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The following article will enhance your understanding of behavior modification and imagery. It is for information only, as none of this will be on your exam for certification. For the purposes of your training for hypnosis certification, our emphasis is on *imagination training*, *systematic desensitization* and *color imagery*. The highlights are mine. Many of these methods, commonly used in a conscious state, are very challenging or even disturbing. For instance I, personally, never have had the need to apply aversion therapy. The key takeaway is that hypnosis has been proven to greatly improve the results of any method described here. We will discuss this in Lesson 22 and in our Zoom Q&A session.

Just add this to your resources and enjoy at your leisure.

Lynn

**Clinical & Experimental Hypnosis: In Medicine, Dentistry, and Psychology, 2nd Edition**

**31. Learning Theory, Hypnosis, Behavior Modification, and Imagery Conditioning**

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Hypnosis facilitates learning. Pavlov—and later, others—contended that maladaptive behavior and faulty conditioning are learned responses. The process by which such symptoms can be learned or unlearned is subsumed under the rubric of learning theory.1 Behavior modification is a form of therapy in which the basic tenets of learning theory—the elementary principles of how learning occurs—are used to change behavior. Since hypnosis enhances the application of these principles, it can be used most effectively in all behavior modification technics.31

It is most important to make the distinction between “overt” *(in vivo)* and “covert” technics. Overt technics deal directly with the environment, while covert technics rely on imagery. While hypnosis has generally been used only with covert technics, it can also be used “on the spot” in dealing with the actual situations. The following are overt behavioral technics. All have covert analogues, and all can be improved with the aid of hypnosis.

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**OVERT BEHAVIORAL TECHNICS**

**Systematic Desensitization**

Systematic desensitization is the procedure most often associated with behavior modification. At first it was used to treat phobias, and a tremendous amount of research has been devoted to its clinical efficacy. It was once thought that the only conditions which could be successfully treated by behavior modification were phobic reactions. Fortunately, many other technics and disorders are now being given close scrutiny by the behavior modifiers.

The procedure consists of gradually exposing the subject to a situation or object which he fears. Gradual exposure alone, however, is not enough. A response incompatible with fear or anxiety must also be present. An early case was reported by Mary Cover Jones in 1924. A child was afraid of a certain animal. The animal was brought closer and closer to the child while he was eating. Eating was the response incompatible with fear. The exposure had to be gradual lest the anxiety elicited by the feared object override the pleasure derived from eating.

There are four basic states considered to be incompatible with fear or anxiety: hunger, thirst, sexual arousal, and relaxation. Pairing them with a feared object leads to counterconditioning in which the positive feelings cancel out the negative ones. I recall a case in which a young man was so anxious in public urinals that he could not urinate, a condition sometimes known as the “pee-shy” syndrome. Treatment involved his taking a copy of Playboy magazine with him to the urinal and gradually becoming aware of the stimuli associated with the washroom.

Pairing erotic feelings with the washroom cancelled out the negative feelings.

Systematic desensitization involves the construction of a hierarchy. The subject begins with an act which he can accomplish with ease and does things that are progressively more difficult until he accomplishes his goal. A person afflicted with herpetophobia, for example, may begin simply by standing outside the room in which a snake is caged. The steps that follow might be enter the room, gradually approach the cage, place a gloved hand on the outside of the cage, hold the hand above the snake, touch the tail, the middle, the head, and finally lift the snake. The steps must be calibrated by the therapist to create as little anxiety as possible.

The most common form of incompatible response used in desensitization today is relaxation. Before approaching the feared object, the subject is often run through previously taught relaxation exercises, the most common of which is Jacobson's technic of progressive relaxation. However, it has been my experience that hypnosis produces a greater state of relaxation than do any of the other methods for inducing relaxation. Since a subject can perform any act under hypnosis, whether it be walking, writing, or having sexual intercourse, he can also go through a desensitization procedure under hypnosis. After hypnorelaxation has been induced, the subject goes through his hierarchy, gradually approaching the feared object. The hypnotic relaxation counter-conditions the fear that would be produced by the phobic object, and desensitization occurs.

It has been mentioned that desensitization works not only with feared objects, but also with feared situations, such as speaking in public or meeting people socially. Again, a hierarchy is first constructed, leading from the easiest situations to the most difficult. Then while actually in these situations, the patient induces hypnosis and neutralizes his anxiety. Since hypnosis, once it is learned, can be induced rapidly, it is more effective in these situations than is a progressive relaxation technic, which may require as many as 30 minutes to accomplish.

**Sensitization or Aversion Therapy**

While desensitization deals with getting the patient to like or not be afraid of a certain stimulus, sensitization leads to his disliking a stimulus which he presently likes. Aversion therapy has commonly been used for cigarette smoking, alcoholism, obesity, and sexual deviations. Stimuli associated with undesirable behavior are paired with a painful or unpleasant stimulus, such as electric shock or drug-induced nausea. This results in suppression of the undesired behavior. The taste of a cigarette, for example, could be paired with a shock to the forearm so that the chronic smoker would experience anxiety or the anticipation of pain whenever he smelled or tasted a cigarette. This procedure can also be applied while the patient is hypnotized. Conditioning is more rapid under hypnosis, and all extraneous distraction is eliminated.

**Flooding and Implosion Therapy**

In flooding and implosion therapy, the situation most deeply dreaded by the patient is presented in intense forms without benefit of associated relaxation. Implosion therapy, unlike flooding, is based on several psychodynamic assumptions which are not within the scope of this chapter. Theoretically, the anxiety elicited by these technics is finally extinguished by the absence of the patient's usual reinforcement: escape avoidance. Experience of anxiety in the absence of any real aversive consequences leads to extinction. A person may be in a hypnotic state without experiencing relaxation. Hypnosis can be used to strengthen any feeling, including intense anxiety, which is necessary for flooding and implosion.

**Massed or Negative Practice**

Massed or negative practice seeks to extinguish a habit by repetitious and exhausting maneuvers. A person, for example, who blushes excessively whenever he hears words with a homosexual connotation may be asked to repeat these words over and over again. The technic has been used most frequently in the treatment of tics. The same procedure may be applied while the patient is in hypnosis.

**Role Playing or Behavioral Rehearsal**

The therapist assumes the role of significant persons in the patient's life. A series of increasingly exacting scenes is enacted within the protective confines of the therapist's office. The therapist then gives the patient feedback as to how he could be more effective in dealing with others to get the responses he desires.

Since the situations to be role-played are often anxiety-provoking for the patient, it may be easier for him to enact the scenes while in a hypnotic state paired with relaxation. This form of behavioral rehearsal while in hypnosis leaves an indelible imprint as to the appropriate means of interaction to be recreated later in the actual situation.

**Assertive Training**

Patients are taught to give appropriate and direct expression of ongoing feelings, both positive and negative. People who habitually fail to stand up for their rights as well as those who typically overreact with rage to real or imagined slights from others are appropriate candidates for assertive training.

Hypnosis should be used in the actual situations where assertive training is necessary. If the individual is shy and passive in social situations, the hypnosis will counter his fears. He will use hypnosis to induce relaxation. He cannot be afraid and relaxed at the same time. If, on the other hand, he is overly aggressive because of feelings of rage in social situations, the relaxation will counter this response as well. He cannot be angry and relaxed at the same time.

**Modeling, Imitation, or Observational Learning**

Virtually all learning phenomena resulting from direct experiences can occur on a vicarious basis through observation of other persons' behavior and its consequences to them. The patient will imitate behavior which he sees rewarded and refrain from behavior which he sees is punished. Fear and avoidance behavior are extinguished vicariously through observation of modeled approach behavior toward feared objects without any adverse consequences accruing to the performer.

An impression made in hypnosis is more durable than one made at a nonhypnotic level. There is no “noise” in the channel to corrupt the signal. Witnessing a model performance while the subject is under hypnosis produces a more lasting impression.

**Token Economies and Operant Principles**

All behavior can be changed or shaped by the appropriate system of reward and punishment. Token economies, work-payment incentive systems, have been used effectively to modify the behavior of institutionalized patients. Much of the research in the field of experimental psychology deals with the most effective ways of applying reward and punishment to influence behavior by means of schedules of reinforcement.

Positive reinforcement is used to develop and maintain appropriate behavior. (“I'll give you an apple if you stop shooting spit balls.”) Punishment is used to discourage inappropriate behavior. (“If you shoot another spit ball, I'll slap your face.”) Withholding positive reinforcement can be used to decrease the frequency of inappropriate behavior. (“If you shoot another spit ball, I'll take away your allowance.”) Removal of punishment can be used to increase the frequency of appropriate behavior. (“You can come out of the corner if you promise not to shoot any more spit balls.”) It is by various combinations of rewards and punishments that learning takes place. And again, the lesson is more complete if learned while in a hypnotic state.

**COVERT BEHAVIORAL TECHNICS**

All covert technics involve imagery. An image is defined as “a mental representation of an actual object.” The stronger the image, the more it approximates the actual object and the more it will generalize to “reality.” The remarkable thing about the image is that it is capable of producing the same response as the actual object. For example, hypnotically imagining a lemon will produce salivation. Imagining holding your hand in a bucket of ice will produce numbness. Imagining holding your hand over fire can actually produce a rise in temperature of the hand. The implications are monumental. However, for our purposes here, we will limit this discussion to how the power of imagery influences hypnotic and behavioral therapy.

Cautela based his work on the assumption that a stimulus presented in imagination can affect overt and covert behavior in a manner similar to a stimulus presented externally.11, 12, 13, 14 He developed a number of behavior modification procedures which require the manipulation of imaginal stimuli and responses in ways analogous to the manipulation of overt stimuli and responses. It will be seen from the description below that what this involves is the imagining, rather than the experiencing, of the behavioral technics described above.

**Covert Desensitization**

Wolpe is usually given credit for developing the desensitization technic.39 In covert desensitization the patient imagines going though the carefully constructed fear hierarchy while in a relaxed state, rather than actually going through it. The patient is asked to signal by lifting his finger if the specific scenes prove disturbing. When this occurs, they are immediately withdrawn and the relaxation is deepened. The distressing scene is presented repeatedly in small doses until the patient can picture it without experiencing anxiety.

Hypnosis is used in conjunction with the covert behavioral technics for the same reasons delineated in the description of the overt technics. However, in the case of the covert technics, hypnosis provides one tremendous additional advantage—it greatly facilitates the production of imagery. All current research bears out that the stronger the image, the more effective are the covert technics, and the more they generalize to reality. If a subject can only vaguely imagine approaching a snake without fear, it is doubtful that he will be able to approach a reptile in reality. However, if his image of approaching the snake is very real, it is quite probable that he will be able approach it in reality. The stronger the fantasy, the greater the probability that it will generalize to reality. A general rule in hypnotic therapy is always to have the subject imagine doing in hypnosis what he would like to be doing in reality.

Deiker and Pollock integrated Erickson's hypnotic “pseudo-orientation” technique into a covert desensitization technic in the treatment of a beach phobic.18,19 The female patient was told during hypnosis to picture herself a week in the future coming out of the therapy room after her final desensitization session without her former fears. This technic was responsible for a shorter treatment time and further corroborates the possibility that extinction can take place in fantasy (i.e., covert extinction).

**Covert Sensitization (Aversion Therapy)**

Covert sensitization was first described in detail by Cautela.10,11 The patient is to imagine a scene in which he is committing the act he wishes to eliminate. The imaginal performance of this act is paired with negative experiences which serve to decrease the frequency of the undesired behavior.

An overweight person, for example, may wish to stop eating chocolates. He imagines a plate of chocolates before him, picturing them vividly. He must experience the situation with all five senses. Hearing the noises in the room, seeing and smelling the chocolates, feeling them when he picks them up. As soon as he tastes the chocolates, he imagines a sense of nausea coming over him. He throws up all over the chocolates. The rancid smell of puke and vomit mix with the sight of chocolates. The image may go on for several minutes, pairing the aversive vomit with the chocolates. This is a sensitization or aversion procedure.

If the patient imagines actually eating the chocolate first and then throwing up, it is a punishment procedure. Here again the image must be clear and the results made as repugnant as possible. As soon as the patient imagines himself to be freed of the sight, taste, and smell of the chocolate, he is to feel better.

Evidence from the behavioral literature indicates covert sensitization to be effective in reducing maladaptive approach behaviors such as smoking,37 alcoholism4 and sexual deviation.8,15,17 Hypnotherapists have also commonly used similar procedures in treating maladaptive approach behaviors including alcoholism,20,29,38 obesity,30 face picking,22 and nail biting.36

**Covert Flooding and Implosion Therapy**

In covert flooding and implosion therapy, the situation most deeply dreaded by the patient is imagined in intense forms. If he has a fear of snakes, he images being covered by them, in a pit of hissing reptiles, with no escape. Theoretically, when he experiences no actual aversive consequences, his anxiety should be extinguished. Flooding techniques are open to much controversy, however, and can produce a stronger phobic response if not adequately handled.

**Covert Massed or Negative Practice**

In covert massed or negative practice, a person imagines repeating a habit over and over until it is exhausted. The covert technic is preferred in cases where repeating the habit in a reality could lead to some form of damage. Such is the case in bruxism, where forcefully grinding the teeth as many as a thousand times in succession could cause harm.

**Covert Modeling**

As mentioned earlier, modeling is a procedure in which a client is exposed to someone else (a model) who engages in the behavior the client wishes to develop. Typically, live or filmed models are employed.7 However, Bandura has observed that modeling is not defined by the mode in which modeling stimuli are presented, but rather by the symbolic and representational processes which code the modeled material and subsequently guide behavior.6 Cautela has suggested that representational processes can be altered “directly” by having subjects imagine a model engaging in various behaviors.15 This idea has received further support from other researchers.16, 25 Modeling based on imagery (i.e., covert modeling) does alter behavior.

Kazdin further developed the parameters involved in covert modeling.26 He found that subjects (in this case herpetophobics) who imagined multiple models, as opposed to a single model, showed greater avoidance reduction. Subjects who imagined a single snake and those who imagined different snakes showed no difference in avoidance.

**Covert Assertive Training**

In covert assertive training, patients are told to imagine giving appropriate and direct expression of ongoing feelings. Another form of this technic is to imagine someone else engaging in effective assertive behavior (i.e., covert modeling).28

**Covert Operant Principles**

In employing covert operant principles, the behaviors and the rewards and punishments are imagined rather than actualized. A cigarette smoker may imagine resisting a cigarette and then being rewarded by seeing himself in Tahiti. In recent years this covert positive reinforcement technic has been applied in over two dozen clinical and experimental studies.13 Several of the experimental studies have failed to replicate earlier effects,24,35,40 or have challenged the simple operant conditioning paradigm of covert positive reinforcement.9,32 Bajtelsmit and Gershman confirm the effectiveness of covert positive reinforcement as a treatment procedure, but fail to support the operant conceptualization of covert positive reinforcement.5

In a covert punishment technic, the patient is asked to imagine himself indulging in an undesired behavior such as drinking liquor. Then he imagines throwing up, feeling embarrassed in front of friends, and waking up with a hangover (punishment).

The removal of a positive reinforcer can also be adapted to covert methods, although there is no particular name for it. Here, for example, the smoker can imagine sitting in a beautiful garden which smells sweet and fresh. He then lights up a cigarette, and the sight and smell of the garden are obliterated.

The imagined removal of punishers to increase the frequency of appropriate behavior is called covert negative reinforcement. This technic, developed by Cautela, rewards the patient for an appropriate response by allowing him to escape or terminate a very unpleasant situation.13 The technic is especially useful for patients who claim that there is nothing reinforcing in their lives and are thus not amenable to covert reinforcement. Patients with a fear of heights, for example, may imagine being caught in a flood. Just as they are about to drown, they climb a ladder to a skylight and are saved. Climbing higher thus becomes an activity associated with terminating a very unpleasant situation, whereas before it was itself a frightening event.

The hypnotherapeutic use of covert negative reinforcement was demonstrated by Abraham in the treatment of hysterical paralysis of the legs.1 The hypnotized patient was told to imagine sitting on a beach in uncomfortably cold water and that he could only escape the cold water (negative situation) by lifting his legs out of it.

If the assumptions of covert positive reinforcement are correct, then it follows that when the subject imagines a response (which is being maintained in reality by external reinforcement) without a favorable environmental contingency, then the probability of occurrence of the response should decrease. This procedure has been called covert extinction because it is analogous to the operant extinction paradigm (i.e., withholding the reinforcing stimulus after the emission of the instrumental response).

An example of covert extinction is to have an overweight patient imagine eating his favorite fattening foods without any flavor. The reward (good taste) for eating is absent, and the behavior (eating) should be extinguished. Ascher and Cautela support this procedure and conclude that covert extinction is an effective method in facilitating the course of extinction, whether or not the environment continues to provide reinforcement for the specific response.3

**FURTHER APPLICATIONS OF IMAGERY**

Lawful relationships between autonomic arousal and imagery parameters have not yet emerged from ongoing research. Haney and Euse studied the relationship of skin conductance and heart rate responses to neutral, positive, and negative imagery.21 Both positive and negative imagery produced and sustained high levels of skin conductance over 1 minute. Positive imagery was rated as clearer than negative or neutral imagery.

Success shown in the use of “emotive imagery” procedures suggests that the elicitation of positive affective states by pleasant imagery does serve to counteract phobic reactions.33 Hurley reports a case of a severe bridge and height phobia treated by modified systematic desensitization.23 The patient imagined an irrelevant pleasurable image at the beginning and again at the end of each session. Ten scenes of crossing bridges and mastering heights were used, but not in hierarchical order. It is interesting that a pleasurable image at the beginning and end of each session was effective as the source of anxiety inhibition (muscle relaxation exercises were not needed) and that the fear stimuli were not visualized in hierarchical order.

Positive imagery is a potent force in the treatment of all mental disorders. Thoughts make us ill, and thoughts make us well. As was stated before, the stronger the image, the greater the probability that what we imagine will become or generalize to reality. For concrete verbalizations on how to develop stronger imagery in hypnosis, and a detailed discussion of the hypnobehavioral model, the reader is referred to the work of Kroger and Fezler on imagery conditioning.31

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