions. The chapter continues with a review of EMDR looking at the theory, protocols and practice of this psychotherapeutic treatment and documents research conducted in a number of different domains for traumatic and debilitating conditions where EMDR has been used.

The remainder of the chapter documents the quantitative and qualitative research into CH and EMDR and gives scientific evidence for the effectiveness and rapid results of both therapies. In conclusion, the future direction and importance of CH and EMDR are considered in the light of current knowledge, their effectiveness as psychodynamic therapies for the treatment of cognitive anxiety, and their relevance to current research as well as the medical practice.

2. Cognitive anxiety

Cognitive anxiety is a complex (learned) emotion where fear is combined with other emotions such as anger, guilt, shame and embarrassment; all of these can be extremely disruptive to human behaviour [1]. Research informs us that there are two types of anxiety: trait and state. Trait anxiety is an individual's normal level of anxiety when in a non-threatening situation and it has been suggested that it is influenced by genetics and as such remains roughly at the same level throughout the life-span [2]. However more recent research has shown that it is also influenced by an individual's experiences and in fact is mutable and can be lowered positively through desensitisation of traumatic memories and negative cognitions [3]. State anxiety is a temporary condition which can be heightened according to environmental situations. It is the anxiety felt for instance when individuals feel they are in the spotlight or 'on show' and are under pressure to do their best. However it returns to its generic level when the situation has passed [4].

It has been found that there is a relationship between trait and state anxiety and that individuals with high trait levels of anxiety will experience correspondingly high state levels of anxiety in what is deemed to be a threatening situation [4, 5].

Evidence from the literature emphasises the multi-dimensional aspects of anxiety, and the affective role that experiences have on primary emotions such as fear and apprehension. This can affect the degree to which cognitive processes influence assumptions, expectations, physiological symptoms and behaviour [6–11].

2.1 The components of anxiety

A complexity of components that have an impact on anxiety have been found, including affective, cognitive, physiological and behavioural factors [12], and this investigative research corroborates the findings of previous work in this field:

- affective subjective experiences generate arousal of pleasure or displeasure [13].
- cognitive processes are generated in a situational state and have effects which lead to either negative or positive appraisal [14].
- physiological adjustments to cognitive processes activate arousal causing uncomfortable somatic symptoms which are unhelpful in a performance state [15].
- behaviour which is not goal-directed can have a negative outcome on the experience [16].

Table 1 shows four interrelated components of anxiety [12].
During the application of both CH and EMDR the principles of affect, cognition, physiology and behaviour as documented in this table are broadly addressed.

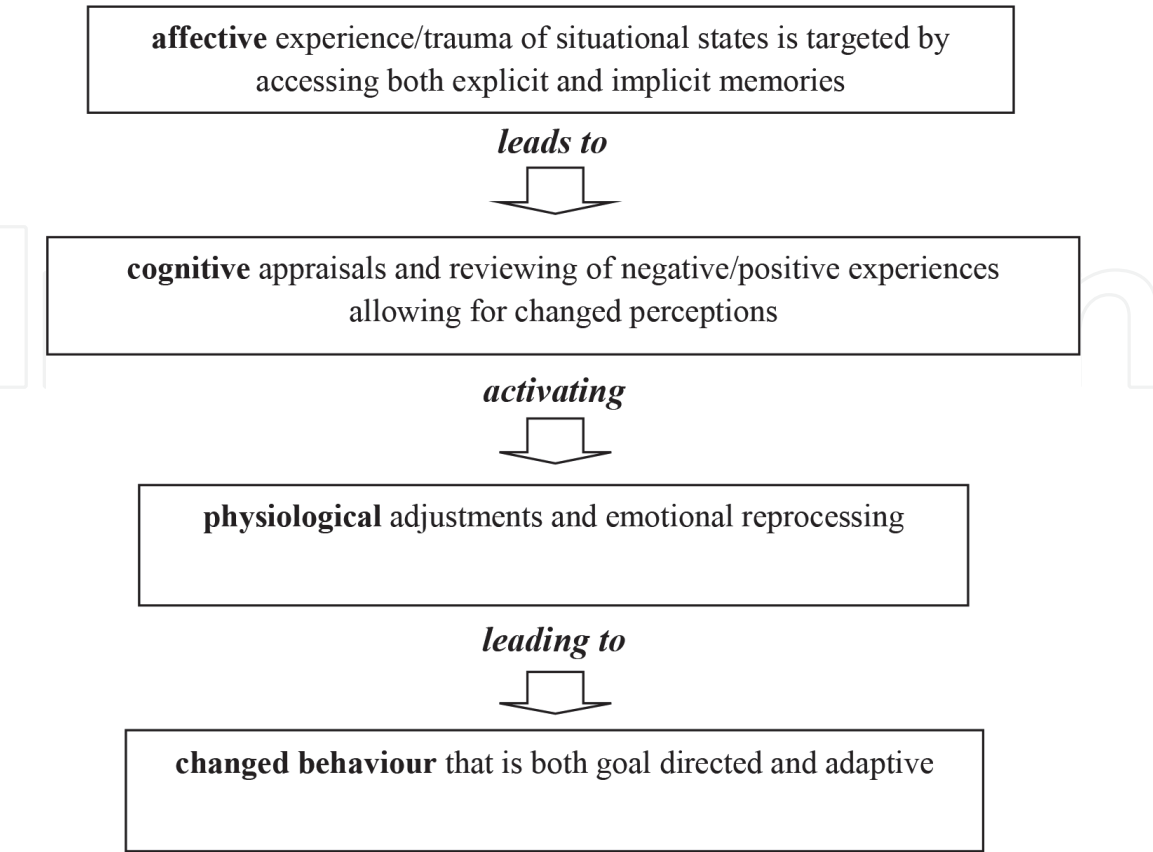


Table 1.
Components of anxiety.

2.2 The role of memories and emotions in generating anxiety

In the 1890s Sigmund Freud observed that memories of negative experiences or events could be changed over time having a new meaning. In conducting his analysis of patients both during and after treatment, he found that subjective memory of events could be re-transcribed years after they had occurred. To be changed however, he argued that memories had to be consciously perceived and those memories in the unconscious mind should be relived rather than just remembered [17].

Research into the phenomenology of memory found that when meaningful material is encoded, associated information such as thoughts and feelings are also encoded; this allows activation of the recollection process which leads to a 'remember' response. This triggers an interaction of latent patterns of negative thoughts, emotions and behaviours, causing both psychological and physiological symptoms [18]. Further research has shown that new experiences are assimilated into existing memory networks, and that pathology results when unprocessed experiences are stored in their own neural network, unable to link up with anything more adaptive. Recall invokes content and affect, and the implicit thoughts and feelings, although no longer in conscious awareness, will impact on present day experiences [19]. In fact it is argued that cognitive disorders can be thought of as mal-connections between the various synaptic regions of the brain, and that mal-adaptive experiences or memories disassemble the connections; however these can be reassembled by positive experiences that bring about change [20].

Implicit processes, sometimes referred to as automated processes, produce an automatic response [21]. This has important implications for the recall of implicit memory and emotions and for the effectiveness of CH and EMDR. Both therapies focus on these processes and are specifically designed to desensitise and reprocess dysfunctional cognitions and memories, giving the individual the opportunity to revisit and change the maladaptive memory from a safe environment [5].

3. Complementary therapies currently adopted for the treatment of cognitive anxiety

A variety of treatment therapies are presently adopted for the reduction of stress and cognitive anxiety, however the main interventions adopted are listed below and fall into several categories:

- Cognitive behavioural interventions: focus is on dysfunctional thoughts, how these may have been generated, coping skills, positive imagery, attentional focus and goal setting.
- Physiological and physically-based interventions: Alexander technique, biofeedback, muscle relaxation and music-enhanced relaxation.
- Meditative interventions: meditation, yoga and autogenic training.
- Psychodynamic interventions: cognitive hypnotherapy, eye movement desensitisation and reprocessing.

In discussing the above interventions positive effects have been reported in the literature in the cognitive therapies; however a large number of sessions are required [3, 22]. Further to this, core problems are insufficiently focused upon and the relapse rate for individuals who have undergone symptom-based CBT is cause

for concern [23]. The physiological and physically-based therapies and assertiveness training demonstrate little beneficial effect; however more promising results have been found in the reduction of cognitive anxiety in meditation and yoga [23]. It has been found however that it takes time to acquire these skills and as with the cognitive therapies the drawback is the length of time taken to effect positive change [3, 23]. More details of the above interventions can be found in the author's doctorate [3].

This chapter now reviews CH and EMDR, two psychodynamic therapies that target implicit processes, thoughts and actions no longer in conscious awareness, for the alleviation of cognitive anxiety. The rationale is that by focusing on the role that these processes exert on anxiety both therapies have the potential to reduce cognitive anxiety quickly and effectively.

4. Cognitive Hypnotherapy

CH is the integration of two disciplines, hypnosis and CBT; therefore to enable the reader to understand the genesis of CH this section of the chapter first reviews hypnosis. This is followed by a brief synopsis of the background of CBT including the protocols and procedures adopted in this therapy. The rationale is given and discussed for the assimilation of these two disciplines before documenting the roots, development and theory of CH. This section concludes with the findings from research in various domains where CH has been adopted for the reduction of cognitive anxiety.

4.1 Hypnosis

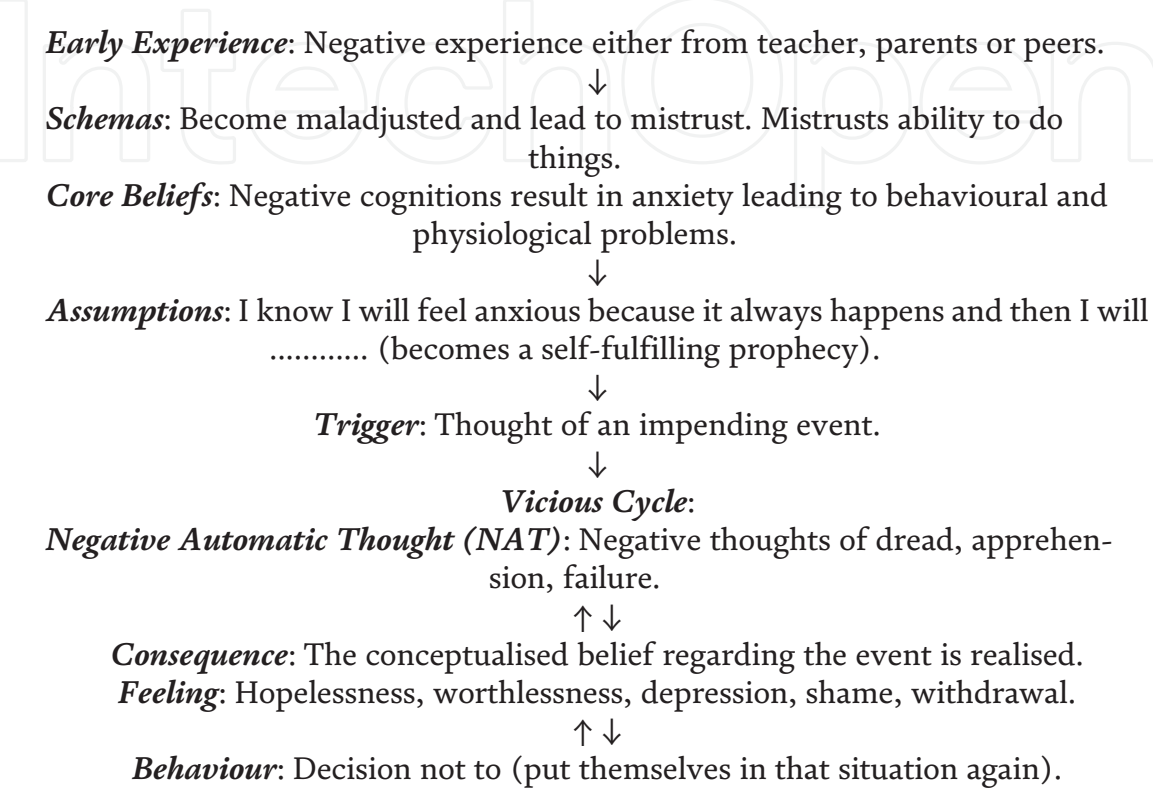
Hypnosis dates back over 220 years as an area of scientific research and clinical practice and has been adopted to bring about positive change in diverse psychological conditions [24]. However there are different approaches to hypnosis. Traditional hypnosis, which is believed to be the earliest form of hypnosis, is more authoritative, using direct commands and orders to bring about positive changes, and has been shown to be less effective than the modern hypnosis [25]. Modern hypnosis was developed by the psychologist Dr. Milton Erikson in the 1930s and was known as Eriksonian Hypnosis. Eriksonian philosophy revolutionised the process of hypnotherapy by recognising that individuals are able to access their own inner resources to improve their quality of life. It adopts a holistic approach to each client, understanding their needs and their individual situation and is the form of hypnosis used by the author when conducting cognitive hypnotherapy. This approach uses metaphors by comparing and contrasting experiences and situations, rather than commands and suggestions. Working in this way it enables the brain to think more creatively, and the suggestions become more acceptable to the unconscious mind [26]. It has been suggested that during hypnosis the memory and meaning of negative experiences and the effect of fear can be changed through emotional processing [27, 28]. It is further suggested that when hypnosis is added to therapy such as cognitive behavioural therapy (CBT) the hypnotic relationship enhances the efficacy of the treatment effects [29].

4.2 Cognitive behavioural therapy

CBT, which has been adopted for anxiety and diverse disparate conditions since the 1980s, uses a combination of behavioural and cognitive interventions aimed at changing dysfunctional thoughts and memories. Individuals are helped in the pursuit of goals, and emotional problems by directing cognitions towards memories,

images, thoughts and attention [30]. Through its development over the last 40 years CBT has adopted treatments for diverse anxiety conditions and emotional disorders [31]. There are a number of protocols and procedures adopted in CBT which allow clients to re-access early negative experiences and enable more understanding of how the negative thoughts, emotions and behaviours have been generated. However for the purpose of this review the formulation by Persons is illustrated as this is most usually associated with CBT [32].

Persons' Formulation 1989



By following the guidelines of the above model CBT helps to redress negative cognitions, and encourages the association of positive thoughts, changing the negativity into positive outcomes. In fact it is argued that suppositions are reiterated with corrected thoughts, enabling positive visualisation of present and past experiences, giving the client confidence in their ability to handle situations so that a positive outcome can be achieved [33].

However, the literature reports that no theory/therapeutic action is without flaws, and a number of issues have been identified with the CBT approach: the effective role that cognition plays on physiological symptoms in the body; the failure to recognise the role of the unconscious mind in overt behaviour; and the failure to recognise that human thought and action are socially embedded [34]. Further to this, evidence from the literature indicates that one of the main drawbacks with CBT is the number of sessions required to effect positive change (10 or more sessions in the majority of cases) [3]. New cognitive models are being developed considering the role of cognitions and emotions in generating anxiety, including a meta-cognitive model (MCM) [35], and an emotion dysregulation model (EDM) [36]. However neither of these models takes into account the role of the unconscious mind in the way that anxiety develops.

4.3 The rationale for the integration of hypnosis with CBT

It has been proposed that hypnosis is based on the affect theory of human emotion and that cognitions locked to unpleasant emotions can become disturbingly

resistant to change until hypnosis alters the affective perceptions of the individual [37]. Intransigent symptoms of dysfunctional cognitions and emotions can be approached and treated through a sequence of interactions as thoughts previously locked to negative affect are processed and changed positively [37]. Indeed It is argued that as a result of incorporating techniques from two disciplines the core ideas of each are integrated changing both and resulting in a new assimilative model [38]. The rationale for the integration of the two disciplines is well documented in the literature. It has been suggested that by combining the treatment of two disciplines gives a quicker resolution of the dysfunctional condition [39]. Further to this it is argued that hypnosis combined with CBT offers a powerful form of treatment approach with rapid effects and has been shown that this treatment approach offers a template for the guidance of treatment strategies for cognitive and emotional conditions [40].

CH uses a model first adopted in the 1990s, not dissimilar to cognitive behavioural therapy (CBT). However the fusion of hypnotic techniques with CBT first proposed in 1994 strengthens the therapeutic outcome, offering an addition to therapy by facilitating the resolution of resistant symptoms [41]. By focusing on the unconscious mind cognitive hypnotherapy targets implicit memories and cognitions no longer in conscious awareness. The impact and added strength of integrating two disciplines maximise therapeutic effect [39].

4.4 Protocols and procedures of CH

CH uses an integrative and holistic approach in the treatment of disparate conditions and focuses on both explicit and implicit processes. Case formulation is guided by case history and the therapist's interpretation of this and a treatment plan is then outlined to the patient. An explanation of hypnosis is given making sure that the patient feels comfortable with this. Whilst in trance the therapist attempts to address the unconscious mind, as during this state the critical part of the mind is bypassed allowing the establishment of positive thoughts, substituting former judgemental cognitions with helpful ones [33]. During the process of hypnotherapy implicit processes which appear to be causing negative cognitions, emotions and behaviours are targeted whilst the patient is in a state of deep relaxation or a trance-like state. In this state the unconscious mind is receptive to positive ideas and behaviours, hypnotic relaxation, positive mood induction, ego strengthening and post-hypnotic suggestions [33].

4.5 Findings from research using cognitive CH as an intervention

The research documented below gives evidence for the effectiveness of CH in various domains and documents the beneficial effects of integration. In fact a meta-analysis was conducted looking at comparative studies of CBT and CH and gave evidence that patients receiving CH as opposed to CBT showed a 70% improvement in their mean scores in comparison with the CBT group [42].

Significant benefits have been found for the following conditions using CH:

Anxiety disorders [43], general anxiety disorder [44], anxiety in cancer patients [45], PTSD [46], cognitive anxiety/trauma [47], pain relief [48], sleep disorders [49], diabetes [50], anxiety in public speaking [51], music performance anxiety [5, 52]. For more information on these studies see Brooker [3].

The above research testifies to the effectiveness of CH for the above conditions. Eye movement desensitisation and reprocessing (EMDR), another psychodynamic therapy used widely for anxiety conditions, is now reviewed.

5. Eye Movement Desensitisation and Reprocessing

EMDR has evolved from a simple technique into an integrative psychotherapy that addresses both the cognitive perception of trauma and the resultant physiological condition, an interaction of mind and body. Psychological problems are addressed and successful treatment outcome is achieved in a short space of time, as negative cognitions and emotions are replaced with positive thoughts and memories, body sensations are changed, and new behaviours emerge [53]. Changes in anxiety and fear are only by-products of a comprehensive reprocessing of the whole experience. The conceptualisation of the transformation of stored disparate experiences and the accompanying memories through a rapid learning process is the key to understanding the basis and application of EMDR [53].

5.1 Background

Initially EMDR was called Eye Movement Desensitisation, beginning with a behavioural orientation similar to the roots of CBT [54, 55], as it was thought that eye movements were unique in causing an effective desensitisation. Subsequently it was discovered that other forms of bilateral stimulation (tactile and auditory) also resulted in positive effects [56]. The word ‘reprocessing’ was added when it was realised that through a process of desensitisation the treatment achieved positive changes in traumatic memories, as well as a reduction in anxiety. EMDR is a relatively new psychotherapy first used in the treatment of post-traumatic stress disorder (PTSD) [57]. However since its inception it has expanded widely now treating a wide range of pathologies including treatment of trauma, anxiety disorders and associative conditions as well as phobias. The treatment protocols have evolved enabling treatment of diverse forms of trauma responsible for psychological and physiological disorders, particularly those that are anxiety-based. The philosophy underlying this hypnotically-based approach to treatment is that individual conditions that are emotionally-based can be healed quickly, effectively and profoundly; dissociative disorders and phobias, and the consequences of these and other past negative-rooted traumas can be changed using EMDR [58]. In 2004 it was placed in the “A” category as strongly recommended for the treatment of trauma and anxiety-related conditions in both the American Psychiatric Association and the American Department of Defence. Through a process of desensitisation it was found that dissociative disorders and past negative-rooted experiences can be changed effectively and quickly, allowing for the emergence of new positive behaviours [58].

5.2 Theory

EMDR is based on the premise that earlier life experiences can elicit a continued pattern of similar affect, behaviour and cognition (the three main constituents of anxiety [59]), and that present-day stimuli can elicit similar affective behavioural memories of earlier experiences. The theory of EMDR adopts a model that emphasises cognitive information processing of past negative experiences and memories, the bilateral movements adopted inducing a light hypnotic trance. Both physical and emotional memories of subjective trauma can be reprocessed resulting in a state of positive mental and emotional wellbeing [56]. A putative neurobiological mechanism for the efficacy of EMDR has been offered [60], which presents a complete model of how EMDR could lead to specific improvements in PTSD and related conditions. It suggests that during EMDR the flow of information from the

hippocampus (which stores information) to the neo-cortex (which analyses information) is directionally reversed in EMDR similar to REM sleep cycles. This allows for cognitive re-evaluation of previously maladjusted/negative encoded information. The theory is that, through guided eye movements or other sources of bilateral brain stimulation such as hand taps or alternating sounds, traumatic information held in neurological networks is changed and connected to more positive cognitions stored in subjective memory [56, 61].

5.3 Disparate memories and EMDR practice

EMDR targets memories directed at the negative/traumatic experience and deals specifically with reprocessing these memories as quickly as possible. It is aimed at the pivotal event that caused the initial fear/reaction and addresses all the contemporary stimuli that might independently trigger the subjective fear [62]. It is believed that traumatic information of disparate memories cause dysfunctional cognitive and emotional behaviour [63], and that this information, held in neurological networks in the brain, is changed during the process of EMDR [61].

It is argued that through assimilation negative memory adds to subjective knowledge regarding expectations and potential warning signs and suggests that when a distressing experience results in persistent anxiety the information processing system has stored the experience without adequately processing it to an adaptive resolution. The event is 'frozen in time' in the moment of fear and pain and this lays the foundation for future inappropriate dysfunctional responses to similar events [62].

When subjective implicit memories have not been processed this may be at the root of a variety of psychological issues in the present [20, 64]. Emotions, sensations and perspectives of earlier events colour the perceived view of similar present-day events; a current situation similar to an earlier event will automatically link into the memory network in which the earlier event is stored [53].

The procedures have been developed to identify, access and target dysfunctionally stored experiences and to stimulate the innate processing system. This allows adaptive resolution of the information and shifts the information to the appropriate memory systems [60, 63]; pinpointing the target (the traumatic experience) and reprocessing the disparate memory is crucial in the initial stages of treatment.

5.4 Protocols and procedure in therapy

During therapy a dual-attention approach is used to facilitate the processing of the cognitive, affective and sensory elements of a recalled disturbing event [64]. An eight-phase psychotherapeutic treatment approach has been adopted with standardised procedures and protocols to address the full range of clinical conditions caused or exacerbated by previous negative experiences [64]. Subsequently this developed into an adaptive information process (AIP) model, the premise of which is that every person has both an innate tendency to move towards health and wholeness and the inner capacity to achieve it [64].

The AIP model has been adopted for experiences for the highest level of trauma, 'A' category, as well as for small trauma designated as 't' trauma. Small trauma is described as experience not rising to the highest level of trauma, but nonetheless causing significant psychological damage to require treatment. The treatment of both 'A' and 't' trauma guides the procedures and protocols of the clinical practice of EMDR [53].

The AIP model: Standardised EMDR protocols and procedure.

1. History taking

This determines whether the subject is an appropriate candidate for EMDR and includes treatment planning.

2. Preparation

Preparing the subject for any disturbance that may arise during the session or between sessions.

3. Assessment

Finding a target or targets and defining its/their components. Memories, physical feelings and negative cognitions.

4. Desensitisation

Using bilateral movements: eye, tactile or auditory to reprocess targets.

Use of Subjective Unit of Disturbance Scale (SUD).

5. Installation

Strengthening the positive cognition throughout the neuro-networks.

Use of Validation of Cognition Scale (VOC).

6. Body scan

Identifying physical feelings manifested in any part of the body and reprocessing any target revealed by the identification.

7. Closure

Returning the subject to emotional equilibrium, discussion of ongoing processing which may cause further disturbances. If this occurs it should be recorded in a diary/log in readiness for the next session. Instruction in the use of relaxation techniques to maintain a state of calm.

8. Re-evaluation

As the processing proceeds memories may emerge that are linked by similar cues such as beliefs or sensations.

5.5 Clinical studies

The methodology used in EMDR has been extensively validated in the following clinical studies and has provided evidence for the effectiveness of this treatment for category 'A' patients (the highest level of trauma, threat of death, extreme trauma):

Survivors of earthquake [65]; terrorist attack (9/11) [66]; sexually abused girls [67]; railway employees, person under train accident [68]; children with PTSD [69].

Further studies have been conducted into experiences categorised as small or 't' trauma (anxiety conditions contributing to significant psychological distress:

Trauma from life events [70]; distressful experiences [71]; depression and social anxiety [72]; pain reduction [73, 74]; phobias (dental) [75].

EMDR standard protocols have been applied to alleviate anxiety in the following fields:

Dressage [47, 76]; athletics [77, 78]; swimming [79]; test anxiety [80]; music performance anxiety [5, 81, 82]. EMDR has also developed a peak performance protocol used to enhance performance, enabling individuals to overcome subjective negativity and anxiety [83].

For more detailed information on all of the above studies see Brooker [3].

This section of the chapter now gives a very brief overview of the effectiveness of CH and EMDR through the quantitative and qualitative research conducted by the author from her doctoral thesis at the University of Leeds [3] and from her private practice [5].

6. Quantitative research: method

At the start of the study 46 advanced pianists (aged 18–26 years and of mixed gender) from three higher educational institutions were randomly assigned to a therapy or control group. The therapy groups received two interventions of either CH or EMDR during a two-week period between two concerts. A quantitative assessment of the state component of cognitive anxiety of all participants was obtained from the Spielberger State-Trait Anxiety Inventory (STAI-Y1) taken at baseline and prior to both performances. The findings reported here are on state anxiety; for the full findings of the author's research, including trait anxiety, somatic/physiological symptoms of anxiety and the behavioural aspects of performance anxiety see Brooker [3].

6.1 Results

At the end of data collection to establish whether anxiety levels decreased more in the intervention groups than the Control, an ANCOVA was calculated comparing levels of state anxiety across the three groups at the first and second performances (before and after treatment). There was a main effect of condition ($F(2, 42) = 4.92$, $p = .012$) such that participants in the two treatment conditions, CH and EMDR, showed significantly lower cognitive anxiety than the Control group at the second performance, post-intervention and that both treatment groups were significantly effective in achieving this (Helmert contrasts, .005 significance level).

This suggests that the therapies applied between the two performances significantly lowered anxiety in both the CH and EMDR groups prior to the second performance and this required two sessions only. This effect was not demonstrated in the Control group.

Figure 1 below shows the standard error of the mean score of state anxiety at the two performances calculated from the STAI Y-1 questionnaire, where 80 represents the highest level of anxiety and 20 the lowest. It illustrates the decrease in state anxiety at the second performance across the three groups.

7. The qualitative research: case study

Qualitative information on music performance anxiety (MPA) is documented here in the form of a case study, taken from the author's private practice [47]. A personal account of performance experience is given which allows for more detail, sensitivity and insight into the understanding of MPA which could not be obtained from quantitative research alone. It gives insight into the process of therapy by

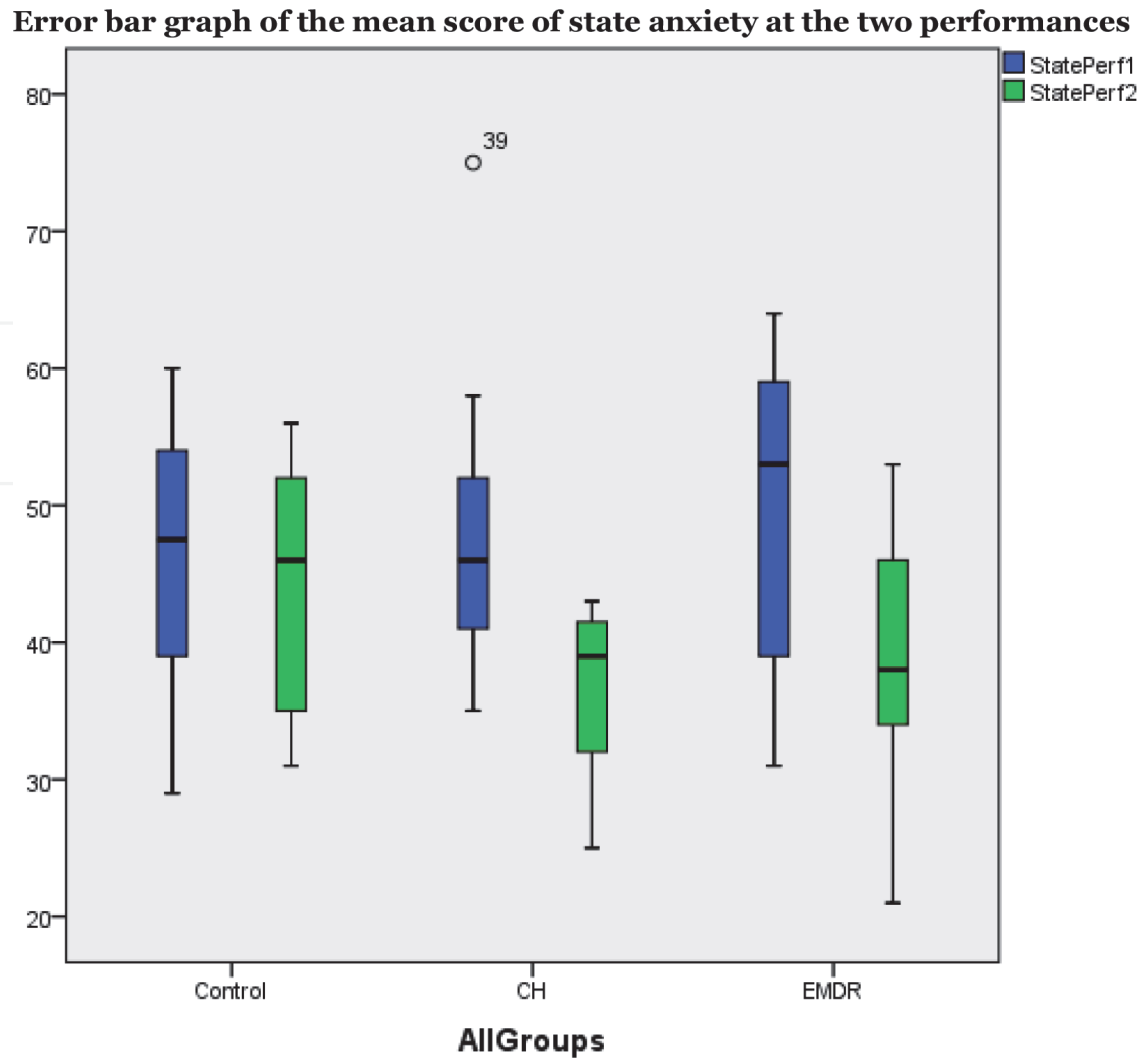


Figure 1.
The standard error of the means of state anxiety from the STAI Y-1 questionnaire taken 15 min prior to performances 1 and 2; error bars show 95% CI of mean.

exploring the internal thoughts, feelings and experience of the individual. This case study begins with the individual’s own words (the narrative). It then continues with an abbreviated description of the progression of treatment and documents the therapeutic outcome, as well as reflecting on the suitability of the treatment administered from a research standpoint and comparisons of possible treatment effects of other treatments. It is the documentation of an individual who received one therapy of EMDR and one of CH for the treatment of MPA, (the name is anonymised).

Identifying information

Name: Rebecca.

Music performance anxiety: Voice.

Age: 41.

Occupation: Student with the Open University studying English and Music (first instrument, voice).

7.1 Case history: Rebecca’s narrative

I had always felt very nervous when performing and always seemed to have the image of my father in the background; I felt that he was judging and criticising me and that I was letting myself down. I was having singing lessons at this time and giving small informal recitals but I was never happy with the outcome; I always felt I fell short of my

true potential. I took Grade 8 ABRSM Singing examination but failed quite badly and this felt like the ultimate disaster. Although I was confident practising on my own, I found singing lessons 'nerve racking' and at the examination I just 'fell apart'.

After I moved here and restarted singing lessons I was very interested in taking part in the Christmas concert as your research was close to my heart as I always get very nervous in performance. I was singing in the second half of the concert but felt nervous in the first half and this got worse, and as soon as I started singing my throat felt tense and I had saliva in my mouth which I had to keep swallowing before the long runs, my heart was beating quickly and I could feel my cheeks flushing. Because of all this I felt that I had not connected with the audience and was disappointed with my performance. I did enjoy taking part however and being part of the research into music performance anxiety and found it somewhat reassuring that others taking part were also feeling nervous, I wasn't the only one.

7.2 Case formulation

Therapist's summary and interpretation of Rebecca's narrative.

Important features in this narrative indicate that the domineering personality and the physically abusive behaviour of her father, who was against her musical ambitions, have had far-reaching consequences on Rebecca's singing performances both as a teenager and as an adult. These emotions are so strong in present-day performances that she imagines the spectre of her father while she is performing. The negative criticism that she experienced from her father has affected her self-esteem and self-worth as a musician in spite of her belief that she has talent as a singer. This was compounded by a boyfriend who had a similar attitude as her father towards her regarding her music. She is confident practising on her own where she perceives that she is not being judged; however she experiences both cognitive anxiety and distressing physiological and somatic symptoms of anxiety in a performance or examination situation where she feels she 'falls apart'.

7.3 Critical analysis: therapist

An analysis of Rebecca's narrative suggests that she is suffering from social phobia in situations where she feels threatened and under scrutiny, such as a singing examination or a live concert performance. Social phobia, rooted in social anxiety, has been summarised [84].

- a. Negative cognitions operating in social situations which include fear of negative evaluation, self-consciousness, self-deprecating thoughts and self-blaming attributions for difficulties.
- b. Heightened physiological activity.

Rebecca experiences cognitive anxiety as well as physiological and somatic symptoms of anxiety in a performance situation. However, although she experiences destructive and crippling anxiety when performing, this phobic reaction does not occur in other areas of her life. The therapist purports that this is as a result of the criticism and physical abuse that she received from her father during her teenage years regarding her ambitions as a singer ('my father literally tried to knock it out of me') and this I believe has had a profound psychological effect on her self-esteem and confidence in her music performances.

In therapy Rebecca presented with the following negative schemas regarding her anxiety (direct quotes):

'I know I'll screw it up'

'I can't control my thoughts'

'I'm hopeless'

'I can't control my emotions'

'I can't control my body'

'I can't control my nerves'

Physiological and somatic symptoms of anxiety were:

rapid heartbeat;

shaking/trembling;

tension in throat;

an excess of saliva.

7.4 Treatment plan: EMDR and CH

7.4.1 First treatment (EMDR): 30 May 2010

Rebecca's MPA is complex as it is not related to a single incident but the systematic criticism that she received as a teenager, undermining her self-belief in the possibility of her pursuing a professional career in music as an adult. The primary aspect of the overall treatment would be targeting the trauma experienced at this time which in the opinion of the therapist is best addressed initially through EMDR by systematic desensitisation of these experiences.

In therapy the negative criticism and upsetting experiences revealed in Rebecca's narrative regarding her father were the main targets, beginning with the most upsetting incident which she rated as 9/10 on the subjective unit of disturbance scale (SUD) (10 being the highest level of anxiety). This rating indicates that significant trauma had been experienced at this time. The most painful negative emotions when recalling this incident were of fear and anger; the strongest physical sensation was tension throughout her whole body which was accompanied by heightened breathing. After fifty minutes of EMDR her rating on the SUD scale decreased to 0, indicating that the negative memories had been desensitised. The negative schemas that she had presented with at the start of treatment had now changed. Where previously she had six negative self-perceptions (four beginning with 'I can't ...'; see above), post-treatment these had changed into positive perceptions of 'I can ...'. She no longer thought of herself as being hopeless or that she would 'screw it up'.

Her rating on the validity of cognition scale (VOC scale was 6/7 (7 being the highest level of positivity): negative schemas cited earlier had been reprocessed. Her bodily sensations which she had experienced at the start of therapy when recalling the traumatic memories had now gone completely, her breathing had normalised and she had no tension anywhere in her body. Having targeted and desensitised the most traumatic memories first, the lesser memories of trauma regarding performance when reviewed were more difficult to hold, and no longer caused Rebecca

the former anguish or physiological/somatic symptoms of anxiety. If the past has been one of negativity or trauma regarding aspects that are important to the individual, the subjective behavioural response to a similar present-day experience will be consistent with the negative affective responses of the past [56]. An adult may experience feelings of fear and being out of control, and will react emotionally and display negative behaviour accordingly.

7.4.2 Second treatment (CH): 6 June 2010

The second treatment session (1 h) was shorter than the first (90 min), the important groundwork having been accomplished in the first session. As the disparate memories had been desensitised and reprocessed in the first session CH should now be beneficial in supporting the reprocessed cognitive perceptions. It should also enhance the positivity achieved in the previous session. Rebecca had experienced hypnotherapy some years previously but it had not been particularly effective. However it was explained that it should enhance the EMDR treatment and the combination of the two therapies would strengthen treatment effects. The most important aspects of her singing performance were discussed; she wanted to feel confident, calm and in control in performance, to connect with her audience and feel eager to do more. Her key words, which were ‘anchored’ on her dominant wrist during hypnotherapy, were *confident*, *calm* and *in control*; these she felt were the words that would enable her to give her optimum performance. The therapy focused on enhancement of performance and included visualisation of her perfect performance.

On completion of hypnotherapy Rebecca was given the therapist’s *Self-Confidence for Musicians* CD and advised to listen to this as often as possible, and especially on the day/evening prior to a performance; this would further relax her and add to her confidence. She left feeling happy and relaxed looking forward to her next singing lesson and her next performance.

7.5 Rebecca’s self-assessment of treatment

My singing in front of audiences can be adversely affected by pre-performance nerves, which seem to stem from my first solo concerts when I suffered with acute stage fright. The EMDR treatment brought my worst singing nightmares to the surface and I was initially sceptical that anything could be done to help my anxiety when performing. However I came away from the first treatment feeling unburdened as if a weight that I had been carrying around for years had lifted. It was like coming out from underneath a dark cloud. The CH treatment in the second session focused my mind on enjoying singing so that when I performed I was in control and relaxed. It appeared to reinforce everything so that I am now looking forward to performing instead of dreading it.

(Email message, June 2010)

7.6 Therapist’s assessment of treatment and reflections from a research standpoint

This case study supports current research into anxiety which suggests that negative affect and beliefs from the past control the individual in the present; however they can be healed quickly, effectively and profoundly when past negative-rooted traumas are changed [58, 64]. The negative cognitions and previous perceptions of subjective performance that this patient held were successfully desensitised and reprocessed in two treatments.

There can be no doubt that the treatment was effective; however reflecting on this as a researcher there are other possible explanations for the resolution of the problems presented here which need to be explored. These outcomes may be explained by a number of different factors. For instance some individuals improve because they have entered therapy, regardless of the specific treatment: a variant of the placebo effect. Fascinating research has been conducted into the well-known phenomenon of the placebo effect with various medical conditions: headaches, pain reduction and even the visual effects of packaging in headache tablets [85, 86].

It could further be suggested that 'narrative smoothing' plays a part in resolving psychological issues, and many psychotherapists support this view [87–89]. It is believed that the process of reconstruction of the initial narration gives more control over the story and can change the patient's perception into something more positive; this underpins the central goals of therapy [87]. Rebecca's narrative was highly charged with specific negative experiences and relating this allowed a different subjective perception.

CBT might also be effective as a therapy in this instance as it similarly uses narration in therapy but treats the presenting symptoms rather than the cause. CBT has similarities with psychodynamic therapies but there are a number of different elements which are distinctive. CBT focuses on the way individuals think and act in specific circumstances and how emotional and behavioural problems may be overcome [90]. However, although CBT appears to be the preferred treatment for anxiety-based conditions, no theory/therapeutic action is without flaws, and a number of issues have been identified with this approach [34]:

1. The failure to consider experiences in the past in relation to the present in generating anxiety.
2. The effective role that cognition plays on physiological symptoms in the body.
3. The failure to recognise the role of the unconscious mind in overt behaviour.
4. The failure to recognise that human thought and action are socially embedded.
5. Core problems are not treated.

In fact there is increasing concern regarding the relapse rate at follow-up sessions for those patients who have undergone symptom-based CBT [19, 90]. It treats the symptoms rather than the cause and as such this may only provide a short-term solution to the problem [16, 34].

7.7 Longitudinal outcome

Since Rebecca's therapy treatments in 2010 she has completed her Open University degree and now holds a Masters in Professional Voice Practice. She still enjoys performing and has regular engagements. Her dream of becoming a professional musician has been realised.

8. Conclusion

The aim of this chapter was to give more exposure to and greater understanding of two highly effective therapies for the rapid reduction of cognitive anxiety: CH and EMDR. The complexities of cognitive anxiety were discussed and the role that

dysfunctional memories, particularly implicit memories no longer consciously perceived, can exert on present-day experiences. The chapter reviewed CBT and the benefits of hypnosis as an adjunct to this therapy, now called CH, as well as comorbid conditions where CH has been an effective treatment. The background and theory of EMDR was documented discussing the role of disparate memories in EMDR practice. The procedures and protocols used in EMDR were highlighted before reviewing the clinical studies that have adopted EMDR as a treatment. The final section of the chapter documented the author's research using CH and EMDR, giving both quantitative and qualitative findings. Both the quantitative and qualitative research documented above (pp. 8–13) gave evidence for the effectiveness and rapid results of CH and EMDR in comparison with other complementary treatments where the main drawback appears to be the length of time required to effect positive change. This chapter further highlighted the important contribution that CH and EMDR have made to current research and in doing so has shown the need for further scientifically-based research into the complexities of anxiety and the role that implicit memories play in maintaining this.


In the UK the treatments of choice being advocated by the National Health Service (NHS) for PTSD and anxiety disorders still tend to be medication or CBT and as such there is no financial cost incurred by the patient. Where individuals experience no positive effects, or are dissatisfied with treatment, they are guided towards private therapists at their own financial cost. The medical profession are aware of CH and EMDR but as yet these treatments are not widely available to the general population, although EMDR is available for PTSD in the military domain. This state of affairs needs to be remedied given the effective and dynamic results which are being seen from both CH and EMDR.

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