Hypno-CBT® (HCBT)

Evidence-Based & Cognitive-Behavioural Approaches to Hypnotherapy

> …the real origin and essence of the hypnotic condition, is the induction of a habit of abstraction or *mental concentration*, in which, as in reverie or spontaneous abstraction, the powers of the mind are so much engrossed with a single idea or train of thought, as, for the nonce, to render the individual unconscious of, or indifferently conscious to, all other ideas, impressions, or trains of thought.
>
> –James Braid, 1852.

What is Hypno-CBT® (HCBT)?

Hypno-CBT® is a specific, proprietary system of cognitive-behavioural hypnotherapy. It is not simply "hypnotherapy *plus* CBT", however. As opposed to "theoretical eclecticism", HCBT is a tight integration of social, cognitive and behavioural psychology with traditional hypnotism. It is based upon various established models of theory and practice which *pre-date* the development of modern cognitive-behavioural therapy (CBT). Nevertheless, HCBT is based on the modern principle of evidence-based "*technical* eclecticism" (Lazarus) which encourages clinicians to seek proven methods from different disciplines and attempt to incorporate them within a consistent theoretical model.

In this article, I will outline the nature of cognitive-behavioural hypnotherapy (CBH) and briefly indicate some of the evidence that shows CBH to be older than CBT, and to have influenced the development of modern cognitive and behavioural therapies. I will also outline the BASIC model of assessment and triple-response (ABC) model of treatment employed in Hypno-CBT®, as these help to illustrate the key features of this approach in a way that has proven popular with our students and other clinicians.

Evidence-Based Practice in Hypnotherapy

Modern research on hypnotherapy is increasingly focused upon the integration of hypnotherapy and CBT since the publication in a mainstream peer-reviewed psychology journal of an influential meta-analysis carried out in 1995 by Irvine Kirsch *et al*. Kirsch's research team pooled data from 18 separate controlled studies, including 577 participants, comparing the efficacy of cognitive-behavioural hypnotherapy to CBT alone. They proved that for between 70-90% of clients, cognitive and behavioural therapies were more effective when integrated with hypnosis, i.e., that for the vast majority of clients cognitive-behavioural hypnotherapy is superior to CBT alone.

> A meta-analysis was performed on 18 studies in which a cognitive-behavioural therapy was compared with the same therapy supplemented by hypnosis. The results indicated that the addition of hypnosis substantially enhanced treatment outcome, so that the average client receiving cognitive-behavioural hypnotherapy showed greater improvement than at least 70% of clients receiving nonhypnotic treatment. […] These results were particularly striking because of the few procedural differences between the hypnotic and nonhypnotic treatments. (Kirsch *et al.*, 1996)

This finding led to the inclusion of cognitive-behavioural hypnotherapy for obesity on the list of empirically supported treatments (ESTs) compiled by the American Psychological Association. The only other therapies to have proven their efficacy sufficiently to meet these stringent research criteria are almost exclusively cognitive-behavioural.

However, throughout the history of CBT, since the 1960s, expert clinicians' reports and individual studies have converged on a similar conclusion, *viz*.,

> We believe on the basis of our clinical experience that when behaviour therapy and hypnosis are used together, a synergistic effect results. (Kroger & Fezler, 1976: 74).

There has long been a consensus among certain clinicians that hypnosis enhances cognitive and behavioural interventions, specifically, by raising "response expectancy", facilitating autonomic relaxation, and improving the client's degree of "imaginal absorption", *etc*.

What is Hypnotherapy?

Although many people believe that psychotherapy only began with Freud, at the start of the Twentieth century, Freud himself studied *hypnotic* psychotherapy at the French "Nancy School" of psychotherapy founded by Bernheim. Indeed, it was largely Bernheim, and his followers who popularised the use of the word "psychotherapy" to describe the hypnotic method. The original model of hypnotherapy, from which their approach derived, was developed in the 1840s and 1850s by James Braid, and was already implicitly cognitive and behavioural in orientation. Braid, a Scottish surgeon, derived his theory of hypnotism from two main sources,

1. **Philosophical Psychology (Stewart).** From his earliest writings, and throughout his career, Braid repeatedly cites the conventional principles of "suggestion", "expectation", "imitation", "sympathy", "attention", "imagination", "association", and "habit", explicitly derived from 19th Century philosophical psychology, as the basis for his theory of hypnotism. In particular, he derived his model from the agenda for a "rational" alternative to Mesmerism set forth during the Scottish Enlightenment period by philosophers of the dominant "Common Sense" school of philosophical psychology. The influential Glasgow professor Dugald Stewart urged Scottish physicians to salvage a "common sense" account of the effects of Mesmerism by trying 'to ascertain how far it is possible to fortify and exalt the imagination, and by what means this may most effectually be done.' (Stewart, 1827). Braid had argued that fixation of the gaze upon a single point led to fixation of attention upon a single idea or train of thought, and induced nervous fatigue to varying degrees, but also heightened responsiveness to the "dominant idea" consciously fixated upon. This simple neurological and psychological observation is relatively uncontroversial when correctly understood, even today, and found immediate support in various empirical studies carried out by Braid and other Victorian scientists.

2. **Victorian Neurology (Carpenter).** As his own reputation as an influential sceptic grew, Braid found an important friend and ally in the eminent Victorian neurologist, William B. Carpenter, who coined the term "ideo-motor response" to describe the observation that minute, unconscious, muscular responses could be observed in response to conscious attention upon a "dominant idea" (by which the Victorians often meant a memory, sensation, sound, or visual image). Braid, Carpenter, and their colleagues used this concept to systematically debunk pendulum dowsing, "table-turning", and other alleged Victorian spiritualist phenomena. They extended the idea to encompass the observation that other bodily systems, such as sensation and the secretion of hormones, could be similarly affected by dominant ideas. Braid supplemented this concept with practical observation that focused attention and other methods could be deliberately used to amplify the ideo-dynamic reflex and this became the basis of his mature theory of hypnotism. He expressed concern over the misunderstanding caused his earlier use of the word "hypnotism" (sleep) and suggested "mono-ideo-dynamics" instead, i.e., the methodology of concentrating attention upon a dominant idea in order to amplify its causal effect on the body's physiology.

Before the term "placebo" was even in widespread use, these cognitive and neurological observations led to early placebo-controlled experiments in which Braid, Carpenter, and their supporters, set about debunking Victorian "quack" or "nostrum" remedies. Most of these pseudoscientific therapies were, however, the predecessors of modern complementary therapies like magnet therapy, homoeopathy, crystal healing, "energy therapies", *etc*.

However, the potent combination of philosophical psychology and Carpenter's neurological theory of ideo-dynamic reflexes seemed to offer an alternative, rational and "common sense", explanation of how these prototypical "complementary therapies" achieved their alleged results. Braid and his followers therefore thoroughly rejected the "occult" and pseudoscientific theories of Mesmerism which he dedicated his mature career to systematically debunking. It is thus ironic that modern hypnotherapy is seen as a form of

complementary therapy itself, when its founder was perhaps one of the most influential Victorian critics of such therapies, whose perceived effects he repeatedly demonstrated to be reproducible by means of simple expectation, suggestion, focused attention, physical manipulation, and other "well-established laws of physiology and psychology", as he put it.

The original hypnotism was, therefore, grounded in a philosophical and neurological model which pre-empts modern cognitive-behavioural models of therapy. Contrary to popular misconception, its original orientation was explicitly "common sense", "realist", "rational", "neurological", "empirical", and "sceptical." Even today, concepts from hypnotism are used by critics of complementary therapies to explain the role of suggestion, *etc*., in their alleged effects. To a large extent, the popular confusion of hypnotism with complementary therapies and other pseudo-scientific methods can be blamed upon the influence of stage hypnosis and "New Age" books on hypnotism which perpetuate the myth that hypnotism is the same thing as Mesmerism.

> The modern father of hypnosis was an Austrian physician, Franz Mesmer (1734-1815), from whose name the word 'mesmerism' is derived. Though much maligned by the medical world of his day, Mesmer was nevertheless a brilliant man. He developed the theory of 'animal magnetism' –the idea that diseases are the result of blockages in the flow of magnetic forces in the body. He believed he could store his animal magnetism in baths of iron filings and transfer it to patients with rods or by 'mesmeric passes.' (Paul McKenna, *The Hypnotic World of Paul McKenna*, 1993)

In fact, this has *nothing* whatsoever to do with hypnotism. The two traditions were opposites and bitter opponents, hypnotism being developed specifically to disprove the pseudo-scientific theory of "animal magnetism" and offer a rational and empirical alternative to Mesmerism's primitive "energy" theory and supernatural claims. It has always been in the interests of showmen and comedy "stage hypnotists", however, to obscure the differences between hypnotism and Mesmerism in order to add an element of drama and mystique to their performances, and to misdirect the attention of their audiences.

Socio-Cognitive & Behavioural Hypnotherapy

Cognitive-behavioural theories of hypnosis began to explicitly develop when mainstream social psychology was used to interpret hypnotic phenomena as far back as the 1940s, forming the basis of what soon became known as the "socio-cognitive" or "cognitive-behavioural" theory of hypnosis. For example, in 1941 Robert White published the seminal article 'A preface to the theory of hypnotism', interpreting hypnosis in terms of early social psychology, as a form of role-enactment behaviour,

> Hypnotic behaviour is meaningful, goal-directed striving, its most general goal being to behave like a hypnotised person as this is continuously defined by the operator and understood by the client. (White, 1941)

Role-enactment does not simply mean "faking", though, as identification with the role ascribed to the hypnotic subject can lead to genuine psychological and physiological changes. Braid himself had already compared the enhanced "ideo-dynamic" ability of the hypnotic subject to the ability of an actor to shed *real* tears in role, by means of deliberate imagination. In the context of therapy, however, Braid was more interested in how focused imagination could be used to induce physiological changes such as altered heart rate, circulation, muscular function, and nervous arousal, in opposition to the patient's prevailing symptoms. On this model of treatment, for instance, a phobic client might be induced to systematically focus upon the idea of profound sleep or relaxation in order to induce measurable reduction in heart rate and other bodily responses. Braid's "psycho-physiological" approach to hypnotherapy clearly pre-empts the concept of "reciprocal inhibition" central to modern behaviour therapy.

White's work was followed by a series of social psychologists and cognitive-behavioural theorists --such as Sarbin, Barber, Spanos and Kirsch-- who abandoned the Freudian psychodynamic model of the unconscious mind as model of hypnotism and, in their

extensive writings, systematically re-interpreted hypnotic phenomena within the framework of mainstream psychology. From the 1950s onward, these researchers increasingly emphasised the role of *conscious* variables such as favourable "expectation, attitude, and motivation" (the "positive cognitive set"), "imaginal absorption", and the use of specific "subjective strategies." A growing body of experimental data led to criticism of the "special state" theory of hypnosis, which posited the existence of a unique "trance" or altered state of consciousness. Instead, "nonstate" theorists, especially influenced by Sarbin and Barber, proposed that hypnosis was best understood as a special application of *ordinary* social, cognitive, and behavioural processes, such as role-taking, expectation, and focused attention.

In doing so, ironically, their work marks a return to the original philosophical and neurological concepts employed by Braid, who had no concept of an "unconscious mind" and instead emphasised the role of conscious attention upon dominant ideas in his definition of hypnotism. Braid repeatedly and vigorously emphasised throughout his career that he viewed hypnosis as the result of ordinary psychological and physical processes,

> I beg farther to remark, if my theory and pretensions, as to the nature, cause, and extent of the phenomena of nervous sleep [i.e., hypnotism] have none of the fascinations of the transcendental to captivate the lovers of the marvellous, the credulous and enthusiastic, which the pretensions and alleged occult agency of the mesmerists have, still I hope my views will not be the less acceptable to honest and sober-minded men, because they are all level to our comprehension, and reconcilable with well-known physiological and psychological principles. (Braid, *Hypnotic Therapeutics*, 1853)

Not only was hypnotism *implicitly* cognitive-behavioural from its very inception, but in the first half of the Twentieth Century it became integrated within the emerging framework of social, cognitive and behavioural psychology, several decades before the appearance of modern *cognitive* therapy (Beck, Ellis, *et al*.), or even its precursor *behaviour* therapy (Wolpe *et al*.), in the late 1950s and early 1960s. Indeed, as Weitzenhoffer and others have shown, hypnotherapy can be seen, in many ways, as the roots and trunk of a historical tree from which cognitive-behavioural therapy, and other modalities, sprouted forth as branches.

> Examination of the hypnotherapy literature leaves little doubt that many hypnotherapists apply a variety of [behavioural] learning principles in conjunction with their hypnotic techniques. In many cases, they use procedures similar enough to those employed by behaviour therapists to identify their approach as "behaviour therapeutically oriented hypnotherapies," or, more simply, "behaviouristic hypnotherapies" [….]. (Weitzenhoffer, 1972: 304).

He notes that 'Much relevant literature in hypnotherapy was published long before "behaviour therapy" became a recognised branch of psychotherapy." Indeed, from the start of the Twentieth Century onwards, other prototypical cognitive and behavioural approaches to psychotherapy came and went, dwarfed by the dominance of the Freudian Empire. The origins of the *modern-day* cognitive-behavioural tradition are therefore usually traced to the late 1950s when Joseph Wolpe's work established the beginning of a coherent system of behavioural therapy, in opposition to psychoanalysis.

Wolpe's method of systematic desensitisation, e.g., the archetypal technique of modern behaviour therapy, was visibly derived from established hypnotherapy methods. In order to induce relaxation during desensitisation, Wolpe himself had initially employed a hypnotic induction derived from Lewis Wolberg's *Medical Hypnosis* (1948), one of the best-known hypnotherapy textbooks of the period. Wolpe therefore referred to his technique as hypnotic "desensitisation." As several sharp-eyed researchers quickly pointed out, however, *Medical Hypnosis* also contained a whole chapter explicitly dedicated to *behavioural* hypnotherapy, entitled 'Hypnosis in Reconditioning', in which the technique of hypnotic "desensitisation" is already described as a treatment for specific phobia and social anxiety.

> Another means of treating phobias is by *desensitisation*. Under hypnosis the patient is given suggestions to *expose himself gradually* to the terrifying situation. The aim in desensitisation is to get the patient to master his fears by actually facing them. It is essential for the individual to force himself

> again and again into the phobic situation, in order that he may finally learn to control it. […] The hope is that the conquering of *graduated doses* of his fear will desensitise him to its influence. (Wolberg, *Medical Hypnosis*, 1948: 235, *my italics*)

Wolberg describes how a patient with social anxiety is taught to relax by means of a 'peaceful isolated scene on the seashore.' He was then asked in hypnosis to visualise progressively more anxiety-provoking social situations while remaining relaxed and emotionally calm. By "reconditioning" him to associate relaxation and pleasure with social situations, Wolberg reported that he was able to do so in reality, overcoming his social phobia. It would seem therefore that the same hypnotherapy textbook from which Wolpe acknowledged deriving his hypnotic induction also contained several descriptions of the behavioural "desensitisation" treatment, unacknowledged by him, which he claimed to have invented. As Weitzenhoffer diplomatically puts it, these and other examples of "desensitisation" in behavioural hypnotherapy "clearly antedate" the founding text of behaviour therapy, Wolpe's *Psychotherapy by Reciprocal Inhibition* (1958).

Similar observations can be made regarding the unacknowledged influence of hypnotherapy over the development of many other CBT interventions, too diverse to cover in this short article, with the following exception from the *cognitive* tradition. Albert Ellis the first modern cognitively-oriented therapist reported that he originally studied the "New Nancy School" approach to hypnotism, in the writings of Coué, as a teenager. The seminal notion of "negative cognition" in CBT is described in Ellis' early writings as a form of "negative autosuggestion." Speaking of his bemusement over the power of hypnotic suggestion, Ellis wrote,

> The answer to this riddle, in the light of the theory of rational-emotive psychotherapy, is simply that suggestion and autosuggestion are effective in removing neurotic and psychotic symptoms because *they are the very instruments which caused or helped produce these symptoms in the first place*. Virtually all complex and sustained adult human emotions are caused by ideas or attitudes; and these ideas or attitudes are, first, suggested by persons and things outside the individual (especially by his parents, teachers, books, etc.); and they are, second, continually *autosuggested* by himself. (Ellis, 1962: 277)

However, this notion of pre-existing negative autosuggestion was already present in the writings of James Braid from the 1850s, and rose to prominence in the New Nancy School of the 1920s.

> By knowing how to practise it [autosuggestion] consciously it is possible in the first place to avoid provoking in others bad autosuggestions which may have disastrous consequences, and secondly, consciously to provoke good ones instead, thus bringing physical health to the sick, and moral health to the neurotic and the erring, the unconscious victims of anterior autosuggestions, and to guide into the right path those who had a tendency to take the wrong one. (Coué, 1922: 5)

The very concept of cognitive mediation, and negative cognition, so central to modern cognitively-oriented therapy, is arguably a necessary concomitant of any theory of hypnotic suggestion. The "dominant ideas" which Braid and Carpenter blamed hysterical illness upon, or the "autosuggestions" of Coué, can be seen as prototypical "cognitive" theories of psychopathology. Even Braid, the founder of hypnotherapy, speaks of employing hypnotism 'so as to break down the pre-existing, involuntary fixed, dominant idea in the patient's mind, and its consequences.' (Braid, 1853). The Freudian transposition of such cognitions to a hypothetical "unconscious mind" obscured the fact that Braid and other hypnotists had, from the outset, recognised the role of *conscious,* but unintentional, attention and *conscious* dominant ideas in determining hysterical illness, i.e., neurosis and psycho-somatic complaints.

Hypno-CBT® (HCBT)

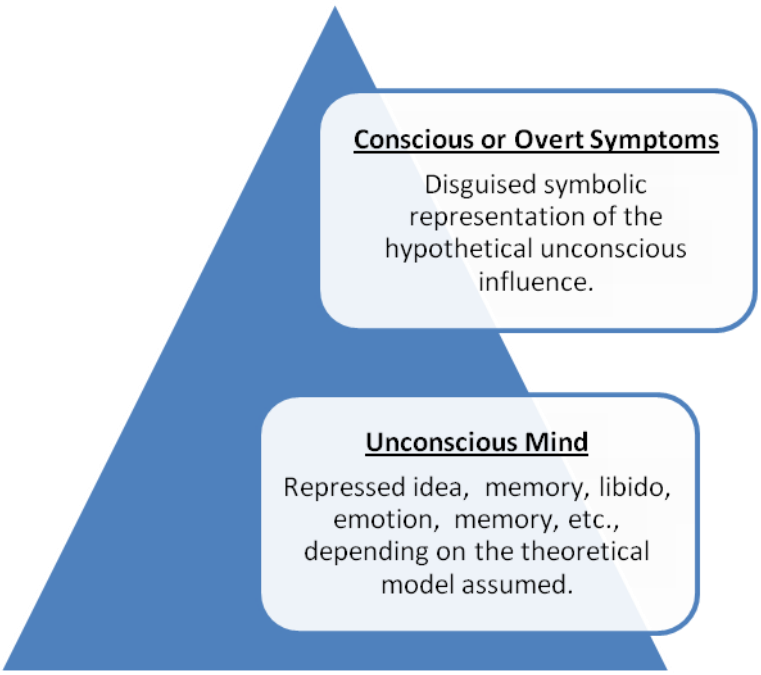
Hypno-CBT® is a proprietary system of cognitive-behavioural hypnotherapy which, at a conceptual level, integrates the original hypnotic theory of Braid with modern social,

cognitive and behavioural psychology. At a practical level, it also integrates hypnotic techniques and strategies with those derived from modern cognitive and behavioural therapies. Hypno-CBT® is based on a cognitive-behavioural "skills training" model of hypnotic responsiveness derived from the seminal "role-taking" model introduced by White in the early 1940s and developed by subsequent socio-cognitive researchers. The theory and practice of HCBT have already been extensively developed, and constitute an accredited training based upon highly-detailed training manuals. However, one of the distinguishing features of this approach is the use of a specific multi-modal and social-cognitive-behavioural model of assessment and treatment, ultimately derived from the Multimodal Therapy (MMT) of Arnold Lazarus and the triple-response model of clinical anxiety issuing from the research of Lang and Rachman.

We reject the outdated and reductionist psychodynamic model of psychopathology, taken for granted in hypnotic regression therapy, in which a hypothetical "unconscious idea" is assumed to produce multifarious conscious and overt symptoms. We likewise reject the potentially counter-productive, and long disproven, theory of "symptom substitution" which claims that unless this hidden emotion, drive, idea or memory is uncovered the client is doomed to relapse or to the formation of new symptoms. This kind of "symptom substitution" is not observed in following-up non-psychodynamic therapy, such as CBT, or when ordinary people quit habits or overcome fears, in daily life, without the aid of any therapy whatsoever. The recovery or interpretation of unconscious memories is now seen as a dangerously pseudoscientific practice by mainstream researchers, following advances in the neuro-psychological understanding of memory in the wake of the "recovered memory" scandals of the 1980s and 1990s. It seems increasingly likely that "recovered" memories are largely "*recreated*" memories, and may or may not be true depending upon the degree to which the client's inflated confidence in their memory, heightened expectations, the leading influence of the therapist, and numerous other factors, impossible to measure or control, may distort the process of reconstruction and turn an educated guess into a partial or total "false memory."

The "reductionist", "vertical" and "linear" model employed by psychodynamic therapists, looks like this,

Figure 1: The Old Psychodynamic Model



We propose instead a “circular” and “multi-modal” approach derived primarily from the BASIC ID model of Arnold Lazarus and empirical psychopathology. The model, employed in Hypno-CBT®, therefore, looks like this,

Figure 2: The New Multimodal (BASIC) Model

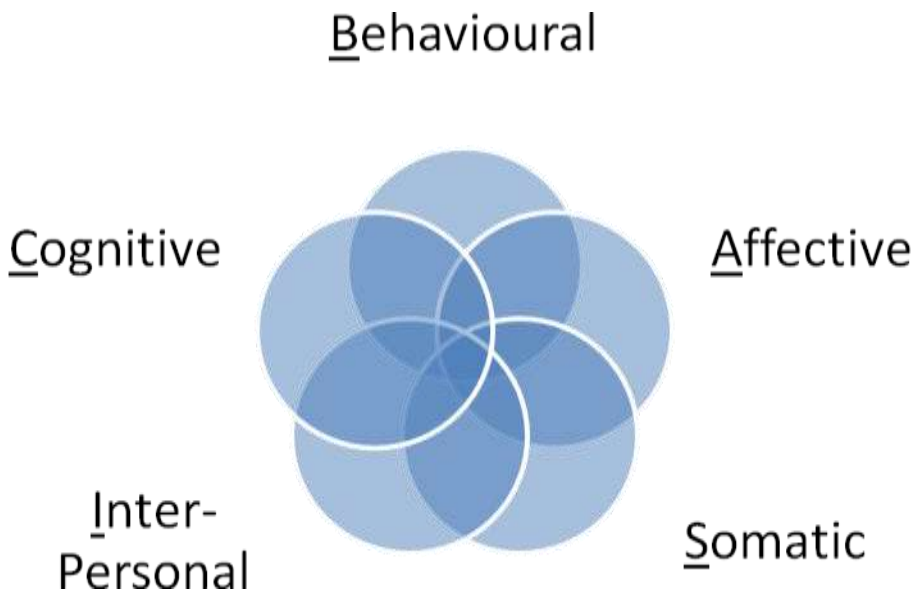


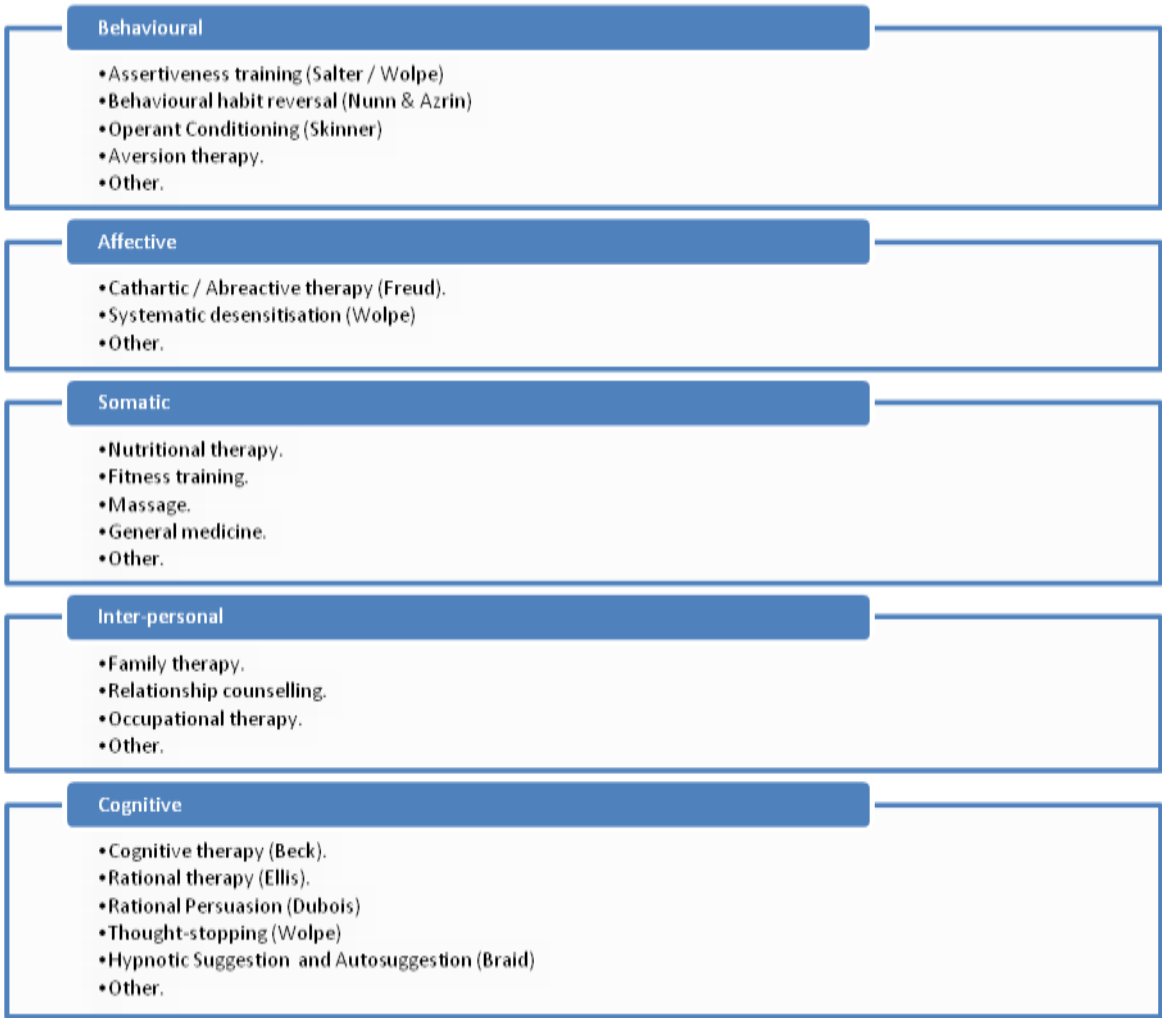
Figure 3: Definitions of BASIC Modalities

Behaviour	Affect	Soma	Inter-personal	Cognition
•Action. •Speech. •Body language. •Avoidance / withdrawal. •Behavioural competence. •Other.	•Emotions. •Feelings. •Bodily sensations. •Other.	•Physiology •Diet •Exercise •Medical condition. •Stress response. •Other.	•Social role and inter-action. •Work relations. •Family relations. •Romantic or sexual relations. •Social relations. •Other.	•Misconceptions. •Fixed ideas. •Thinking errors. •Autosuggestion. •Other.

Symptoms are inter-active *and* overlapping, they are *not* conceptually distinct. Removal of symptoms in all dimensions constitutes *complete* cure; removal of symptoms in some dimensions, while remaining in others, is *incomplete* and leaves clients vulnerable to relapse. For example, removing the drinking *behaviour* (B) of a socially anxious alcoholic, through aversion therapy, without treating their *feelings* of anxiety (A), through desensitisation, may leave them vulnerable to relapse in the future or encourage them to seek alternate forms of self-medication, e.g., drug abuse. However, improvement in one dimension may often have a direct effect upon other dimensions, e.g., the same alcoholic may find that he experiences increased self-confidence from stopping drinking which, in itself, spontaneously reduces his social anxiety over time, leading to total cure. Therapists are optimally effective when they help clients to identify all dimensions which contribute to or are affected by their presenting problem. Clients are optimally able to fulfil their role in treatment when they are able to understand all modalities of their own problem and the relationships between different dimensions. Some problems predominantly relate to one or more modalities, and are less relevant to others, though, as should be obvious.

Different modalities of therapy focus upon different dimensions of the problem. For instance,

Figure 4: Correlation of Different Treatments & Modalities



Individual therapy often aims to influence the inter-personal modality *indirectly* by changing the client's behaviour to make them more assertive at work, etc., but if only one person is in the consulting room it is not *directly* inter-personal. Likewise, *psychological* therapy attempts to influence the somatic modality *indirectly* by influencing the client's emotions to reduce stress, etc., but it does not usually *directly* influence the client's physical health unless the psychotherapist is also qualified in nutrition, medicine, or as some kind of physical therapy.

It came as a shock to Freudians to discover that other types of therapy, which did *not* attempt to unearth the hypothetical unconscious roots of a problem, were more effective, in a much shorter span of time, than their own method. On Freud's theory, strictly speaking, CBT, and every other therapy model, should have little more than a 0% success rate --which is obviously not the case. The fact that most different modalities of therapy demonstrably have moderate or large effect sizes proves that client problems can be effectively addressed from a number of different angles, and suggests that conscious and overt symptoms are intertwined and *not* simply caused in a linear manner by repressed memories, drives, or emotions. As Andrew Salter, an early cognitive-behavioural hypnotherapist and critic of psychoanalysis stated in the 1950s: *a vicious circle does not have a root.*

Consequently, Hypno-CBT®, like conventional hypnotherapy, focuses directly upon the three modalities of Affect (A), Behaviour (C), and Cognition (C), and only indirectly, as a

result of personal psychological change, upon the client's health (S) and inter-personal environment (I). Hypnotherapy is primarily a *cognitive* therapy, though, because it explicitly focuses on the use of verbal autosuggestion and suggestion, and other "cognitive strategies" (Spanos), in order to facilitate emotional and behavioural changes.

In treatment, moreover, the therapist is optimally effective when he carefully identifies *specific* situations or events which the client currently responds badly to, i.e., the client has a phobia of dogs which *specifically* causes them distress when they attempt to walk across their local park on the way to work each morning and they see people walking past them with dogs, especially large ones. Ideally, specific situations or events which the client will face, or may choose to face, within the next 7 days are identified. This allows the therapist to combine imaginal therapy (*in vitro*) with real world (*in vivo*) graded exposure. For example, the client may choose to walk through the park tomorrow morning in order to test their response following treatment. Of course, real world exposure requires careful management to avoid unnecessary distress and is therefore combined with coping skills training and the collaborative setting of a graded hierarchy of manageable goals, where appropriate.

A similar approach can be modified for the treatment of memories, abstract thoughts, etc. However, the simplest and most common treatment protocol takes the following form. The client is hypnotised, following preliminary assessment, education and skills training, etc., and repeatedly imagines the target situation while mentally rehearsing more healthy and adaptive responses, with the assistance of the therapist. This is done in accord with established cognitive-behavioural methods based on clinical research. However, we employ the following triple-response or "three dimensional" template for mental rehearsal which accords with modern "desynchrony" models of anxiety treatment, developing out of clinical research in the 1970s,

> It is helpful to think of fear as comprising three main components: the subjective experience of dread, associated physiological changes, and behavioural attempts to avoid or escape from the threatening situation. The three components of fear do not always correspond. Some people experience subjective fear but remain outwardly calm and show none of the expected physiological correlates of fear, such as trembling, palpitations, or perspiring; others report subjective fear but make no attempt to escape from or avoid the supposedly threatening situation. The existence of these three components of fear, and the fact that they do not always correspond, makes it helpful to specify which component of the fear one is describing. (Rachman, 2004: 8-9)

This short assessment form is used in classroom training, and employs our three dimensional (or "ABC") model as a preliminary to a wide range of cognitive-behavioural hypnotherapy interventions. Our dog phobic, in the example, may answer,

Target Situation: Walking through my local park tomorrow and seeing someone pass me with a large dog.

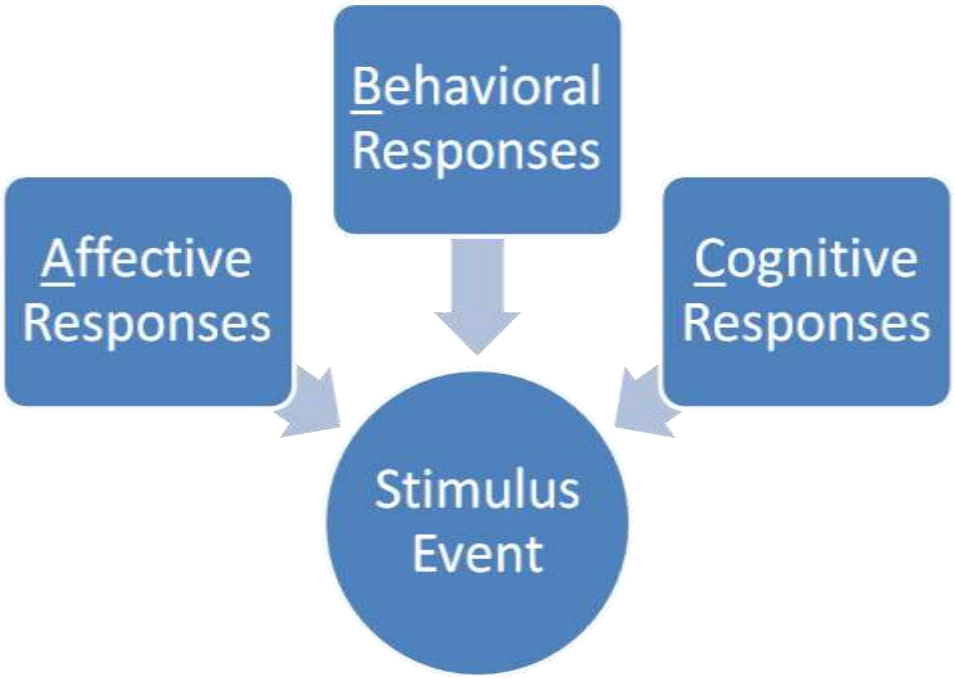
SUD: 9 **/ 10**

ABC Model	Old (Presenting Problem)	New (Therapy Goal)
Affect (Feelings)	Fear, anxiety, trembling, sweating palms, knot in stomach, etc.	Calm, confident, steady, grounded, relaxed.
Behaviour (Actions)	Want to run away, avoidance, delaying, etc.	Walking along path without hesitation, approaching friendly dogs and stroking them, greeting owners, etc.
Cognition (Thoughts)	"I can't handle this, I'm going to panic and everyone will look at me and think I'm an idiot!"	"I can do this if I focus and use my coping skills, and think positively. So what if look a little bit nervous, who cares? I'll soon get over it with practice."

The therapist will, most typically, employ this as a framework for mental rehearsal, or imaginal exposure. Often one modality is addressed at a time, over 3-4 sessions of treatment, or as required. However, the choice of which order to address modalities in will also depend upon the preference and personality of the client and the nature of their problem.

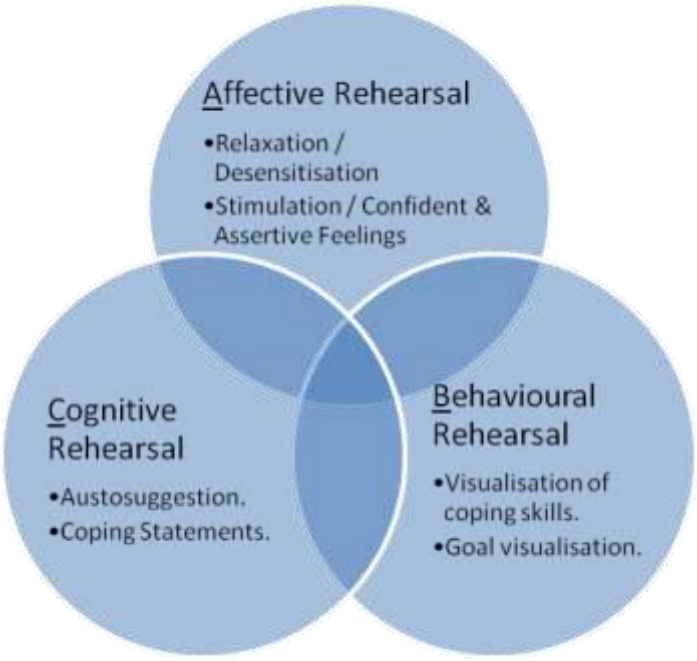
As Salter (1949) said, the "cardinal technique of psychotherapy" is simply that the *stimulus* be presented, while the *response* is prevented. On a triple-response model of treatment this means that during mental rehearsal, and subsequently during real-world exposure, clients rehearse facing their fears (or other challenging issues) in a controlled manner, with focused attention, and while employing certain evidence-based "cognitive-behavioural strategies", derived from the technical eclectic armamentarium or chosen by the client themselves, to prevent negative feelings (A), and actions (B), and thoughts (C) and replace them with more adaptive ones.

Figure 5: "Triple Response" (ABC) Stimulus-Response Model



These three modalities of assessment correspond, very neatly, to three established modalities of treatment intervention used in mental rehearsal, the central component of Hypno-CBT®. In its simplest and most typical form, e.g., mental rehearsal consists of facing one's fears repeatedly in imagination while responding with relaxed physiology and calm emotions (Affect), visualising "acting as if cured" (Behaviour), and repeating positive, congruent, and realistic autosuggestions (Cognition).

Figure 6: ABC (Triple Response) Model of Therapy



Put very simplistically, our dog phobic may, at this stage, be hypnotised and asked to picture walking through the park, several times. To begin with he may be trained in relaxation skills and asked to focus on inducing muscular and autonomic relaxation while facing his fears in this way, following a standard hypnotic desensitisation protocol, influenced by Wolpe. When he reports, by using a SUD (Subjective Units of Disturbance) scale or similar measure, that he is ready, he will proceed to incorporate behavioural and cognitive components to his mental rehearsal.

He may choose next to relax and picture walking in the park while imagining now that he walks confidently and even approaches dogs in a calm friendly manner, gradually building up a more detailed and congruent image of success in graded steps, following a standard "coping to mastery" imagery protocol. At first it helps to picture minor setbacks, like a slight sense of panic, and to see himself recovering from it, for the purposes of relapse prevention. Finally, however, he pictures himself "acting as if cured", as we put it.

When he is satisfied, he may now address the cognitive dimension. This can be done at any stage through simple autosuggestion, i.e., telling himself congruently that "I can do it", using a self-efficacy statement (Bandura), being the most generic method. However, in the latter stages of treatment negative cognitions should be actively identified and the client helped to counteract and dispute them systematically. For instance, the client may fear that his improvement is temporary and he should be encouraged to monitor the effects of this thought and to seek a more rational and helpful alternative, e.g., "If I keep practising and think positively, I can make relaxation more automatic and lasting in this situation, until it becomes permanent."

Statements like this can then be rehearsed systematically in hypnosis and measured by means of a self-efficacy scale ("How confident do you feel about handling that situation, from 0-10?") or a validity of cognition scale ("How true does that positive statement feel, at an emotional level, as a percentage?"). Affective, Behavioural, and Cognitive components of rehearsal can be practised separately in sessions, or combined together. They may be tackled in a different order than ABC, though this is the most common sequence. Clients may employ similar interventions as homework between sessions, often facilitated by means of a specially-tailored recording.

Conclusion

In this short article, I have outlined in cursory fashion, the historical basis for Hypno-CBT® and demonstrated the fact that it can claim historical precedence over modern CBT. As Kirsch *et al.* (1995) observe, in published research, cognitive-behavioural hypnotherapy (CBH) and CBT are often indistinguishable in terms of the techniques and protocols used. However, most of the techniques employed can be found in hypnotherapy literature prior to the development of modern CBT, and the inclusion of socio-cognitive and cognitive-behavioural theories and concepts within the framework of mainstream hypnotherapy research began as far back as the early 1940s. Traces of similar techniques and concepts, and an explicitly evidence-based and rational-empirical orientation, visibly dominate the writings of James Braid, who introduced the concept of hypnotism in the early 1840s.

I have not had space to describe the huge armamentarium, or "toolbox", of therapeutic interventions which are employed in HCBT within a cognitive-behavioural model, derived from Lazarus' philosophy of evidence-based technical eclecticism. However, I hope to have clarified the multi-modal nature of HCBT assessment and treatment planning and to have provided clinicians with a basic understanding of the ABC or triple-response approach to mental rehearsal which constitutes the central intervention employed within HCBT.

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