Cognitive Behavioural Hypnotherapy for Anxiety: Integrating Evidence-Based Approaches in Counselling Practice

Sadhna Makhija

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Abstract

Anxiety disorders remain one of the most prevalent mental health presentations encountered in Australian counselling and psychotherapy practice. While Cognitive Behavioural Therapy (CBT) carries a strong evidence base, this paper advances the view that hypnosis, integrated thoughtfully within a CBT framework, offers a practical approach to address this problem. Combining these modalities, the paper presents Cognitive Behavioural Hypnotherapy (CBH) as an integrative approach in which brief hypnotic induction is used to reduce physiological arousal and enhance receptivity, creating the neurological and psychological conditions that enhance CBT effectiveness. The paper examines anxiety mechanisms, CBT evidence, hypnosis science, and their integration, drawing on contemporary neuroscience (Barrett, 2017) and on long-standing traditions in clinical hypnosis (Erickson & Rossi, 1979; Bandler & Grinder, 1975) and existential-relational therapy (Yalom, 1980). Two detailed clinical case studies, one involving generalised anxiety disorder with perfectionism and one involving panic disorder with agoraphobia, illustrate how this approach unfolds in practice, with both clients achieving meaningful symptom reduction and improved daily functioning. The framework is grounded in trauma-informed and person-centred values.

Introduction

Mental health professionals working in Australian counselling and psychotherapy have noticed that anxiety disorders dominate the caseload. Anxiety disorders are the most prevalent mental health condition in Australia, with approximately 17.2 per cent of Australians (1 in 6 people) experiencing an anxiety disorder within a 12-month period (Australian Bureau of Statistics [ABS], 2023). Across community mental health settings, private practice, and healthcare clinics alike, anxious clients are the norm rather than the exception. Globally, anxiety disorders affect hundreds of millions of people, with significant consequences for relationships, occupational functioning, physical health, and overall quality of life (Bhattacharya et al., 2023). In the Australian context specifically, this burden is well documented, and the demand for effective, accessible psychological treatment continues to outpace the supply of appropriately skilled practitioners. It is against this backdrop that questions of treatment effectiveness, and treatment reach, become pressing concerns for clinicians, not merely for researchers.

CBT has, rightly, become the psychological treatment of first choice for anxiety disorders. Its evidence base is extensive and remarkably consistent: meta-analyses of randomised controlled trials across generalised anxiety disorder, panic disorder, social anxiety, and specific phobias demonstrate large effect sizes and clinically meaningful outcomes that hold up well at follow-up (Bhattacharya et al., 2023; Furukawa et al., 2024). The CBT model offers a coherent account of how anxiety is maintained, through distorted cognitive appraisal, sympathetic nervous system activation, and behavioural patterns of avoidance and safety-seeking, and targets each of these maintaining factors through structured intervention (Newman et al., 2022). For many clients, this is sufficient. But in clinical practice, “many” is not “all”, and the clients who do not respond fully to standard CBT deserve a different approach and serious attention.

CBT has been proven effective; however, clinicians who work with anxious individuals will observe a significant clinical phenomenon that challenges effective treatment delivery: clients have a greatly diminished capacity to engage with standard CBT strategies precisely when anxiety levels are high (Newman et al., 2022). In my own practice, this emerges as a recognisable and persistent challenge. A client arrives dysregulated, their nervous system already primed for threat. I invite them to examine a thought, to consider an alternative interpretation, to stay with a feeling rather than withdraw from it, and they simply cannot get there. The cognitive machinery that CBT relies upon, reflective thinking, mental flexibility, the capacity to hold uncertainty, is precisely what high anxiety degrades. Elevated arousal shifts neural resources away from the prefrontal cortex, the seat of rational deliberation, and toward the limbic threat-detection systems that are working exactly as evolution intended (Pappaianni et al., 2020; Grecucci et al., 2020). The result is a client who is physiologically and cognitively unavailable for the intervention that would help them most. This is not a failure of the client, nor a failure of CBT. It is a mismatch between what the therapy requires and what a highly anxious nervous system can currently offer.

This observation has been consistently noted across clinical contexts. Clinicians and researchers have long

Corresponding Author: Sadhna Makhija

Email: sadhna@missionyou.health

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recognised the tension between CBT's cognitive demands and the neurobiological reality of high anxiety (Newman et al., 2022; Eysenck et al., 2007). What has been slower to develop is a structured, practitioner-focused framework for addressing it. The integration of hypnosis with CBT is not itself novel: Alladin & Alibhai (2007) and Schoenberger (2000) produced foundational work in this space, and Alladin's cognitive hypnotherapy model represents an important contribution. The broader hypnotherapy tradition, however, has much earlier roots. Milton Erickson's naturalistic and individualised approach to clinical hypnosis (Erickson & Rossi, 1979), and the linguistic modelling of his work by Bandler & Grinder (1975), continue to inform how contemporary practitioners think about indirect suggestion, utilisation of the client's own frame of reference, and the language of induction. What remains underdeveloped is a clinically detailed account of how hypnotic induction can be used strategically to address the state-dependent obstacles that undermine CBT engagement in anxiety, one that is practically grounded, referenced to current neuroscience, and applicable to the specific presentations Australian counsellors and psychotherapists commonly encounter. The growing literature on hypnosis and anxiety (Rosendahl et al., 2024; Palsson et al., 2023) increasingly supports the case for integration, yet clinical implementation guidance lags behind the research. This paper is an attempt to address that gap.

Recent meta-analytic evidence supports what many clinicians with hypnotherapy training have observed first-hand: hypnosis produces meaningful reductions in anxiety symptoms, and when combined with CBT, appears to amplify outcomes beyond what either modality achieves alone (Rosendahl et al., 2024; Palsson et al., 2023). The mechanisms are increasingly well understood. Hypnotic induction reduces sympathetic arousal, narrows attentional focus, enhances imaginative absorption, and appears to reduce the cognitive resistance that can block therapeutic progress, precisely the conditions under which CBT interventions are most likely to land. This paper draws on that evidence base, on contemporary affective neuroscience (Barrett, 2017), and on the author's own clinical experience, to articulate a coherent practitioner framework for Cognitive Behavioural Hypnotherapy (CBH). It begins with the theoretical foundations: anxiety mechanisms, CBT evidence, and the neuroscience of hypnosis, before moving to practical implementation guidance and two extended case studies that illustrate what CBH looks like in the consulting room. The goal is not to replace CBT, which remains the cornerstone of evidence-based anxiety treatment, but to extend its reach to clients whose arousal levels otherwise put its most powerful techniques beyond their grasp.

Theoretical Foundations: Understanding Anxiety, CBT, and Hypnotic Integration

The Neurobiological and Psychological Architecture of Anxiety

Understanding why CBH works requires a reasonably detailed account of what anxiety is and how it persists over time. Contemporary cognitive-behavioural models, supported by decades of psychological and neuroscientific research, describe anxiety as an interaction between cognitive, physiological, and behavioural systems that reinforce one another over time (Pappaianni et al., 2020). At the cognitive level, anxious individuals tend to process ambiguous information through a threat-oriented lens, reading neutral social cues as hostile, interpreting physical sensations as dangerous, and catastrophising about uncertain outcomes. This reflects not irrationality but a highly sensitised threat-detection system doing what it was designed to do, activating more readily and frequently than is adaptive.

Recent affective neuroscience offers an additional and clinically useful layer of understanding. Lisa Feldman Barrett's theory of constructed emotion (Barrett, 2017) reframes anxiety not as a fixed reaction triggered by an external event but as an active construction of the brain, which continuously uses experience and learned concepts to predict and regulate the body's response to incoming sensory information. From this perspective, anxiety arises when the brain's predictive models repeatedly forecast threats and instruct the body to mobilise accordingly, even when the external situation does not warrant it. This view is consistent with, and enriches, the cognitive-behavioural framework: the catastrophic appraisals and physiological cascades described in CBT models can be understood as the experiential output of a brain making threat-biased predictions on the basis of accumulated learning history. The clinical implication is that lasting change requires not only modifying surface cognitions but also providing the nervous system with new predictive evidence, an objective to which both behavioural exposure and hypnotic experience are well suited.

Physiologically, this cognitive-affective construction elicits activation of the sympathetic nervous system – the fight-flight-freeze response – producing the physical signatures of anxiety that clients describe so vividly in session: racing heart, constricted breathing, muscle tension, sweating, and the surge of cortisol and adrenaline that prepares the body for action (Grecucci et al., 2020; Leo et al., 2024). In the context of an actual physical threat, this cascade is adaptive. In the context of a job interview, a social gathering, or an intrusive thought about the future, it becomes a persistent source of distress not readily alleviated by reassurance.

Avoidance and safety-seeking behaviours provide short-term relief while maintaining distress over time. By never remaining in feared situations long enough to discover that the catastrophe does not arrive, the anxious person never accumulates the disconfirming experience their nervous system needs to revise its threat estimate (Scheveneels et al., 2025). This maintenance cycle, threat appraisal driving arousal driving avoidance driving further sensitisation, is the clinical target that CBT, and CBH, must interrupt.

Evidence-Based CBT: Mechanisms of Action and Treatment Efficacy

CBT addresses all three systems of the anxiety cycle through coordinated, evidence-based intervention (Bhattacharya et al., 2023; Furukawa et al., 2024). Cognitive interventions help clients examine the accuracy and helpfulness of threat-related thinking, identifying cognitive distortions and working toward more balanced appraisals. Behavioural interventions, principally graduated exposure, systematically target avoidance by bringing the client into contact with feared situations while blocking safety behaviours, allowing new, disconfirming learning to consolidate (Craske et al., 2014; Deacon et al., 2013).

Physiological regulation techniques, including progressive muscle relaxation, diaphragmatic breathing, and interoceptive awareness training, address the somatic dimension of anxiety and support the client's capacity to tolerate distress during exposure. The research base for this integrated approach is extensive and consistent; meta-analyses confirm large, clinically meaningful effect sizes across all major anxiety presentations, with gains generally maintained at follow-up (Schaeuffele et al., 2024). CBT, in short, works. The clinical question addressed in this paper is how to proceed when the client's anxiety, in the moment, limits access to the intervention.

The Challenge: State-Dependent Limitations in CBT Engagement

The state-dependent limitation is, in this author's view, the most under-recognised challenge in CBT delivery for anxiety. The problem is neurobiological: when the threat-detection system is activated, the prefrontal cortex, which supports the reflective thinking, cognitive flexibility, and emotional regulation that CBT depends upon, becomes functionally less available (Newman et al., 2022; Pappaianni et al., 2020). Limbic reactivity increases, executive capacity decreases. The client sitting in the session, heart pounding and thoughts racing, is not being resistant or difficult. They are functioning within heightened neurophysiological arousal in which the cognitive and behavioural tools of CBT are least accessible. Asking a highly activated person to examine their thoughts from multiple perspectives, or to deliberately approach what they have been avoiding, is asking a great deal of a nervous system that is currently organised around survival rather than reflection (Grecucci et al., 2020). This is not a critique of CBT as a modality; it is an argument for creating the clinical conditions that enable its mechanisms to be effectively accessed and applied.

Hypnosis: Contemporary Scientific Understanding and Therapeutic Mechanisms

It is necessary to address explicitly the common misconceptions surrounding hypnosis, as these can interfere with therapeutic engagement. Clients frequently present with impressions shaped by stage shows or film portrayals: hypnosis as mind control, as unconsciousness, or as an externally imposed process in which the individual assumes a passive role. The scientific picture is entirely different. Contemporary neuroscience and psychology understand hypnosis as a state of focused concentration, heightened inner awareness, and increased receptiveness to therapeutic suggestion (Rosendahl et al., 2024). The person remains fully conscious, retains their values and volition, and cannot be made to act against their will (Leo et al., 2024). What changes is the quality of attention, the accessibility of imagery, and the degree of physiological calm, changes that are, from a clinical perspective, of considerable therapeutic utility.

The contemporary clinical use of hypnosis owes much to the legacy of Milton Erickson, whose naturalistic and individualised approach reshaped the field in the second half of the twentieth century. Erickson (Erickson & Rossi, 1979) demonstrated that effective hypnotic communication does not require formal, ritualised induction; rather, it works through what he termed utilisation, the therapist's responsiveness to the client's own language, imagery, beliefs, and pacing. Bandler and Grinder (1975), in their detailed linguistic modelling of Erickson's work, codified many of the indirect suggestion and pacing-and-leading techniques that continue to inform contemporary hypnotic communication. These traditions remain clinically relevant: they provide a flexible vocabulary for inductions that can be tailored to individual presentations rather than applied as fixed scripts, and they fit naturally within an integrative, person-centred frame.

Neuroimaging research has begun to map the neural correlates of hypnosis. Functional MRI studies show altered activation across networks governing attention, emotional regulation, self-referential processing, and sensory integration (Hanson et al., 2024). These changes are consistent with what clinicians observe: a person in a hypnotic state is more focused, less distracted by internal chatter, more able to engage with guided imagery, and generally less defended against new cognitive and emotional material.

The therapeutic mechanisms of hypnosis are increasingly well supported empirically (Zimmer et al., 2025). Hypnotic induction activates parasympathetic pathways, reducing sympathetic arousal and producing the physiological calm that is so difficult to achieve through instruction alone. It narrows attentional focus in a way that reduces rumination and enhances absorption in present-moment experience. It facilitates vivid imaginative engagement, a capacity that is central to many CBT techniques, including imaginal exposure and cognitive defusion work. It also appears to reduce the critical, evaluative resistance that can prevent clients from engaging openly with therapeutic material, and emerging evidence suggests a role in memory reconsolidation that may support lasting change (Farris et al., 2025). Each of these effects corresponds to a key constraint that limits the effective delivery of CBT interventions in anxious populations.

Rationale for Integration: Creating Optimal Conditions for Therapeutic Change

The integration rationale is conceptually straightforward. Hypnotic induction addresses the state-dependent barriers that undermine CBT engagement. It temporarily shifts the client from a high-arousal, threat-oriented neurological state to one of relative calm, focused attention, and cognitive openness, a state in which CBT techniques can be received and processed more fully (Guth et al., 2025). Hypnosis, in this model, is not an alternative to CBT and not a competitor. It is a preparatory and enhancing modality that creates the internal conditions under which CBT is most likely to work. The sequencing matters: induction first, then intervention. The calm that hypnosis produces is not the end point; it is the starting point for the cognitive and behavioural work that follows (Scheveneels et al., 2025). This is a genuinely integrative model in which both components contribute meaningfully.

A Comprehensive Practitioner Framework for Cognitive Behavioural Hypnotherapy

Assessment, Formulation, and Treatment Planning

Effective CBH is predicated on thorough assessment, and in my experience the assessment phase for this kind of integrated work needs to accomplish more than a standard CBT intake to adequately inform intervention planning. Beyond mapping the usual terrain (specific anxiety triggers, maintaining cognitions, physiological symptoms, and behavioural patterns), the clinician must also develop an understanding of the client's relationship with internal experience, including thoughts, emotions, and bodily states. How readily can this person access imagery? Can they tolerate sustained inward attention, or do they become more anxious when focus turns to their own body and mind? Is there a history of trauma that warrants particular care around induction approaches? How do they respond to suggestion, to metaphor, to slowing down? These questions matter because hypnotic work is not one-size-fits-all, and the induction and imagery approaches chosen should be tailored to the individual formulation rather than applied generically (Craske et al., 2014; Deacon et al., 2013). It is also important at this stage to screen carefully for contraindications: active psychosis, certain dissociative presentations, and some trauma histories may require stabilisation before any hypnotic work is appropriate. The assessment is not merely a data-gathering exercise; it provides the conceptual and clinical foundation upon which the entire treatment rationale is developed and justified.

Psychoeducation, Informed Consent, and Building Therapeutic Alliance

Before introducing any hypnotic intervention, the clinician must engage in comprehensive psychoeducation, extending beyond a brief disclaimer to a collaborative and clinically meaningful conversation. In my practice, this phase typically occupies the majority of the second session. Clients present with a broad range of prior associations with hypnosis, including curiosity, scepticism, and, in a significant proportion of cases, anxiety-related concerns about loss of control or coercion. All these reactions are understandable and should be explored directly within the therapeutic context. Hypnosis is introduced as a state of focused and relaxed attention, comparable to naturally occurring experiences of absorption, such as deep engagement in reading or travelling a familiar route with minimal conscious awareness.

This conversation also does something important beyond information transfer: it models the collaborative, transparent therapeutic relationship that CBH depends on (Palsson et al., 2023). It reflects what Yalom (1980) described as the indispensable conditions of effective therapy, a genuine encounter, transparency about process, and the freedom of the client to engage authentically with what is offered. Informed consent should be thorough and revisited, not treated as a one-time formality. When clients feel genuinely informed and genuinely free to choose, their engagement with the hypnotic work is qualitatively different: more open, more absorbed, and more therapeutically productive.

Hypnotic Induction Techniques Adapted to Anxiety Presentations

Hypnotic induction is the process by which a person is guided from their usual waking state into a state of focused attention and absorption (Hanson et al., 2024). In CBH, inductions tend to be brief (typically 3–8 minutes), structured according to a clearly articulated protocol, and tailored to the client's specific anxiety presentation. The core features of effective induction include focused attention, progressive deepening, somatic settling, and state anchoring. Drawing on Ericksonian principles of utilisation, inductions can incorporate the client's own metaphors, sensory preferences, and natural pacing, rather than imposing a generic script (Erickson & Rossi, 1979; Bandler & Grinder, 1975). Inductions are then further adapted to the particular presentation of anxiety (Zimmer et al., 2025; Farris et al., 2025). For clients presenting with generalised anxiety disorder, inductions typically emphasise mental quietening and the experience of psychological stillness. In panic disorder, inductions are structured to reframe bodily sensations within a context of safety and non-threatening interpretation. In social anxiety, where the focus is typically external evaluation, inductions emphasise inner stability, self-confidence, and alignment with the self (Guth et al., 2025).

Integration of Hypnosis with Cognitive, Behavioural, and Imagery Interventions

Once a client is in a settled hypnotic state, the accessibility and efficacy of CBT techniques become substantially enhanced, facilitating deeper engagement with the therapeutic process. Cognitive restructuring, which can be laboured and intellectualised in standard CBT sessions, often deepens considerably under hypnosis (Schaeuffele et al., 2024). The reduction in critical resistance allows clients to approach feared thoughts with more curiosity and less defensiveness, and the enhanced imagery capacity makes defusion techniques, such as visualising thoughts as objects, clouds, or passing events rather than facts, vivid and experientially meaningful rather than merely conceptual (Leo et al., 2024). Clients often notice that, under hypnosis, their thoughts feel less compelling and more like passing mental events. This is the same shift cognitive therapy works towards, and hypnosis can sometimes help it emerge more naturally and effortlessly. For behavioural interventions, hypnotic mental rehearsal is a particularly useful bridging technique (Craske et al., 2014; Deacon et al., 2013). Guiding a client to vividly imagine approaching a feared situation, not avoiding it, not escaping it, but staying with it and discovering that it is survivable, can substantially lower the activation threshold for real-world exposure. For highly avoidant clients where even the first step of an exposure hierarchy feels out of reach, imaginal rehearsal under hypnosis often creates an entry point. It is not a replacement for actual exposure, but a means of preparing for it.

Clinical Application: Comprehensive Case Studies Illustrating CBH in Practice

Case 1: Generalised Anxiety Disorder with Perfectionistic Traits

Sarah (a composite, de-identified presentation) was a 36-year-old professional who arrived in counselling describing 12 years of anxiety she had largely managed to conceal from the people around her. Sarah said, "I worry most of the day, especially about work and making mistakes. I am always tense, not sleeping well, and get headaches." Her concerns centred on work performance, fear of making errors, and a pervasive worry about future outcomes she could not control. She estimated spending six to eight hours of most days in active, intrusive worry. Physically, she was chronically tense; she noted that she could not remember the last time her shoulders had felt relaxed, and her sleep had deteriorated significantly over the preceding two years. Tension headaches occurred several times a week. She held high perfectionist standards, applied them relentlessly, and was harshly self-critical when she perceived herself as falling short.

The CBH formulation identified a number of interlocking maintaining factors. Catastrophic thinking was prominent; she reliably overestimated the probability and severity of negative outcomes while underestimating her own capacity to cope. Intolerance of uncertainty drove compulsive planning, list-making, and checking behaviours that provided momentary relief but kept the anxiety alive. Physiological hyperarousal was chronic rather than episodic, which further narrowed her cognitive flexibility and kept her nervous system primed for threat (Newman et al., 2022; Eysenck et al., 2007). Perhaps most importantly, worry itself functioned as a form of cognitive avoidance: staying in her head, analysing and planning, meant she never had to fully contact the underlying emotional experience she was afraid of. Viewed through Barrett's (2017) constructed-emotion lens, Sarah's nervous system had spent years building and rehearsing predictive models in which uncertainty equalled danger and effortful control equalled safety; her chronic arousal was the lawful output of those models, not a malfunction. All of this pointed toward a central CBH challenge: when her anxiety was elevated, she became cognitively rigid in precisely the ways that made standard CBT techniques (perspective-taking, hypothesis-testing, defusion) difficult to use. The hypnotic work needed to address that first.

Treatment was delivered across 10 weekly sessions. The initial sessions involved comprehensive assessment, thorough psychoeducation about the anxiety maintenance cycle, and an introduction to CBT and the rationale for combining it with hypnosis. Hypnotic induction was introduced in Session 3, using

a breathing-based relaxation and mental quietening protocol lasting approximately four minutes. The client was guided to follow her breath becoming slower and deeper, to notice her shoulders dropping away from her ears as tension released, and to allow her mind to become quieter and clearer with each breath. Following the induction, the client expressed surprise: "My mind felt silent. That is what I have wanted for so long. My brain hasn't been quiet in years." Hypnotically enhanced cognitive restructuring was conducted in Sessions 4 and 5.

Significant improvements were observed at the conclusion of treatment (Session 10). Self-reported worry, measured on a 0–10 scale, dropped to 2–3/10 from an 8/10 baseline. Time spent worrying was reduced to approximately 20–30 minutes per day from six to eight hours, accompanied by an increased capacity to notice the worry process, disengage from it, and reorient attention to the present moment, alongside greater self-compassion. Sleep initiation improved considerably. Muscle tension throughout the day reduced significantly. Cognitively, the client demonstrated an improved capacity to consider alternative perspectives on threat predictions and reported substantially reduced belief in catastrophic outcomes. Sarah particularly valued the hypnotic exercises, noting that when she visualised her thoughts at a psychological distance, they seemed less real and less true. These gains were largely maintained at three-month follow-up (Alladin & Alibhai, 2007; Schoenberger, 2000).

Case 2: Panic Disorder with Agoraphobia and Safety Avoidance

James (a composite, de-identified presentation), a 41-year-old male, presented for counselling six months after an unexpected panic attack while driving on a highway during heavy traffic. James described it as his first panic attack: severe chest tightness, breathlessness, dizziness, heart palpitations, and a wave of terror that he believed signalled he was about to die. What followed was, in retrospect, a textbook panic disorder trajectory. Catastrophic interpretation of the original sensations led to anticipatory anxiety about recurrence, which in turn drove a steadily expanding pattern of avoidance. By the time he presented for treatment, he was no longer using freeways, public transport, shopping centres, or restaurants. He had stopped attending social events. He relied on his partner to accompany him most places. The world had contracted sharply around him. He exhibited significant intolerance to internally directed attention, with an inability to sustain eyes-closed, breath-focused awareness for longer than approximately ten seconds.

The formulation was organised around the panic disorder maintenance cycle (Barrera et al., 2014). The initial spontaneous attack had seeded a catastrophic interpretation of physical sensations: his body's normal arousal responses were now read as evidence of impending catastrophe, which triggered further arousal, completing a feedback loop that could escalate to full panic within seconds. Avoidance and safety behaviours provided short-term relief but prevented the disconfirmation his nervous system needed, namely, the direct experience of physiological arousal that did not, in fact, lead to disaster (Wald & Reeve, 2005). He was also profoundly hypervigilant to bodily sensations, scanning internally at a near-constant rate. Read through Barrett's (2017) framework, James's brain had developed strong predictive models in which interoceptive signals reliably forecast catastrophe; the work of therapy was to provide enough new, embodied evidence to revise those predictions. The CBH opportunity here was clear: his relationship to his own body needed to change. Rather than treating interoceptive signals as a threat alarm, he needed to learn to observe them as neutral information. Hypnotic work, which can shift the quality and valence of bodily awareness, offered a direct route into that process (Farris et al., 2025).

Treatment ran across 12 weekly sessions. The first three sessions focused on assessment, thorough psychoeducation about the panic cycle, and breath-focused awareness with eyes open, followed by diaphragmatic breathing training, establishing both a conceptual framework and a basic physiological regulation skill before introducing hypnosis. The decision to delay induction until Session 5 was deliberate: James was already highly vigilant about his bodily sensations, and it was considered important that he first develop a sense of agency and tolerance in relation to his own physiological responses before engaging in sustained internally directed attention. The Session 5 induction was grounded in safe, neutral bodily awareness, a systematic, slow scan through the body using language designed to orient him toward physical sensation simply as sensation, without evaluation or alarm. By the end of the session, a marked shift in his physiological arousal was observed, and a simple physical cue was established to anchor this state for subsequent use. Sessions 6 and 7 introduced interoceptive exposure: deliberately inducing mild, controlled versions of the sensations he feared, within the grounded state produced by hypnotic preparation (Guth et al., 2025). The effect was striking: sensations that had previously triggered immediate panic were met, in this context, with curiosity rather than terror. Sessions 8 through 10 moved to graduated real-world exposure, progressing through a hierarchy constructed collaboratively with James (Scheveneels et al., 2025).

Positive shifts were registered by the twelfth session. By this stage of the therapeutic process, there was a clear reduction in both the frequency and intensity of panic episodes. Whereas previously panic attacks had occurred several times per week, they were now experienced as occasional surges that approached but did not fully escalate into a panic state. These episodes became more noticeable to James as events he could observe in their early formation, rather than experiences that overtook him abruptly.

This shift was accompanied by an increased sense of agency. James demonstrated an emerging capacity to recognise early physiological and cognitive cues and to respond intentionally, engaging strategies to regulate and rein in his internal state. Although anticipatory anxiety regarding the possibility of panic episodes remained present, it no longer held the same level of dominance. Instead, it functioned as a signal prompting action. In response, James would actively engage in movement and apply the techniques that had been collaboratively developed in therapy and made readily accessible within his environment. These externally anchored prompts supported the translation of therapeutic work into in-the-moment regulation, reflecting a transition from reflective coping toward embodied self-regulation.

James had also begun to use public transport gradually, re-engage in social interactions he had been avoiding, and felt much less dependent on his partner for safety and reassurance. Hypervigilance about bodily sensations had reduced significantly; he reported that bodily sensations no longer automatically triggered fear, and that he had learned to observe sensations without catastrophic interpretation. Safety behaviours had significantly diminished. These gains were maintained at three-month follow-up. The surges leading to panic attacks remained rare (Craske et al., 2014; Deacon et al., 2013).

Discussion: Understanding the Clinical Mechanisms and Significance of CBH

The two case studies outlined above illustrate several essential principles: how Cognitive Behavioural Hypnotherapy can address state-dependent barriers to effective CBT engagement, how it can facilitate therapeutic change, and how it can assist clients to achieve meaningful levels of symptom

alleviation and functional recovery (Schaeuffele et al., 2024). The underlying patterns in the two cases are similar. Both involved clients experiencing significant difficulties in adopting basic CBT approaches in moments of high arousal. In both cases, the hypnotic framework produced the regulatory states necessary for more effective therapeutic engagement (Zimmer et al., 2025; Leo et al., 2024).

The use of mental imagery within hypnosis was also clinically valuable in both cases. Hypnotic imagery facilitated the kind of emotionally engaged, durable learning that underpins lasting therapeutic change, the very kind of new predictive evidence that, in Barrett's (2017) terms, the brain requires in order to revise its threat-biased models. CBH offers practical advantages to practitioners as well. Hypnotic inductions are brief and time-efficient, typically accomplished within 3–8 minutes of a standard 50-minute session, which makes CBH applicable to real-world practice contexts. CBH does not require practitioners to abandon their existing approach; rather, it is designed to be complementary to established CBT protocols (Hanson et al., 2024). The approach is also consistent with trauma-informed and person-centred values, with its emphasis on client autonomy, genuine collaboration, and informed choice, an emphasis that resonates with the existential-relational concerns articulated by Yalom (1980) regarding the centrality of the therapeutic encounter itself.

Important Limitations, Considerations, and Research Directions

It would be misleading to characterise CBH as a universally applicable intervention, and intellectual integrity requires naming its limitations clearly. Not every client will be a candidate for hypnotic work. Some may present with strong cultural or personal reservations, while others may experience increased physiological arousal when attention is directed inwards, particularly in the early stages of treatment. In these instances, a more gradual integration supported by extended preparatory work may enhance tolerance and facilitate engagement. Where hypnotic work is not suitable, CBT alone remains a highly effective approach and the right one to prioritise (Bhattacharya et al., 2023; Furukawa et al., 2024). Hypnosis should always be offered as one option within a collaborative treatment plan, never positioned as something the client must accept. Trauma history requires particular care; some clients will need substantive stabilisation work before sustained inwardly focused attention is appropriate and safe. The randomised controlled trial literature on CBH specifically, while promising, is thinner than the literature for CBT alone, and the case studies in this paper are illustrative rather than probative (Rosendahl et al., 2024). Larger, methodologically rigorous trials with standardised outcome measures are needed. Finally, this approach cannot be implemented responsibly without proper training in both CBT and hypnotherapy. Neither modality should be attempted on the basis of superficial familiarity; each requires substantive competency, ongoing supervision, and continued professional development.

Ethical Considerations, Professional Standards, and Safe Practice

The ethical framework for CBH practice in Australia is grounded in the codes and standards of the Psychotherapy and Counselling Federation of Australia (PACFA), the Australian Counselling Association (ACA), and the Australian Hypnotherapy Association (AHA). These frameworks articulate the foundational principles that govern this work: client autonomy, informed consent, competent practice, and confidentiality. In the context of hypnotherapy specifically, these principles carry additional weight. Informed consent must be genuinely informed, meaning clients understand what hypnosis is and is not, what the induction involves, what their rights are during the process, and how hypnotic work relates to the broader treatment goals. Psychoeducation is not merely good practice; it is an ethical prerequisite. Equally, the clinician must work within their actual competence. Offering CBH on the basis of a brief introduction to hypnosis, without proper training and supervised practice in both modalities, would be ethically untenable regardless of good intentions. The case vignettes presented in this paper are fully de-identified composite presentations drawn from patterns encountered across clinical practice; no identifying information has been retained.

Conclusion: Advancing Anxiety Treatment Through Thoughtful Integration

Anxiety is not a problem that yields easily. Many clients who present for CBT have already spent years trying to think or reason their way out of their symptoms, only to discover that insight alone does not reliably calm a sensitised nervous system. CBT addresses this more systematically than any other psychological treatment, and its evidence base deserves the respect it has earned (Schaeuffele et al., 2024). But there remains a cohort of clients for whom standard CBT delivery is not enough, not because the model is wrong, but because they arrive in a state that puts its most powerful techniques out of reach.

CBH is this author's response to that clinical reality, developed and refined across years of integrated practice and informed by long-standing traditions in clinical hypnosis (Erickson & Rossi, 1979; Bandler & Grinder, 1975), contemporary affective neuroscience (Barrett, 2017), and the relational-existential commitments articulated by Yalom (1980). It does not ask practitioners to abandon what they already know and do well. It asks them to consider adding a brief, well-evidenced, neurologically coherent preparatory process that may allow their existing CBT skills to land more deeply and durably. The investment required is real: learning hypnotic induction techniques properly, understanding how to adapt them to different anxiety presentations, and integrating them seamlessly into existing case formulations takes time and supervised practice. But the clinical return, in this author's experience, justifies that investment for practitioners who work regularly with anxious clients (Farris et al., 2025).

Anxiety disorders continue to represent a significant public mental health challenge within Australian communities and beyond, with a persistent gap between the level of need and the accessibility of effective care. Cognitive Behavioural Hypnotherapy is not a singular solution to this gap; however, it offers practitioners a meaningful and pragmatic extension of their therapeutic repertoire. Grounded in established principles and supported by emerging evidence, CBH provides a structured yet flexible approach to engaging clients whose anxiety has remained resistant to conventional interventions. In this way it represents not only an additional modality but a clinically useful pathway for reaching those who might otherwise remain underserved.

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