Chapter

Cognitive Hypnotherapy

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Abstract

Cognitive hypnotherapy (CH) is an assimilative therapy rooted in cognitive therapy and behavioural therapy, with the addition of hypnosis. It is a psychodynamic therapy that focuses on the unconscious mind (implicit thoughts, actions and emotions) no longer in conscious awareness. This chapter gives a brief synopsis of the hypnotic procedures and protocols that are most pertinent for understanding the case for integration. It gives the background of cognitive behavioural therapy (CBT) and a brief history of how this therapy evolved. It further gives the rationale for the integration of hypnosis with CBT, corroborated with evidence from the literature. CH treatments are documented in some detail in a number of different domains where hypnosis is used as an adjunct to therapy for the treatment of debilitating psychological conditions. The techniques and procedures are designed to desensitise and reprocess dysfunctional cognitions, emotions and memories enabling positive change in cognitive perceptions and visualisation. The author, an academic and experienced clinical practitioner of CH for more than 10 years, recognises that there is much scepticism regarding this therapy. It is hoped that this review will give greater understanding and more credence to this highly effective therapy in both the scientific community and medical profession.

Keywords: cognitive hypnotherapy, hypnosis, unconscious mind, psychodynamic therapy, CBT

1. Introduction

Cognitive hypnotherapy (CH), rooted in cognitive behavioural therapy (CBT) with the addition of hypnosis, focuses on the ways in which individuals think and act in specific circumstances, and how emotional and behavioural problems may be overcome. The fusion of hypnotic techniques with the cognitive and behavioural therapies was proposed in 1994 to strengthen the therapeutic outcome and was termed cognitive hypnotherapy. This offered an addition to therapy by facilitating the resolution of resistant symptoms [1]. CH is a psychodynamic therapy that focuses on the unconscious mind and targets implicit or automated processes (thoughts and feelings) no longer consciously perceived.

The aim of this review is to give greater understanding of CH and its quick-acting and beneficial effects in a number of diverse conditions. A further aim is to give corroborated scientific evidence from the literature of the processes adopted in this assimilative therapy underpinned by documentation of studies in a number of different areas. The objective is to give more credence and understanding of CH in both the scientific and medical domains.

This chapter first asks the question 'what is hypnosis'? and gives an overview from a scientific stand-point of the techniques and protocols of hypnosis that are most pertinent for understanding the case for integration with CBT. It gives a brief review of the background of CBT from its roots in cognitive therapy and behavioural therapy. It further evaluates the nature and efficacy of CBT together with its suitability from a psychological perspective as an appropriate therapy for the addition of hypnosis. The impact and added strength of integrating two disciplines for the maximum therapeutic effect is explored, together with the rationale for integration. Documentation is given of scientific studies in a number of different domains where hypnosis has been used as an adjunct to CBT and the treatment effects of this multi-modal approach. However this chapter concludes with the premise that there appear to be few guidelines for practitioners for an integrative procedure for the treatment of diverse psychological conditions and this needs to be addressed in future research.

2. What is hypnosis?

Hypnosis dates back more than 220 years as an area of scientific research and clinical practice and is used to bring about positive change in a wide variety of conditions. It has been suggested that in a trance-like state, as in hypnosis, a process of communication with the unconscious mind occurs. This results in an unconscious response to suggestion [2] allowing individuals to relax deeply. In fact trance has been described as a natural state of mind that is entered into without realising, as in daydreaming [3]. While in trance the therapist attempts to address the subject's unconscious mind; selective thinking of positive thoughts is established, substituting former judgemental cognitions with helpful ones [4]. Cognitive psychology deals with the meaning of events, the underlying processes and ways of structuring and interpreting experiences. It encompasses affect, perception and behaviour [5]. It is reported that during trance, behaviour may be altered, enabling subjects to re-associate and reorganise inner psychological complexities [2]. Perceptions can be changed and negative cognitions supplanted by positive ideas. The unconscious mind is reprogrammed, allowing the individual in the conscious state the freedom to act and carry out new, positive subjective ideas. In fact, breakthroughs relating to the neurobiology of emotion and the endocrinology of stress are providing new data for conceptualising learning and behaviour as one of the major psychological foundations of therapeutic hypnosis [4].

It has been proposed that hypnosis is based on the affect theory of human emotion and that through the use of specific language they (hypnosis and cognitive therapy) are based on similar ideas of affect [6]. In fact, it is suggested that intransigent symptoms of dysfunctional cognitions and emotions are approached and treated in cognitive therapy through a sequence of interactions similar to hypnosis, as thoughts previously locked to negative affect are processed positively. The literature further suggests that cognitions locked to unpleasant emotions can become disturbingly resistant to change until hypnosis alters the affective perceptions of the individual [6]. It is argued that psychotherapeutic interventions can effect substantial change in the affective, behavioural and cognitive areas of the brain [7]. Hypnosis itself is not a therapy; however it is suggested that when used as an adjunct to therapy the hypnotic relationship enhances the efficacy of the treatment effects [8].

In the current review, Ericksonian Hypnotherapy is critiqued as this technique uses a set of procedures designed to alter the state of consciousness. Ericksonian philosophy emphasises the ability of individuals to access their own resources to

improve the quality of their lives, recontextualising the memory, the effect of fear and physiological hyper-arousal. It has been suggested that during this state the memory and meaning of negative experiences can be changed through emotional processing, as well as decreasing the somatic symptoms of anxiety associated with the event [9–11].

2.1 The techniques and protocols of hypnosis

The following is a brief synopsis of the techniques and protocols of hypnosis with corroboration of these statements taken from the literature:

Hypnosis enhances the effectiveness of therapy and creates the belief of self-efficacy [12]. Evidence from the literature informs us that perceived self-efficacy not only creates a sense of hope but also affects the treatment [13], and that expectation of self-efficacy is central to all forms of therapeutic change [14].

Hypnosis adds leverage to treatment and shortens treatment time [15]. When patients are fully relaxed, positive subjective experiences occur replacing negative cognitions, which appear to bring great comfort and relief [16]. Rapid changes are attributed to the brisk and profound behavioural, emotional, cognitive and physiological changes brought about by hypnosis [17].

Hypnosis breaks resistance when indirect hypnotic suggestions are applied in therapy [18]. Oppositional statements given by the therapist are used to obtain compliance. An example of this would be 'and the more you try to open your eyes the more they remain tightly shut'. The word 'try' pre-disposes failure, so it is used in therapy whenever the opposite is required [18].

Hypnosis facilitates rapid transference, which reinforces the suggestions given in therapy. During hypnosis, there is greater access to fantasies, memories and emotions, allowing the rapid occurrence of full-blown transference manifestations [19]. During the hypnotic state, the critical faculty of the mind is bypassed, enabling the processing of thoughts in the unconscious mind, which are then transferred to the conscious in the waking state [4].

Hypnosis induces deep relaxation, and in this state suggestions can be made that are effective for the reduction of anxiety [10]. A trance is a special psychological state in which patients can re-associate and reorganise their inner psychological complexities. It is argued that during therapy an inner resynthesis of the patient's behaviour is achieved by the patient [4], and further argued that suggestion and post-hypnotic suggestions during therapy emphasise the innate tendency of the mind to heal itself [20].

Hypnosis strengthens the ego by enhancing self-confidence and self-worth [21]. Ego strengthening is a belief that when positive suggestions are repeated sufficiently they become embedded in the unconscious mind to be acted upon in the conscious state [22].

Hypnosis facilitates divergent thinking, maximising awareness, attentional focus and concentration. It minimises distraction and interference from other sources and stimuli increasing the potential for learning alternatives [23]. Corroboration from the literature reports that breaking through the limitations of conscious attitudes frees the unconscious potential for problem-solving [4].

Hypnosis allows engagement of the non-dominant hemisphere in the brain. It provides direct entry into the cognitive processing of the right cerebral hemisphere (in right-handed subjects), which accesses and organises emotional and experiential information. It can be utilised to teach restructuring of cognitive and emotional processes that are influenced by the non-dominant cerebral hemisphere [22]. Many of the sensory-perceptual languages of the mind (visual, auditory and kinaesthetic information) are encoded like a map over the cerebral cortex of the brain [24, 25].

Hypnosis facilitates imagery conditioning. In this state, imagery and cognitive restructuring are intensified. The use of the word 'hypnosis' and the application of various hypnotic techniques appear to augment the power of the suggestion [26]. Evidence from the literature suggests that when the patient is hypnotised, the power of imagination is increased and that possibly hypnosis, imagery and affect are all mediated by the same right cerebral hemisphere [27].

Hypnosis uses post-hypnotic suggestions and is an important part of therapy and is used to shape desired future behaviour; it can be powerful in altering problem behaviours, dysfunctional cognitions and negative emotions [28]. It is reported that post-hypnotic suggestions function as positive ideas for desired future behaviour, and are regarded as a necessary part of the therapeutic process, enabling the patient to act upon the suggestions in future experiences [16].

Hypnosis enhances training in positive self-hypnosis, which provides a strategy for counteracting negative cognitions [29]. It is argued that negative thinking can lead to negative affect, biased thoughts, impaired motivation, concentration and cognition [30]. Positive techniques can be practised during self-hypnosis, thus reinforcing and strengthening hypnotherapy.

Hypnotic techniques are easily exported and can be easily assimilated with many forms of therapy. When hypnosis is used as an adjunct to a particular form of therapy whether behavioural, cognitive or cognitive behavioural therapy, the effects can enhance the treatment outcome [12].

The above techniques and protocols suggest that by adopting hypnosis as an adjunct to therapy addressing the unconscious mind, change can be implemented quickly, is more profound and therapy outcome is enhanced. By adopting this therapeutic procedure, it follows that therapy outcome should be more effective than CBT alone. An overview of the background of CBT is now given together with the rationale for the integration of CBT with hypnosis.

3. The background of CBT

3.1 Cognitive therapy

Cognitive therapy is organised around the idea that behaviour is based on schemas and that these are shaped by early experiences. Schematic thoughts consist of memories, attitudes, core beliefs and assumptions and are factors that, when occurring in certain circumstances, can result in individuals spiralling into negativity and consequential psychological problems [31]. Implicit memories (memories no longer consciously perceived) and explicit negative memories of past experiences can trigger latent patterns of thoughts, emotions and behaviour, resulting in a vicious cycle that maintains and exacerbates the non-helpful behaviour. It is argued that implicit memory is the unconscious remembering of thoughts that accompanied specific events. If negative thoughts have been encoded, implicit feelings are brought into conscious awareness causing both physiological and psychological symptoms [32]. It has been concluded that interventions should focus on problematic over-activation of safety behaviours [33]. This research was extended when the common elements in different anxiety disorders (dysfunctional thinking, physiological reactions, and behavioural responses based on the 'fight or flight syndrome', the body's reaction to unpleasant experiences) were reviewed, and a process map of treatment formulated enabling therapists to adhere to a treatment plan [34].

3.2 Behavioural therapy

Behavioural therapy, in contrast to cognitive therapy, is based on the premise that undesirable behaviours are learned and as such can be 'unlearned' through a process of systematic desensitisation. It is argued that desired behaviours can be taught and reinforced and unwanted behaviours eliminated [35]. Behavioural therapy was expanded when the theory of shaping behaviour by a system of rewards and punishment was first postulated [36]. Behavioural theorists consider that specific phobias and anxiety conditions are acquired through a process of classical conditioning, and that all learned responses derive from innate behavioural patterns, the stimulus/response paradigm [37]. The basis of behavioural therapy encouraged therapists to use techniques aimed at changing the negative affect, introducing positive cognitions through the use of language [38].

While behavioural therapy is based primarily on learning theory and cognitive therapy is rooted more in cognitive theory, the two systems have much in common [39]. Both behavioural and cognitive therapy focus on changing dysfunctional behaviour that occurs in feared situations and both concentrate on positive visual imagery of the environment and situation in which the maladaptive behaviour occurs. Other commonalities are management of physiological and somatic symptoms of anxiety and verbal-assisted coping strategies. However, there are differences in the techniques used in each therapy: the behaviourists concentrate on systematic desensitisation and sequencing of negative images [40], whereas cognitive therapists target the patient's unhelpful reported thoughts [39]. However, the methodologies of behavioural therapists were integrated with cognitive therapies, resulting in a heterogeneous set of techniques and procedures that distinguished between conscious beliefs and unconscious representations in memory [41]. This was a new concept developed from behavioural therapy and became known as cognitive behavioural therapy, resulting in specific cognitive behavioural treatments being developed for a variety of psychological problems [42].

3.3 Cognitive behavioural therapy (CBT)

Since the 1960s, cognitive behavioural theory has gained popularity. CBT uses a combination of behavioural and cognitive interventions aimed at changing negative thinking patterns and behaviours and is one of the most researched psychological interventions [43]. CBT is frequently used in the clinical environment and its practice is evidence-based. It focuses on the way individuals think and act in specific circumstances and how emotional and behavioural problems may be overcome. It adopts a formulation of protocols and procedures that are used to treat psychological conditions, and enables development of flexible realistic beliefs [22]. Individuals are helped in the pursuit of goals, and emotional problems are aided and overcome by directing cognitions towards memories, images, thoughts and attention [42].

Specific patterns of thinking are associated with a range of psychological problems and through its development, CBT has adopted treatments for anxiety conditions and emotional disorders such as depression, generalised anxiety disorder, panic disorder, post-traumatic stress and specific phobias [44]. There are a number of distinctive diktats and protocols that contribute to an effective model of CBT. Various longitudinal formulations have been devised to aid the management and treatment of problems. However, for the purpose of this review, the formulation devised by Persons [45] is used, as this diagram is most usually associated with CBT and bridges the gap between behavioural and cognitive formulations [38]. An adaptation of the diagram illustrates the relationship to the root cause and effect of anxiety.

Persons' Formulation (1989)

Early Experience: Negative experience either from teacher, parents or peers.

↓

Schemas: Become maladjusted and lead to mistrust. Mistrusts ability to do things.

Core Beliefs: Negative cognitions result in anxiety leading to behavioural and physiological problems.

↓

Assumptions: I know I will feel anxious because it always happens and then I will ..... (becomes a self-fulfilling prophecy).

↓

Trigger: Thought of an impending event.

↓

Vicious cycle:

Negative Automatic Thought (NAT): Negative thoughts of dread, apprehension and failure.

↑ ↓

Consequence: The conceptualised belief regarding the event is realised.

Feeling: Hopelessness, worthlessness, depression, shame and withdrawal.

↑ ↓

Behaviour: Decision not to put themselves in that situation again.

Working on the supposition that the way an individual thinks and feels largely determines the outcome of the personal experience, CBT helps to redress negative cognitions. It is reported in the literature that CBT is cognitively orientated to future events, and encourages the association of specific positive thoughts, feelings and behaviour in a particular context [38]. Through changing beliefs and self-help, individuals are encouraged to change negativity into positive outcomes [22]. Goal-orientated ideas and suppositions are reiterated, aimed at strengthening the ego, making strong links through visualisation and imaginings. Corrected thoughts enable the handling of situations and feelings in such a way that a positive outcome is achieved and anxiety reduced [4].

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 failure to consider experiences in the past in relation to the present in generating anxiety; 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 [46]. 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 some cases) [47].

Practitioners of hypnosis often employ techniques used by CBT therapists [48]. However, the protocols and procedures adapted by hypnotherapists explore past and present negative experiences in relation to the presenting problem, together with

the effect of cognitions on physiological and behavioural outcomes [47]. It is argued that the addition of these protocols with the added impact of hypnosis incorporated with CBT is a means of enabling a quicker and stronger resolution to the clinical condition [22]. There now follows a description of the suitability of hypnosis being used as an adjunct to CBT therapy.

4. Assimilating hypnotic techniques with CBT: rationale for integration

4.1 Assimilation

The following is evidence from the literature for the potential assimilative practice of hypnosis with CBT.

It has been suggested that as a result of incorporating techniques from another approach into one's own main theoretical domain, the core ideas of the former are integrated into the latter (or 'host' theory), changing both and resulting in a new assimilative integrative model [49]. Multimodal therapy was first used when hypnotic techniques were incorporated into behavioural procedures, and hypnosis was used with psychoanalysis [13]. There are many reasons for assimilating hypnotic techniques with CBT, which are beneficial to both therapists and patients. Change in any one area will lead to changes in other areas as patient and therapist consider thoughts, bodily feelings, emotions and actions [50]. The use of hypnosis can also be used as a means of empowerment in new and creative ways. Social psychological theories of hypnosis suggest that the major mechanism mediating hypnotic response is the increased motivation elicited by the demand characteristics associated with hypnotic techniques [51]. Participants are more highly motivated to engage in the therapist's requests while in the hypnotic state. Enhancing participants' motivation may be beneficial to a degree; it could be suggested that by addressing the unconscious mind, the process of hypnosis establishes positive cognitions that are then acted upon in the conscious state. This process of communication results in positive imaging, memory recall and suggestions for future stressful idiographic encounters (tools used in hypnotherapy). Muscle relaxation and focused breathing used in the hypnotic induction contribute to the reduction of anxiety.

4.2 The rationale for integration

The rationale for the integration of the two disciplines is given below:

- Hypnosis provides a broad range of techniques that can easily be integrated into CBT. This allows CBT therapists to continue practising within the framework of their training without losing the benefits of effective techniques generated from the area of clinical hypnosis. A review of the strengths and weaknesses of CBT concluded that CBT and hypnotherapy can be combined to form a powerful treatment approach [29].

- The application of a model of cognitive hypnotherapy for various emotional problems and disorders offers a template for the guidance of future therapies and treatment strategies [29].

- The powerful treatment approach gives a quicker resolution of the unwanted condition. Rapid changes are attributed to the brisk and profound behavioural, emotional, cognitive and physiological changes brought on by hypnosis [17].

- The integrative approach offers a much needed theoretical framework, thus guiding practice [49].

- Treatment based on individual case formulation is prescriptive and not haphazard [29].

Having considered the rationale for integration of hypnosis with CBT, the next section provides a short overview of key findings from research of cognitive hypnotherapy treatments.

5. Cognitive hypnotherapy (CH): treatments

A meta-analysis was conducted by critically reviewing 18 studies where a cognitive-behavioural therapy was compared with the same therapy supplemented by hypnosis across a wide variety of targeted disorders. Evidence showed that the addition of hypnosis to CBT enhanced treatment outcome compared to CBT treatment alone. The mean scores of the patients receiving cognitive-behavioural hypnotherapy showed a substantial improvement compared with 70% of the patients receiving only CBT [52].

The use of CBT and hypnotic techniques to enhance treatment effects has occurred in various domains and several studies have demonstrated the effectiveness of the integration.

In the first controlled treatment study using hypnosis as an adjunct to CBT for acute stress, it was found that CBT + hypnosis resulted in a greater reduction in stress than CBT alone, which was still evident at a 6-month follow-up. However, the researchers reported that a limitation of the study was the lack of specific guidelines regarding the mechanisms that potentially mediate hypnosis in the context of CBT and this could have weakened the procedure as the guidelines were unclear [9].

Evidence for the added effect of combining hypnosis with CBT in the management of chronic depression was provided in a seminal investigation [29]. It was found that hypnosis enhanced the overall beneficial effect of the treatment and reduced the number of sessions needed in comparison with CBT treatment alone. This investigation using cognitive hypnotherapy met the criteria laid down by the American Association Task Force and provided validation (for patients' safety) of the integration of hypnosis with CBT in the management of depression [53]. Further information was supplied when evidence-based hypnotherapy was reviewed for the treatment of depression [8].

The potential benefits of hypnotherapy were investigated with 32 patients suffering from chronic combat-related post-traumatic stress disorder (PTSD) [54]. The patients were already being treated with anti-depressants and supportive psychotherapy and were randomised into two groups. Fifteen patients in the first group received Zolpidem 10 milligrams nightly for 14 nights, and 17 patients in the hypnotherapy group were treated by symptom-orientated hypnotherapy, two 1.5-hour sessions each week for 2 weeks. All patients completed the Stanford Hypnotic Susceptibility Scale, Beck Depression Inventory, Impact of Event Scale and Sleep Quality Questionnaire prior to and post-treatment. It was found that there was a significant main effect of condition in the hypnotherapy group on PTSD symptoms as measured on the Post-traumatic Disorder Scale, and this effect was maintained at a 1-month follow-up. No such effects were reported in the non-hypnotherapy group either during the main data collection period or at the 1-month monitoring. The hypnotherapy group experienced additional benefits: decreases in intrusion and avoidance reactions and improvement in all sleep variables assessed. This investigation

demonstrates the beneficial effect of hypnotherapy with positive results achieved in a 2-week period. The methodology is robust as it uses a number of different scales and incorporates a control group. To aid further research in this domain, guidelines and protocols for the integration of hypnosis with CBT in the treatment of PTSD was set up [22].

An investigation into the treatment of headaches and migraines provided an update of the literature first reviewed in 1996 by the National Institute of Health Technology Assessment Panel on the Integration of Behavioural and Relaxation Approaches into the treatment of chronic pain and headaches. It concluded that hypnosis is very effective and virtually free of side effects and adverse reactions and it meets the clinical psychology research criteria for being a well-established treatment. The research further drew attention to the ongoing expense associated with medication treatments [55].

The literature also gives evidence of the beneficial effects of cognitive hypnotherapy in the following domains:

CH was adopted as a therapy for investigations studying irritable-bowel syndrome-induced agoraphobia [56]. The research demonstrated the efficacy of CBT with the integration of hypnosis, and the effectiveness of this multi-modal treatment in aiding the accompanying agoraphobia. A further study into irritable bowel syndrome condition using hypnotic techniques was conducted with eight female patients [57]. This research supported the earlier findings and demonstrated a significant improvement in the quality of life of the patients.

Hypnotic techniques have also been researched regarding common sleep disorders [58]. However, there appears to be little empirical 'sleep research' integrating CBT with hypnosis. Therefore, the goal of this research was to educate clinicians on how to incorporate hypnosis with CBT in the management of sleep disturbance. This will be of value both in this research field and to therapists.

Hypnosis as an adjunct to therapy has been investigated in the management of both Type 1 and Type 2 diabetes [59]. The authors report that hypnotherapy appears to be psychologically beneficial and warrants further investigations. The findings indicate promising results for the stabilisation of blood glucose and decreased peripheral vascular complications. However, it is not reported whether comparisons were made with a control group, where no treatment was given, which would be a limitation of this research. It has been argued as to what constitutes sound methodology [54]; the minimal threshold of 'soundness' suggested is a design that compares a treatment with some form of minimal or non-treatment condition. The above investigation into diabetes however adds to current knowledge and is important in highlighting the effects that psychological aspects exert on recovery of this condition.

Hypnotherapy studies have been conducted in the following domains: pain management in burn patients [60], pain relief during labour and childbirth [61] and mild hypertension [62]. The results of these studies indicate that the psychological treatment through hypnotherapy can be very beneficial; however, the studies appear not to have a control group, which weakens the research.

Investigations have also been conducted in performance anxiety using hypnosis as an adjunct to therapy.

Performance anxiety and treatment outcome were investigated when CBT and CBT with hypnosis were tested for effective treatment of public speaking anxiety. It was found that although both treatments effectively reduced anxiety when performing, the addition of hypnosis to CBT generated expectancies for greater change among participants, which further enhanced treatment effects and produced a faster drop in anxiety levels post-treatment [63]. It was concluded in a review of the empirical status of the use of hypnosis in conjunction with CBT programmes [64]

that existing studies demonstrate substantial benefits by the use of hypnosis as an adjunct to CBT, supporting the meta-analysis conducted in 1995 [52].

A large-scale study was conducted with pianists looking at the effect of hypnotherapy on music performance anxiety (MPA) [65]. Using two groups, it was found that the hypnotherapy group but not the control group showed a significant reduction in MPA post-intervention, which was still evident 6 months later. At that time, there were no definitive protocols and procedure for the adoption of CH as an intervention for MPA but these have now been recently documented, giving guidelines and clear directives for the process of integration in this domain [47].

Recent research was conducted into MPA with 46 advanced pianists where participants were randomly assigned to a cognitive hypnotherapy (CH), eye movement desensitisation and reprocessing (EMDR) or non-treatment group and given two sessions only of the allocated therapy. They were tested in two concert performances pre- and post-intervention. Significant decreases in performance anxiety (the cognitive, physiological and behavioural aspects of performance) were found in both the therapy groups but not in the control group [66]. This research was extended when trait levels of anxiety (an individual's general anxiety level) were tested at 4 months and 1 year post-intervention. Statistical evidence at both monitoring points demonstrated a significant reduction in trait anxiety levels below baseline, showing the effectiveness of both CH and EMDR over time [67].

Nine case studies documenting performance anxiety in different domains have recently been published (five in music, two in the sports arena and two in the workplace) where CH was one of the interventions adopted. The effects of CH were recorded immediately post-intervention and longitudinally, and shown to be beneficial in a short space of time for the reduction of negative, psychological perceptions in a performing situation [68].

The findings from the above studies indicate that the addition of hypnosis to CBT protocols for the treatment of a variety of disorders is an effective remedy. It brings positive change rapidly in cognitive perceptions and physiology which impacts on subjective behaviour. However, there appear to be few guidelines for an integrative procedure and the assimilation of hypnotic techniques for the treatment of diverse medical conditions, and this needs to be addressed in future research.

As hypnosis influences behavioural and psychological responses, it is difficult to assess whether a placebo effect is operative here and, if it is, the extent to which it plays a role. For a number of individuals, hypnosis may act as a placebo due to positive expectations. There is evidence that hypnotic trance inductions are beneficial for those patients who believe in their efficacy [13, 69] and there is further evidence that patients' attitudes and beliefs can have a profound therapeutic effect on both medical and psychological conditions [70]. This effect may be difficult or impossible to control but if it enhances suggestibility and positive therapeutic outcome, then it can be beneficial and add to the impact and strength of the therapy.

6. Conclusion

This chapter has reviewed the evidence and given the rationale for the assimilation of hypnotic techniques with CBT and has documented the effects of CH treatments in a number of different domains. There is a growing body of scientific literature attesting to the fact that hypnosis enhances CBT, and a plethora of research suggesting that combining CBT with hypnosis is effective for a variety of psychological, behavioural and medical disorders. It has been shown that the addition of hypnosis shortens the number of sessions required to effect beneficial, rapid change, which is long-lasting. One-dimensional procedures have their

limitations; however, a multi-modal approach integrating hypnosis and CBT offers an effective alternative. A weakness of CBT therapies is the number of sessions required and there appears to be a paucity of research in the general domain using comparative interventions of CBT with CH [9, 52, 63]. This needs to be addressed in future studies so that comparisons of symptom effects and number of therapy sessions required can be assessed. There is case formulation, including guidelines and protocols, in the domains of PTSD, the management of depression and in music performance anxiety. However, there appears to be little empirical research with case formulation pertaining to the use of CH for the treatment of diverse medical conditions or the management of anxiety per se. An assimilative integrative model that can be understood and undertaken by therapists in the field is required. This will increase and verify the credibility of CH and help both scientific researchers and clinical therapists have a greater understanding of this psychodynamic therapy.

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