A Brief Introduction to Cognitive-Behavioural Hypnotherapy (CBH)

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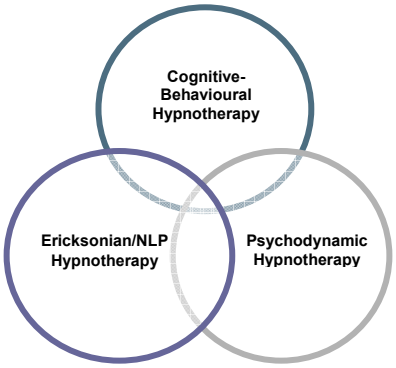
Based on *The Practice of Cognitive-Behavioural Hypnotherapy* by Donald Robertson, available in 2008. See our website www.HypnoSynthesis.com for details of training courses.

What is Cognitive-Behavioural Hypnotherapy?

Cognitive-behavioural hypnotherapy (CBH) can be regarded as one of three core models of hypnotic psychotherapy ("hypno-psychotherapy"). It combines hypnotherapy with techniques and concepts from cognitive-behavioural therapy (CBT).



Although more books and articles specifically outlining a CBH approach began to appear in the 1980s, cognitive-behavioural approaches, albeit usually under another name, have always been central to hypnotherapy. For example, Braid and Bernheim, probably the two most important figures in the original hypnotherapy of the 19th Century, are arguably "cognitive" and "behavioural" in orientation when viewed from a modern perspective.

Hypnotherapy & Behavioural Therapies

Therapies which emphasise the role of (classical and operant) conditioning principles in learning theory are generally deemed behavioural in orientation. Assertiveness skills training and systematic desensitisation are therefore the two most archetypal modes of modern behavioural therapy. Likewise, modern, evidence-based hypnotherapy makes considerable use of hypnotic skills training and conditioning of the relaxation response. The physiological mechanism of relaxation is central to both behaviour therapy and hypnotherapy.

Although he had many precursors, Joseph Wolpe's *Psychotherapy by Reciprocal Inhibition* (1958) is generally considered to mark the beginning of modern behaviour therapy. The central concept of Wolpe's therapy is Sherrington's "reciprocal inhibition", defined by Wolpe as the fact that when two physiological responses are in competition the stronger one will tend to progressively inhibit the weaker one until the latter is extinguished. In systematic desensitisation, the relaxation response is used to systematically inhibit the anxiety response in relation to specific cues. This is also a central presupposition in most hypnotherapy, especially following the New Nancy School established by Émile Coué in the 1920s. A similar therapeutic principle can be found in James Braid's seminal *Neurypnology* (1845), the first book published on hypnotism, where neuro-hypnotism ("nervous sleep") is specifically used to counter-act morbid states of physical tension or nervous arousal.

Hypnotherapy & Cognitive Therapies

Cognitive therapies are generally defined as those therapies which emphasise the role of "cognitive mediation" in learning theory. Cognitive mediation is the theory that the client's current patterns of thinking, especially beliefs and conceptualisations, determine how they will respond to specific stimuli or cues. The two most influential modalities of cognitive therapy in this sense are the Rational-Emotive Behaviour Therapy (REBT) of Albert Ellis and Cognitive Therapy (CT) of Aaron Beck, both of which originated in the late 1950s but rose to prominence more slowly than Wolpe's behaviour therapy which they eventually eclipsed in the form of what has become popularly known as Cognitive-Behavioural Therapy (CBT). The old stimulus-response (S-R) model of behaviourism is modified to become the stimulus-cognition-response (S-C-R) model of modern cognitive-behavioural theory. This also resembles the input-processing-output schema used in the modern "computational" model of the mind.

Ellis explains the notion of cognitive mediation through his famous "ABC model." He suggests that most of us tend to act and feel as if activating events (A) "cause" emotional and behavioural consequences (C), i.e., I cry because someone shouts at me. In reality, however, our responses are "mediated" by our belief system (B). I cry because someone shouts at me and I believe that it's unbearable; someone who believes it's trivial might laugh rather than cry. Most emotional problems are maintained by failure to recognise the role of cognitive mediation, i.e., A-C thinking rather than A-B-C thinking. Most books on CBT follow Ellis in illustrating the concept of cognitive mediation by quoting one of the core precepts of ancient Stoic philosophical therapy from Epictetus: "People are not disturbed by things, but by the judgements which they form about things." (*Encheiridion*, §5).

The role of suggestion in hypnotherapy is very similar to that of cognition in cognitive therapy. Especially in the New Nancy School of Coué, the old concept of the *idée fixe* (fixed idea) evolves into an emphasis upon the role of negative autosuggestion as the essence of psychopathology. In the 1980s, Daniel Araoz popularised the notion of "negative self-hypnosis" which has become central to modern

cognitive-behavioural hypnotherapy. The notion of negative self-hypnosis or autosuggestion in hypnotherapy is very similar to Beck's notion of "negative automatic thoughts" in cognitive therapy.

The Cognitive-Behavioural Theory of Hypnosis

As every hypnotherapist knows, the central theoretical debate in the history of hypnotism was over the extent to which hypnosis should be characterised as a "special state", sometimes loosely designated "hypnotic trance." This topic is traditionally known as the "state versus nonstate" debate. Proponents of the nonstate position, which has risen in popularity among researchers during recent decades, also describe their position as the "socio-cognitive" or "cognitive-behavioural" theory of hypnosis.

This debate has been dogged by semantic confusion. Essentially, *state* theorists have argued that the effects of hypnotic procedures are best explained on the underlying basis of a unique or "special" neuro-psychological state. One of the most recent and credible attempts at a "special state" theory of hypnosis was Hilgard's "neodissociation" model, which regarded hypnotic trance as an artificially-induced state of psychological dissociation.

On the other hand, *non*-state theorists have argued that hypnosis is a special application of a number of relatively ordinary psychological states, like heightened concentration, expectation, and imagination. A corollary of the nonstate position is the notion that hypnosis is best explained by using relatively familiar concepts drawn from other branches of mainstream psychology, such as role theory (Sarbin). By contrast, the state theorists have tended to construct special theories which are restricted to explaining hypnosis itself and fail to find support more widely in academic psychology.

It is now widely conceded that heightened suggestibility can be reliably induced in a "hypnotic" manner without conventional hypnotic induction routines. This, along with numerous other conceptual and empirical findings, has been taken to support the cognitive-behavioural theory of hypnosis. More recently, support has been found for the notion that certain types of hypnotic response may be facilitated by certain genetic endowments or traits such as the ability to allocate attention fully. However, although these suggest the role of a neuro-psychological "state", such as imaginal absorption, it is not clear that this is *essential* to hypnotic responsiveness or that it is *unique* to hypnotic subjects. Such factors have therefore been interpreted as fundamentally compatible with the nonstate theory.

It is important to realise that the cognitive-behavioural *theory* of hypnosis and cognitive-behavioural *hypnotherapy* are two fundamentally different things. Nevertheless, both draw upon contemporary research findings and use the concepts and terminology of socio-cognitive learning theory. It is therefore no surprise to find that cognitive-behavioural therapists have often favoured the cognitive-behavioural, nonstate, theory of hypnosis.

What is the Evidence for CBH?

Research evidence overall consistently favours cognitive and behavioural therapies, and to some extent hypnotherapy, over other modalities of psychotherapy.

Smith *et al.* (1980) carried out one of the largest and most influential studies ever conducted on comparative psychotherapy outcomes. From meta-analysis of 475 controlled studies, employing tens of thousands of participants, they pooled data comparing different modes of psychotherapy in a genuinely seminal analysis that initiated the modern era in psychotherapy efficacy research. Measurement of the "effect size" of different modalities of psychotherapy showed that only four categories performed better than the average (the mean for all therapies). Specifically, "Cognitive, cognitive-behavioural therapies, hypnotherapy, and systematic desensitisation appeared most effective." (Smith et al., 1980: 124).

Efficacy of Different Modalities of Psychotherapy (Smith *et al.*)

1. "Other cognitive therapies." (Including cognitive-behavioural hypnotherapy, d=2.38)
2. Hypnotherapy. (Mainly of a psychodynamic nature, d=1.82)
3. Cognitive-behavioural therapy. (d=1.13)
4. Systematic desensitisation. (Which often employed hypnotic induction, d=1.05)

Hypnotherapy more than doubled the effect size of conventional psychodynamic psychotherapy. By this time many researchers and clinicians had already observed that hypnotherapy seemed to create a "synergistic" effect when combined with cognitive-behavioural therapy. In the initial decades of behaviour therapy, a number of small studies converged on this conclusion. Subsequently several very well-designed, multi-factorial, controlled studies by Donald Tosi and his colleagues established the benefits of cognitive-behavioural hypnotherapy over either hypnotherapy or CBT alone for a range of conditions. Finally, in the 1990s, even more conclusive evidence came from an influential meta-analysis of 18 controlled studies, using 577 subjects, published by Irvine Kirsch which proved that 70% of CBT clients experienced more improvement when CBT was combined with hypnosis, i.e., from cognitive-behavioural hypnotherapy.

> Meta-analyses have established that different psychotherapies have different outcomes. Cognitive-behavioural therapies are significantly more effective than psychodynamic therapies, and their superiority increases when long-term follow-up is assessed. Hypnosis enhances the efficacy of both psychodynamic and cognitive-behavioural psychotherapy, and this effect is especially strong in long-term outcome of treatment for obesity. (Kirsch, 1996)

As a result of these studies, cognitive-behavioural hypnotherapy was formally endorsed by the American Psychological Association (APA) as an empirically-supported treatment for obesity, the only application of hypnotherapy to meet their stringent criteria for evidence of efficacy in psychotherapy.

What is Evidence-Based Eclecticism?

"Technical eclecticism" is a philosophy of psychotherapy which adopts specific techniques on the basis of their proven efficacy rather than for theoretical reasons. It is not wedded to a particular theoretical orientation but forms the basis of the Multimodal Therapy (MMT) of Arnold Lazarus. Lazarus endorses technical *eclecticism* in marked preference to "*integrative*" psychotherapeutic theory, which attempts to weld together disparate theoretical concepts. Lazarus objected that "integrative" psychotherapy has often led to the construction of unwieldy and incoherent theories and to dogmatically theory-driven practice. Eclecticism is a more empirical approach to therapy as it selects techniques on the basis of their proven efficacy rather than for theoretical reasons.

Modern research on psychotherapy tends to favour an evidence-based eclectic approach. As a body of research on the efficacy of psychotherapy interventions and approaches has evolved, modern studies are increasingly in the position of being able to derive their hypotheses from careful review of preceding research findings, which inevitably leads to an evidence-based, tailored and technically eclectic approach to therapy.

Hypnotherapy is virtually unique among modalities of psychotherapy in that it defines itself primarily in terms of a cluster of techniques, rather than a set of theoretical assumptions. Hypnotherapists tend to draw on different theories of psychotherapy, some are psychodynamic, some cognitive-behavioural, and some humanistic, or a combination of the above. We therefore believe that hypnotherapy is already, historically, an inherently eclectic psychological therapy. Hypnotherapy based upon scientific research, which incorporates well-established techniques from other schools of psychotherapy, may already constitute a specific branch of technical (evidence-based) eclecticism.

The Armamentarium of Cognitive-Behavioural Hypnotherapy

Many traditional techniques used in hypnotherapy would best be classified as cognitive or behavioural interventions. Weitzenhoffer and others have explicitly drawn attention to the fact that many CBT interventions are derived from technique already used for many decades in hypnotherapy. Most hypnotherapy for issues like smoking cessation or pain control traditionally draws on symptom-focused techniques which are predominantly cognitive-behavioural in orientation.

The table below provides a menu of interventions employed within the cognitive-behavioural hypnotherapy modality derived, where possible, from efficacy research on psychotherapy.

Armamentarium of Cognitive-Behavioural Therapy

1. Self-Hypnosis Training
2. Relaxation Skills Training / Breathing Exercises
3. Hypnotic & Autosuggestion Skills Training
4. Therapy Recordings (Self-Hypnosis CDs, etc.)
5. Alert Hypnosis
6. Hypnotic Desensitisation Therapy (Systematic Desensitisation / Regression Desensitisation)
7. Aversion Therapy / Covert Sensitisation
8. Assertiveness Skills Training (Conditioned Reflex Therapy)
9. Direct Therapeutic Suggestions & Positive Goal Imagery
10. Mental Rehearsal of Coping Skills
11. Imaginal Exposure Therapy & Response Prevention
12. Thought-Stopping & Thought-Substitution (Habit Reversal)
13. Mental Rehearsal of Positive Cognitions
14. Mindfulness Training (Body Scan) & Thought-Spotting (Gestalt Therapy)
15. Self-Monitoring (Thought Forms, etc.)
16. Socratic Questioning & Verbal Disputation (of Thinking Errors & Negative Cognitions)
17. Shaping Behaviour by Positive Reinforcement of Successive Approximations (Coping to Mastery)
18. Ego-Strengthening / Self-Efficacy Suggestions & Imagery
19. Structured Client Assessment & Evaluation
20. Psycho-education / Education in the Therapeutic Model
21. Tension Control / Progressive Muscle Relaxation
22. Biofeedback Training
23. Cue-Controlled Emotions ("Anchoring")
24. Cognitive Mood Induction / Rational Emotive Imagery
25. Resilience & Relapse Prevention Training
26. Linguistic Training (General Semantics)
27. Acting "as if" / Role-Taking
28. Covert Role-Modelling Imagery
29. Collapsed Coping Statements / Symbol Suggestion
30. Role-Play / Behavioural Psychodrama (in Autosuggestion Training)

31. Acceptance / Forgiveness Exercises
32. Evocative Imagery & Cognitive Regression Therapy
33. Self-Image Therapy
34. Cognitive Time Projection Imagery / Contrasting Consequences
35. Negative Practice / Paradoxical Intention Therapy
36. Covert Self-Reinforcement
37. Behavioural Assignments / Corrective Experiences
38. Bibliotherapy (Prescribing Self-Help Literature)

Even among traditional hypnotherapists, tailored treatments for smoking cessation, pain control, insomnia, etc., have often favoured cognitive-behavioural interventions and strategies like these instead of psychodynamic techniques like regression. The same could be said of group work such as self-hypnosis classes or corporate stress management training.

Some Further Reading

The Practice of Cognitive-Behavioural Hypnotherapy by Donald Robertson, will be available in 2008.

Platonov, K.I. (1959). *The Word as a Physiological & Therapeutic Factor: The Theory & Practice of Psychotherapy According to I.P. Pavlov.*
Kroger, W.S. & Fezler, W.D. (1976). *Hypnosis & Behaviour Modification: Imagery Conditioning.*
Dowd, E. T. (2000). *Cognitive Hypnotherapy*.
Golden, W.L.; Dowd, E.T.; Friedberg, F. (1987). *Hypnotherapy: A Modern Approach*.
Dengrove, E. (ed.) (1976). *Hypnosis & Behaviour Therapy*.
Clarke, J.C. & Jackson, J.A. (1983). *Hypnosis & Behaviour Therapy*.

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About the Author

Donald Robertson is a registered senior clinician member of NCH and a registrant of UKCP and EAP. He is the principal and director of The UK College of Hypnosis & Hypnotherapy. Donald is the author of a number of articles on philosophy and cognitive approaches to therapy published in professional journals and is currently writing two books on cognitive-behavioural approaches to therapy.

Contact Details

The UK College of Hypnosis & Hypnotherapy
Freephone 0800 195 9809
Web www.HypnoSynthesis.com
Email HypnoSynthesisUK@aol.com