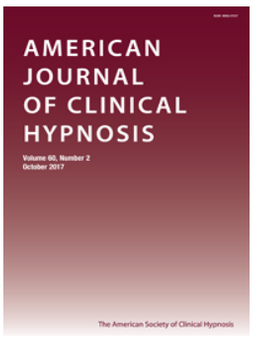

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Treating Panic Disorder Hypnotically

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A hypnosis protocol for treating panic disorder is provided. The implementation of this protocol is demonstrated through a case example involving the successful treatment of a 28-year-old firefighter presenting with a 4-month history of near-daily panic attacks. Core principles associated with this protocol include: (1) Elementary education about the physiology of panic; (2) A review of primary factors contributing to the evolution and manifestation of panic; (3) Encouragement of physical activity; (4) Utilization of hypnosis applications; and (5) Monitoring and measuring progress evidenced by a reduction in the frequency and intensity of panic attacks. Six years after his last hypnosis session, "Jason," the once panicked firefighter returned to my office for concerns unrelated to panic, and reported that he remained panic-free, retained his job, and was twice promoted.

Keywords: anxiety attacks, hypnosis, panic disorder, trance

I thought I was going to die: A common statement uttered by many following their first, and most unexpected, panic attack. Unfortunately, the majority of these first-time panic attack victims will not involve a "one and done" experience. Rather, like the aftershocks of an earthquake, odds are that unpredictable, and perhaps debilitating, anxiety attacks are sure to follow. In many (if not most) cases, anticipatory fear of subsequent panic in conjunction with a perceived loss of control over one's physiology, potentiates the risk of future panic attacks.

Anxiety is a universal human emotion that alerts us to potential threats while compelling us to prepare for anticipated challenges to our integrity. Anxiety can be an appropriate reaction to a stressful circumstance; however, large proportions of society experience excessive anxiety that is overwhelming and debilitating. As a diffuse mood state, anxiety has been defined as an unpleasant emotional experience marked by a significant degree of apprehension about the potential appearance of future aversive or harmful events (Barlow & Cerny, 1988).

Unlike relatively mild transient anxiety experiences brought about by a stressful event (i.e., taking an exam, getting a speeding ticket), anxiety disorders typically persist for at least 6 months and usually become worse when untreated (American Psychiatric Association, 2013). Interestingly, readily identifiable external events themselves are not usually the primary impetus of experienced anxiety. Rather, it is the unrealistic expectations or irrational beliefs that individuals maintain about *how* these external events or circumstances should be. And

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since this kind of worrisome or catastrophic thinking is not uncommon in western cultures, it is not surprising that an estimated 40 million American adults suffer from one or more anxiety disorders within a given year (Kessler, Chiu, Demier, & Walters, 2005).

Panic disorder is characterized by unexpected events involving intense fear accompanied by cognitive and physical symptoms that may include fear of dying, fear of going "crazy," chest pain, heart palpitations, shortness of breath, excessive perspiration, dizziness, abdominal distress, and nausea. Typically, individuals suffering from panic disorder experience persistent anxiety concerning future panic attacks, and, therefore, engage in maladaptive (and largely unsuccessful) behaviors intended to ward off future panic experiences (e.g., avoidance of exercise, or locations associated with prior panic attacks). In a given year, nearly 3% of adults in the United States are diagnosed with panic disorder with approximately 45% of these cases classified as "severe" (Kessler et al., 2005). The median age of onset of panic disorder is between 20–24 years of age with women outnumbering men at a rate of approximately 2:1 (American Psychiatric Association, 2013). Sadly, according to Wang et al. (2005), less than one-quarter of individuals diagnosed with panic disorder receive "minimally adequate treatment."

It has been this author's anecdotal observation that many who suffer from panic disorder present with histories of unexpected or prolonged stress, tend to internalize or suppress emotions, maintain a strong need or desire for maintaining control over their life experiences, are acutely aware of and excessively focused on their own physiological functioning, and tend to engage in catastrophic thinking.

Hypnosis for Anxiety and Panic Disorder

Hypnosis has consistently enhanced the treatment of anxiety disorders by facilitating adaptive coping skills through more realistic thinking, improved flexibility and stress management, and effective problem-solving skills (Flory, Salazar, & Lang, 2007; Hammond, 2010; Lynn, Barnes, Deming, & Accardi, 2010; Rossi & Rossi, 2006; Saadat et al., 2006; Wallace, Allen, & Propper, 1996; Yapko, 2010). Moreover, hypnosis has been shown to effectively curtail anxiety associated with dental procedures (DiClementi, Deffenbaugh, & Jackson, 2007; Eitner, Schultze-Mosgau, Heckmann, Wichman, & Holst, 2006; Eitner, Sokol, Wichmann, Bauer, & Engels, 2011), needle phobia (Abramowitz & Lichtenberg, 2009), fear of flying (McIntosh, 2007), fear of swallowing (Epstein & Deyoub, 1981; Reid, 2016), agoraphobia (Golden, 2007), blood phobia (Noble, 2002), and claustrophobia (Steggles, 1999).

Empirical studies evaluating the efficacy of clinical hypnosis for treating panic disorder are restricted and limited to case studies (Du-Fay & Lewington, 1990; Iglesias & Iglesias, 2005). Van Dyck and Spinhoven (1997) failed to find any beneficial effect of including hypnosis in the therapeutic treatment of 64 adults suffering from panic disorder with agoraphobia, though "hypnotizability clearly correlated to outcome in the combined therapy" (p. 172).

Gilligan (1987) proposes that individuals suffering from anxiety and depression spend much of their lives in trance, albeit negative or unhealthy trance. Therefore, it stands to reason that by recognizing symptoms as manifestations of unhealthy trance (unconscious) states that are intended, albeit ineffectively, to make the world safer on some level, clinicians can appreciate (and reframe) unwanted symptom impact. Whether manifest symptoms involve generalized anxiety, insomnia, fear of failure, smoking, overeating, or panic, opportunities for hypnosis intervention are apparent given the cognitive and behavioral responses associated with these concerns that can be modified using trance.

A Protocol for Treating Panic Disorder Hypnotically

Panic disorder involves recurrent panic attacks involving physical and cognitive symptoms, as well as anticipatory trepidation regarding future panic episodes. A multipronged treatment plan including interventions targeting both physical and cognitive symptoms common to panic is, therefore, preferred. With this in mind, a hypnotic protocol for treating panic disorder is offered below and comprised of the following therapeutic interventions:

1. Elementary education about the physiology of panic:
   a. Sympathetic Nervous System (fight-or-flight) versus Parasympathetic Nervous System (rest and digest)
   b. It is all about the adrenalin/cortisol drip
   c. Reinforce "your body is working just fine"
2. Sharing the "recipe" for making panic
3. Physical activation of patients
4. Implementation of hypnosis work:
   a. Introduce hypnosis and dispel myths/misconceptions as needed
   b. Consider cognitive and behavioral responses associated with anxiety for treatment planning (see Table 1)
5. Monitoring and measurement of treatment progress

The Physiology of Panic: False Alarms and Dripping Faucets

Subsequent to the gathering of relevant clinical information including symptom, psychiatric, and medical history, initiation of treatment for panic disorder should begin with educating patients about the nature of their panic symptoms and how these symptoms involve an adaptive response to perceived (real or imagined) threat. When perceiving a threat to one's well-being, the body responds in certain and predictable ways (e.g., rapid heartbeat, tightness in the chest, perspiration) once adrenaline and cortisol are released into the blood stream.

TABLE 1
Cognitive/Behavioral (C/B) Responses and Treatment Interventions for Anxiety Disorders

Anxiety Symptoms	*C/B Responses*	*Treatment Strategy/Intervention*
Fear	Time Expansion	Here and now suggestions/ego strengthening/projection
Sense of Urgency/Immediacy	Time Contraction	Time expansion imagery
Heart palpitations, preoccupation with physical symptoms	Hyperesthesia	Relaxation, heaviness/lightness depending upon individual preference/personality
Loss of control	Dissociation	Ego-strengthening, mindfulness
Rumination	Hypermnesia	Here and now/mindfulness
Catastrophic Thinking	Age Progression	Mindfulness focusing/Ego-strengthening
Agoraphobia	Catalepsy (rigidity in thinking and behavior)	Movement/levitation imagery

Explaining how unwanted and uncomfortable symptoms associated with panic involve natural responses to certain life circumstances may eliminate secondary fears about losing control, or in some cases angst about suffering a myocardial infarction, or worse, death. Furthermore, explaining how symptoms are the by-product of natural unconscious processes permits a greater appreciation of how the body is essentially functioning appropriately. In fact, informing your patient that his fight-or-flight system is working fine, though "misbehaving" at inappropriate and inconvenient times, can permit an awareness that some control is possible, and it is only a matter of learning more adaptive ways of managing stress and anxiety.

Before and during formal hypnosis interventions, metaphors including false alarms (see below) and dripping faucets can provide patients with a practical understanding of the fight-or-flight system. The unanticipated experience of panic can be readily explained through the analogy/metaphor of a leaking faucet dripping water into a cup. Drop by drop, the cup eventually fills until one drop generates overflow, causing water to spill from the cup. Like that, I explain to my patients, internalized stress eventually turns on the proverbial faucet that drips adrenaline and cortisol into the bloodstream. Eventually, a critical level is reached and the body responds accordingly by increasing heart rate, respiration, perspiration, and other physical symptoms associated with panic. This, in turn, explains how panic manifests in places and times when it is least expected such as churches, during sleep, and even while on vacation.

A Recipe for Panic

It may also be helpful to inform patients about the common characteristics (i.e., ingredients) associated with panic. As a brief review, these include: unexpected and/or prolonged stress, internalization or suppression of emotions, strong needs to maintain control, an excessive focus and acute awareness on one's physical well-being, and tendencies toward catastrophic

thinking. Not only will reviewing these characteristics resonate with patients, providing this information and insight promotes rapport, which is essential for enhancing success when including hypnosis in any treatment plan (Rossi & Rossi, 2006).

It, therefore, stands to reason that when working with individuals suffering from panic disorder, eclectic therapeutic interventions (including hypnosis) should focus on enhancing stress management, encouraging appropriate externalization of emotions, minimizing apparent needs for control, facilitating ego-strengthening, as well as addressing somatic preoccupation and catastrophic thinking.

Activate Your Patient to Get a Move On

It has been my experience that encouraging individuals to engage in physician-approved aerobic activity (i.e., walking up and down a flight of stairs, going on a brisk walk) on a regular basis minimizes the risk of future panic episodes. Additionally, when I encourage my patients to engage in aerobic activity immediately upon experiencing a symptom they associate with pending panic, the intensity and longevity of the attack is diminished. I inform my patients that increasing their heart rate with cardio work (i.e., walking up and down a flight of stairs, going on a brisk walk or jog) during a panic attack will allow the brain to perceive their increased heart rate, respiration, and perspiration as "normal" body functioning. This association and physiological experience is very familiar to the body and does not generate cognitive dissonance. In contrast, encouraging relaxation or providing calming suggestions in the midst of panic is counter-productive and may prolong uncomfortable symptoms. After all, suggestions to "relax," once cortisol and adrenalin flood the bloodstream are destined to fail, and in the end, will only serve to intensify anxiety and protract panic.

Elicit Trance Through Hypnosis

When considering hypnosis interventions for treating anxiety disorders, and in particular, panic disorder, it can be helpful to consider the cognitive and behavioral responses associated with presenting symptoms that can be benefitted by hypnosis. Doing so can facilitate and guide treatment planning (see Table 1).

More specifically, cognitive and behavioral responses (italicized below) associated with panic disorder symptoms include the following: *time contraction (or time condensation)* involving a sense of urgency (Lankton & Lankton, 2008/1983; O'Hanlon, 2009; Yapko, 2003), *hyperesthesia* manifested through heart palpitations, preoccupation with physical symptoms (Edgette & Edgette, 1995; Weitzenhoffer, 2000), *dissociation* (Edgette & Edgette, 1995; Gilligan, 1987; Lankton & Lankton, 2008/1983; Yapko, 2003; Zeig, 2014), *hypermensia* manifested through rumination (Edgette & Edgette, 1995; Yapko, 2003) and *age progression* evidenced by catastrophic thinking (Edgette & Edgette, 1995; Yapko, 2003).

Therefore, it follows that targeted hypnotic interventions (italicized below) may include, but are not necessarily limited to the following: *time expansion* (for urgency/immediacy), *relaxation/calming suggestions* (for heart palpitations, preoccupation with physical symptoms), *ego-strengthening, mindfulness/here and now focus* (loss of control), and *ego-strengthening* (for catastrophic thinking).

When treating people suffering from panic attacks, I frequently associate their symptoms to a functioning smoke alarm and insert the following story during trance:

> One Thanksgiving morning while preheating my oven, smoke began seeping from the oven and filled the kitchen and adjacent living and dining rooms. As other family members threw open windows in the kitchen and dining room, the smoke alarm sounded, causing a greater sense of urgency. The alarm performed as expected. It did its job, despite the absence of any fire. The house was never in threat of burning to the ground. But of course, the alarm had no way of knowing if the smoke coming from the oven was benign, or life threatening.

Ultimately, it may be beneficial to connect this metaphor with the body's natural ability to respond to stress and anxiety. After all, the mind and body fail to appreciate the difference between real and imagined threats. For instance, pulsating blue lights appearing in my rearview mirror are likely to trigger an autonomic nervous system reaction prompting a fight-or-flight response. Whether the speeding ticket I anticipate I am about to receive is real or imagined, the physiological response is the same. Furthermore, this automatic physical reaction does not immediately dissipate once the police officer drives past me, and my brain registers that I am not getting a speeding ticket. Rather, several minutes will pass before my body returns to a state of equilibrium. This concept is important for patients to understand and can serve as a basis for helping them understand that the body may "make future panic attacks" (as it usually does) until the sympathetic nervous system settles down.

Predicting future panic with an expectation that symptoms will be less intense and less frequent, may help the patient cognitively process future attacks with a new perspective. Knowing they will not die or go crazy limits the additional release of cortisol and adrenaline.

Monitor Progress: Success Breeds Success

Before initiating any therapeutic interventions for treating panic disorder, I query my patients about the frequency and intensity of their experienced panic. I also ask them to estimate the likelihood that they will experience another panic attack within the next 24 hours, 48 hours, week, or month on a scale from 1 (very unlikely) to 10 (definitely likely). This estimation is requested during every session and is utilized to assess treatment efficacy and progress. Initial ratings greater than 5 are optimal. Treatment of individuals experiencing monthly panic attacks can be very challenging. In such cases, several months must past sans panic before one can determine if treatment

interventions are beneficial. On the other hand, treatment efficacy can be readily determined if daily panic attacks are reduced to once weekly, bi-weekly, or monthly experiences.

Once patients experience a reduction in the frequency and/or intensity of panic attacks, they typically gain a greater sense of confidence in their ability to manage their physiology. This, in turn, minimizes any anticipatory anxiety that previously potentiated the risk for future panic attacks.

Ultimately, this hypnotic protocol for treating panic disorder aspires to influence and shift the dysfunctional perception/belief that "the body controls the person" to a healthier and more functional perception/belief that "the person controls the body."

Case Example: The Frightened Firefighter

At the time of his initial consultation, "Jason" was a 28-year-old firefighter referred for a psychological evaluation to determine his eligibility for disability. He presented with a 4-month history of near-daily panic attacks, most occurring when on duty at the fire station while engaging in rather mundane activities such as inspecting equipment, washing vehicles, and/or making meals for the crew. Jason never experienced dysfunctional anxiety or panic when responding to alarms or upon arriving at sites associated with potential fires or other emergencies.

Jason's reported symptoms included rapid heart rate, chest pain, difficulty breathing, light-headedness, and episodic, though brief, crying spells. It is also noteworthy that his symptoms began 1 week after his mentor died unexpectedly from a heart attack. Though Jason was grieving the loss of his friend and colleague, his symptoms did not meet criteria for Persistent Complex Bereavement Disorder (American Psychiatric Association, 2013). Jason also reported a history of panic attacks as a young child and again during his high school years though he never identified them as such and he never sought formal treatment. Unlike his reported symptoms during his initial consultation, intense fear of dying was also not associated with his prior panic attacks. During the initial consultation, Jason rated the likelihood of having a panic attack within the next 24-hours as a 9 on the scale previously introduced. He also shared that he enjoyed playing the guitar and had performed in local venues many times over the past few years.

Jason was voluntarily admitted to a private psychiatric unit on two occasions over a 2-month period of time prior to his initial consultation. At the time of our initial meeting, he was prescribed Zoloft, 50 mgs daily, Ambien, 10 mgs each night for sleep, and Klonopin 0.5 mgs up to three times daily as needed. While Ambien was helpful for sleep facilitation, he continued to experience terminal insomnia and daytime fatigue. Klonopin was not helpful for controlling his panic and likely contributed to some of his reported daytime fatigue.

Subsequent to his second hospitalization, he was informed by his Chief that he had 3 weeks to either file for disability, seek early retirement, or risk being fired if he was deemed unfit for duty. Rather than review procedures associated with psychological testing, I took

time to introduce Jason to the autonomic nervous system, fight-or-flight responses, and the "sources" of his panic attacks. Like baking a cake, I told him, if all the ingredients are present and the recipe is followed appropriately, the outcome is inevitable.

I also informed Jason that I did not believe all treatment options had been exhausted and introduced him to the potential benefits of hypnosis. Like many patients suffering from panic attacks who will do nearly anything for relief, Jason required little information about hypnosis, preferring instead to initiate treatment as soon as possible. I also contacted his Chief and requested permission for Jason to stay at the fire station when he was scheduled to work, though he would not go out on calls. I informed the Chief that it was essential for Jason to live in the environment where he experienced panic attacks rather than in his home. The fire station served as a more appropriate setting to appraise any treatment progress.

Knowing time was not on our side, I met with Jason three times weekly. He was very responsive to hypnosis interventions and readily experienced trance (evidenced by slowed and deeper breathing, lacrimation, and episodic hand and arm levitation) during treatment sessions. I also relied on ideomotor communication, particularly his discontinuation of leg shaking to identify trance and began to "talk" to his unconscious mind, offering posthypnotic suggestions.

Though promoting a sense of relaxation seemed the logical plan, I opted instead to utilize trance interventions based on Jason's identified strengths and the unhealthy coping skills that brought him to my office: hyperesthesia (focus on physical sensations), time contraction (his sense of urgency), and age progression (excessive focus on a fearful future). In addition to being somatically preoccupied, his preferred sensory modality was visual as he reported imagining in his mind what he would likely encounter when responding to a fire alarm. Consequently, I realized the importance of incorporating somatosensory experiences (e.g., arm levitation) and suggestions involving vivid visual images into his trance work (e.g., see your future self, doing something, anything at the fire station, notice how you feel, if you are standing walking, alone, with others. See whatever you can see . . . perhaps seeing some equipment, a truck, hoses, and notice what you feel as this future self experiences what is possible).

Jason's treatment plan (see Table 2) includes the identification of unhealthy coping skills associated with his symptoms, trance interventions that could be helpful for addressing his concerns, and personal preferences and life experiences that could be utilized to initiate and enhance his trance experience.

Hand and arm levitation was also used to facilitate and deepen trance for Jason. I assumed that he would be very responsive to this technique given his overused skill of body awareness and physical activity associated with his job and playing the guitar. The lightness associated with levitation facilitated a relaxation response that demonstrated for the unconscious mind that not only can it increase tension and worry, but more importantly, allow the body to remain calm and relaxed. Since Jason's preferred sensory modality was visual, I employed visualization of life experiences that he could relate to (the bucket on the

TABLE 2
Hypnosis Treatment Plan for Jason

Presenting Symptoms/Concerns: Associated C/B Responses:
Panic attacks involving rapid heart rate hyperesthesia
Difficulty breathing, excessive perspiration
Exaggerated fear of death age progression
Sense of doom time contraction
Loss of mentor age regression
Client's Preferred Sensory Modality and Evidence for Support:
Visual: Visualizes fighting fire and possible situations he is likely to encounter when responding to a fire alarm.
Auditory: N/A
Kinesthetic: Very somatically focused on physical symptoms and fear of having a heart attack.
Hypnotic Strategies to Employ:
Age Regression: Back to success, 28+ years of nonpanic
Age Progression: Ego strengthening, positive expectations
Time Expansion: Slowing, Calming, Relaxing, here and now, mindfulness
Hyperesthesia: Encourage an awareness of physical sensations during trance and how to identify/distinguish differences from nontrance sensations reveal efficacy of subconscious mind for control of body.
Resistance Present: Yes/No: If yes, how is it manifesting:
None likely given his strong desire to return to work as a firefighter.
Strategies for Utilizing Resistance:
Education/Address Myths: Patient very willing to try hypnosis. Little to no education re:
hypnosis is needed.
Educate patient about panic/autonomic nervous system/and "ingredients for making"
panic attacks.
Permissiveness: "if you want" "it's really up to you."
Go-slow messages: Not needed
Give client control: For depth of trance—use analogy of controlling water from a
fire hose: Adjust pressure, angle, speed, etc.
Prescribe Symptoms in light trance: Not needed
Client's Preferences/Interests for Eliciting Trance:
Plays guitar—use automatic references, no need to think, motor memory
Metaphors, Words, Images for Trance/Hypnotic Suggestions:
Words: cooling sensations, putting out fires, false alarms, fire bucket elevation for arm/hand levitation
Tell story of responding to a false alarm, how crew responds, "gets back to normal," no need to over-react when there "is no fire."
Playing guitar in public—pre-performance butterflies, but no panic, subconscious mind knows how to "keep things settled."
Age regression to past successful experiences, remind unconscious mind of his 28+ years of living without panic.

fire truck that is slowly rising above the ground). His arm became the bucket that slowly elevated off his lap and remained in the air until his unconscious mind was ready to lower it.

Understanding that Jason was engaging in less than conscious age regression, he was encouraged to reflect upon times in his life when he was significantly stressed and overwhelmed yet his body did not create panic. I then coupled this suggestion with a reminder that his alarm (i.e., language familiar to him) was well-calibrated to appreciating the difference between a real emergency and a false alarm.

Below is an excerpt of one of Jason's sessions following elicitation of trance as evidenced by hand and arm levitation (italicized notations represent emphasis provided as Jason inhaled):

> . . . and your arm can continue to feel lighter with each breath you take. Maybe you can notice how different you feel right now compared to how you felt when you first walked into my office. As you sit there, one hand resting on your lap the other like a bucket on a fire truck up in the air, your unconscious mind can become available to you to help you . . . an opportunity to access the resources and skills that are there . . . just like accessing a water source to settle a fire, a solution to a problem . . . knowing your mind and your body have handled stress, anxiety, problems and was able to keep things calm (age regression), knowing how to respond to the alarm and when it is just another false alarm. And with what you do everyday as a fire fighter, exactly what you need to do to put the fire out . . . to cool things down and make sure the situation is controlled and managed. And if you want, and it seems right for you, you can take time right now and slowly (time expansion) realize how you respond to an alarm when it goes off . . . how your body knows exactly what to do (ego strengthening) . . . without even thinking . . . knowing that adrenalin is pumping through your body and preparing you to respond . . . and how your body knows it can remain calm. And even though your heart beats faster . . . your breathing is heavier . . . you're feeling warmer (hyperesthesia) your body knows, it's okay . . . it's supposed to do this. And by the time you return to the firehouse after putting out the fire (age progession), your body has settled and your unconscious mind can tend to the things it does best . . . managing all those automatic things your body does without needing to even think about it (dissociation).

Most hypnosis sessions with Jason involved suggestions and interventions similar to those provided previously. I continued to offer opportunities for Jason, while in trance, to enhance ego strengthening and gain a greater sense of control on the part of the unconscious mind with less need for his conscious mind to be involved in the management of his physiological functioning.

During his third session, 1 week after his first hypnosis session, Jason reported that he had been panic-free for 5 days. By the sixth session, he was confident that he would not have a panic attack, rating the probability at a 0.5 on the 10-point scale employed during his first visit. Two days after his sixth session, he returned to work on a full-time basis. I met with Jason twice after he returned to work as a means of reinforcing his capacity to manage stress as well as minimize any relapse. I encouraged him to exercise regularly as he had not been doing this since his mentor passed away. Jason missed the following two scheduled sessions due to scheduling conflicts though left a message on my voicemail that he was "doing fine, with no signs of panic" and that he would see me the following week for his scheduled appointment. He arrived for this appointment and did not believe additional hypnosis was needed as he was very confident that he was not going to have any further panic attacks. He, nevertheless, scheduled an appointment for 1 month later and upon arrival immediately informed me that he was "doing great." He also discontinued all psychotropic medication after his sixth session.

Six years following the termination of his treatment, Jason returned to my office for concerns unrelated to his panic attacks, and reported that since his last session, he remained panic-free, retained his job, and was promoted to Lieutenant of the Fire Department.

Summary

Panic disorder refers to recurrent, typically unexpected, panic attacks associated with an abrupt surge of intense fear involving both physical and cognitive symptoms. This article proposes a treatment protocol including hypnosis for panic disorder. At its core, and serving as a basis for the implementation of specific treatment interventions utilizing trance, is an appreciation of the cognitive and behavioral responses associated with symptoms common to panic disorder that are amenable to clinical hypnosis interventions. Educating the patient about the physiology and common characteristics associated with panic including internalization of emotions, needs for control, and acute awareness of one's physiological functioning are also important aspects of this protocol. Encouraging regular aerobic activity may negate the need for any further intervention, including hypnosis, and should be included in the treatment plan as soon as possible. A case example was presented to demonstrate pragmatic and effective applications of the proposed protocol for treating panic disorder.

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