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***Commentary on: Paradoxical Intention (PI) Combined With Hypnosis in the Rapid Treatment of Anxiety Disorders: The Cases of "Fran" And "Emily"***

# Paradoxical Intention and Hypnosis for Anxiety Disorders: Cautious Promise and Considerations from a CBT Perspective

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## ABSTRACT

This commentary discusses the case studies of "Fran" and "Emily," treated by Sam Hamburg (2026) with Paradoxical Intention (PI) combined with hypnosis to address panic disorder and agoraphobia in Fran and aviophobia in Emily, with both patients showing a rapid positive response. Hamburg (2026) presents a compelling and novel approach to treating anxiety disorders in just three sessions, a notable departure from traditional CBT protocols that typically require 6–20 sessions to see clinically meaningful change. Drawing on our expertise in third-wave CBT frameworks, including Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT), we highlight strengths of Hamburg's approach while identifying areas that warrant further clarification. We then propose an alternative mechanism of action in Hamburg's treatment with "Fran" and "Emily," with particular emphasis on the inhibitory learning model as a process underlying PI combined with hypnosis. Finally, we underscore the importance of approaching techniques such as PI and hypnosis with both openness and caution in the treatment of anxiety disorders given the limited empirical evidence.

*Key words:* case study; clinical case study; panic disorder; agoraphobia; aviophobia; Cognitive Behavior Therapy (CBT); paradoxical intention; hypnosis; inhibitory learning model; acceptance and commitment therapy

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In his case studies with "Fran" and "Emily," Sam Hamburg (2026) applies paradoxical intention and hypnosis to address the clients' anxiety disorders. In this Commentary we focus on Hamburg's theory and practice with Fran and Emily from the perspective of the functioning of cognitive-behavior therapy (CBT) mechanisms, including the Third-Wave CBT frameworks of Acceptance and Commitment Therapy (ACT) and Dialectical Behavior Therapy (DBT). As a

context for this, it is important to first clarify more recent explanations of the mechanisms underlying exposure therapy, a core component of CBT.

## EVOLVING CONCEPTUALIZATIONS OF THE CBT MECHANISMS OF ACTION FOR ANXIETY DISORDERS

There have been significant developments in how the process of exposure is understood within the last 20 years, and while the intervention and impact remain the same, the proposed mechanisms fundamentally differ. Specifically, explanations of how exposure works have moved away from the earlier desensitization-focused models such as Wolpe's (1958) reciprocal inhibition and Foa & Kozak's (1986) Emotional Processing Therapy (EPT) to a model based on inhibitory learning (Craske et al., 2008). This change reflects a critical shift from viewing exposure therapy functioning to erase or modify a fear memory and instead creating a new, competing safety memory. This theoretical shift will be important to review, as many of the statements made by Hamburg (2026) seem to relate to the desensitization model, rather than this more recent inhibitory learning model.

The desensitization model was originally developed in 1958 by Joseph Wolpe, who proposed reciprocal inhibition, in which relaxation techniques inhibited anxiety, stating "a response antagonistic to anxiety…occur in the presence of anxiety-evoking stimuli," typically pairing physical relaxation techniques (e.g., deep breathing) with graded exposure" (Wolpe, 1958, p. 71). Within this early model, repeated exposure to a stimulus was hypothesized to have an attenuating effect, with heightened sensitivity to distressing stimuli diminishing and ultimately subsiding through the process of habituation. This early theory was later disproven by research finding that the relaxation component was not the essential ingredient in exposure therapy, and that exposure alone led to notable fear reduction (e.g., Rachman, 1968).

In the 1980s, amidst the "cognitive revolution" in psychology, Edna Foa and Michael Kozak proposed Emotional Processing Theory (EPT), which built on behavior therapy for phobias (e.g., Pavlov, 1927; Wolpe 1958,) and cognitive psychology and memory network theory (e.g., Lang, 1979; Foa & Kozak, 1986). EPT posited that exposure worked by modifying the underlying pathological fear structure, a mental framework for reacting to threat that includes the feared stimulus, anxious response, and cognitive appraisal of the stimulus and the anxious response. According to EPT, effective exposure involves activating the fear structure and then incorporating incompatible information (i.e., the feared outcome doesn't occur) that replaces the maladaptive fear association, with habitation both within and between therapy sessions serving as the primary evidence of this corrective emotional processing (Foa & Kozak, 1986). This explanation of the mechanism of change in exposure therapy has recently been called into question, as research has shown that fear reduction within sessions does not always predict long-

term gains, and, instead, between-session decreases in fear and variability in exposure contexts are better indicators of long-term change (Craske et al., 2008).

It is important to note that both the desensitization model and emotional processing theory propose that the fear structure itself is directly modified through the process of exposure. In desensitization, repeated exposure and relaxation processes gradually reduce the intensity of anxiety--much like how water running through a riverbed will eventually smooth the jagged rocks beneath. Emotional processing theory suggests a somewhat different mechanism, in which incompatible information is incrementally introduced until the fear structure is no longer experienced as distressing. Metaphorically, this is akin to adding smooth stones to the uneven riverbed over time, eventually allowing it to be crossed without discomfort.

In the early 2000s, the Inhibitory Learning Model (ILM) framework, primarily advanced by Craske and colleagues (e.g., Craske et al., 2008), was developed in response to the limitations and inconsistent findings of the desensitization and emotional processing models. The ILM represents a fundamental paradigm shift in exposure therapy, suggesting that the heightened fear sensitivity associated with conditioned stimuli is never fully eliminated (as suggested by previous models of exposure), but instead the original fear memory remains intact and coexists with a newly learned, non-threatening association. Rather than focusing on reducing fear during exposure (habituation), ILM focuses on creating and strengthening new safety learning that inhibits the retrieval of old fear association. Within this model, the goal is to maximize the strength and flexibility of the new learning regardless of fear level, where exposures are intentionally varied and unpredictable. Expectancy violation (e.g., "The things I feared didn't happen" or "I felt anxious and I could handle it") is considered the key marker of success. These newly formed safety memories are not replacing the old ones; instead, they compete against the original fear memory, eventually being strengthened to such a point that they become the naturally chosen response to the distressing stimuli.

To return to the river analogy, ILM suggests that the old river and its jagged rocks remain largely untouched. However, through repeated exposure, therapy is gradually carving a new channel alongside the original river. Each time water runs through it, the passage widens and deepens, eventually becoming the natural route for rainfall to travel. The old river, however, is never gone; under severe enough conditions, water will once again rush into the old riverbed and over its jagged rocks—just as individuals who have experienced trauma or severe anxiety retain the capacity for fear and distress to return in the presence of old stimuli, given the right combination of variables.

As the field continued to refine its understanding of how change occurs in anxiety disorders, the emergence of "Third Wave" CBT—particularly Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) and Dialectical Behavior Therapy (DBT; Linehan, 1993)—

further expanded conceptualizations of the development, maintenance, and treatment of emotional suffering. Although these approaches arose in response to distinctly different clinical needs—DBT for individuals with severe emotion dysregulation and life-threatening behaviors, and ACT for individuals struggling with pervasive experiential avoidance and verbal/cognitive rigidity—they converge in a fundamental shift: rather than attempting to directly modify the fear structure (or other emotion structures), both models focus on altering one's relationship to internal experiences (e.g., thoughts, emotions, bodily sensations) to live a more meaningful, values-based life (Hayes et al., 2006; Linehan, 1993).

In ACT, exposure is understood through the lens of psychological flexibility. Instead of attempting to reduce fear or correcting fear-based cognitions, individuals practice approaching previously avoided stimuli while allowing discomfort, disengaging from unhelpful cognitive processes (e.g., through cognitive defusion), and engaging in values-based action.

In parallel, DBT incorporates exposure principles by teaching individuals to more effectively experience intense internal states using mindfulness, emotion regulation, and distress tolerance, rather than relying on maladaptive avoidance strategies such as self-harm and substance use. With time and continued skills practice, individuals develop a greater capacity to approach and remain in contact with difficult internal experiences while responding more adaptively, resulting in increased cognitive and behavioral flexibility and more effective interpersonal functioning (Lynch et al., 2006).

Indeed, these Third Wave models effectively integrate inhibitory learning principles through their emphasis on new learning about one's ability to tolerate challenging internal states while engaging in flexible, adaptive behavioral repertoires across contexts, ultimately aiming to enhance well-being and engagement in values.

## "FRAN"

We will first focus our commentary on Hamburg's case of "Fran" by examining Hamburg's distinction between the theoretical foundations of traditional CBT and those of paradoxical intention. In his discussion of "Fran," a 32-year-old woman with panic disorder and agoraphobia, Hamburg (2026) presents two "diametrically opposed" hypotheses regarding the nature of panic disorders: (1) "panic attacks originate as mental phenomena and produce physical sequelae," and (2) "panic attacks originate as physical phenomena and produce mental sequelae" (Hamburg, 2026, p. 4). According to Hamburg, the first hypothesis he outlines informs the conventional CBT approach to panic disorder, whereas the second informs the paradoxical approach underlying PI.

While Hamburg presents these hypotheses as opposing, we argue that Hypothesis #2 can also support a CBT approach, given that CBT theory, including the CBT triangle of emotion,

conceptualizes mental phenomena (i.e., thoughts and emotions) as bidirectionally influencing physical sensations. In addition, Hamburg stated, "the aim of CBT is to desensitize the person's fear of the bodily changes that signal the onset of a panic attack" (p. 4). This explanation of the mechanism of action of CBT for panic disorder appears to be based on the habituation model, emphasizing the gradual habituation to fear triggers we discussed in the introduction, which is an earlier conceptualization of exposure therapy's mechanism of action (Foa & Kozak, 1986).

Furthermore, in advocating for the PI approach to panic disorder, Hamburg (2026) asked, "Might it not be quicker and easier to treat the individual's fear of the panic attack itself, rather than desensitize the anxiety attached to the physical experiences it produces?" (p. 6) This statement seems to suggest that the CBT approach focuses on exposure to the physical panic symptoms and fails to address the more future focused anxiety and/or dread of having a panic attack. While interoceptive exposures to feared internal cues are certainly a key aspect of CBT protocols for panic disorder, leading CBT treatment manuals for panic disorder also explicitly target patients' fear of panic attacks—typically via psychoeducation; cognitive restructuring or defusion (i.e., gaining distance from one's thoughts by viewing them as just thoughts); and exposure practice that often involves the individual exposing themself to situations that were previously avoided due to fear of triggering a panic attack (e.g., Barlow & Craske, 2007). Thus, we found that Hamburg's overall approach to treating Fran was in alignment with the CBT model, with Hamburg's use of PI as a unique experiential framework to approach exposure work.

Additionally, we appreciated Hamburg (2026)'s psychoeducation related to panic attacks and his rationale for the paradoxical procedure, which we argue could have functioned as a powerful intervention in and of itself. This psychoeducation provided Fran with corrective information about the nature of panic attacks while also orienting her towards a more accepting stance towards her panic symptoms, thereby setting up the experiential practice of acceptance via PI. Although psychoeducation is a common and integral component of most psychological interventions, we found Hamburg's approach to be particularly incisive and artful.

Hamburg (2026)'s emphasis on disrupting control-based strategies in order to paradoxically regain control over anxiety and panic also echoes the ACT process of creative hopelessness. In this process, the therapist helps the client recognize that attempts to control or avoid painful thoughts, feelings, and/or situations may provide short-term relief but ultimately fail to support long-term well-being. Importantly, the therapist achieves this not by persuasion but by experientially guiding the client in becoming hopeless about the idea that continuing to engage in their old, unworkable solutions will lead to the kind of life that they want for themselves. This recognition can inspire patients to creatively explore new ways of approaching what they've historically tried to avoid through acceptance, mindfulness, and values-based action

(Hayes et al., 2012). The psychoeducation that Hamburg provided Fran may have evoked a similar sense of hopelessness, increasing her openness and motivation to try a different, counterintuitive approach to managing Fran's panic attacks–namely, the paradoxical intervention.

Hamburg's (2026) use of PI with Fran can also be understood as a mechanism that aligns with exposure-based learning and acceptance processes. Within the psychoeducation, Hamburg noted: "There are two advantages to staying instead of escaping. The first, of course, is the money. The second is that you leave the scene with a sense of mastery instead of in a state of terror. And so that situation does not end up becoming a cue for future attacks" (p. 11). This rationale closely reflects the Inhibitory Learning Model (ILM), emphasizing new, corrective learning rather than habituation. Hamburg further explained: "Fran exposed herself to situations she thought would stimulate a panic attack, but the panic attacks never happened because they were averted by the paradoxical intention—and so there was nothing for Fran to habituate to. Her exposure sessions are better understood as repeated experiences of safety signals—that the panic was not going to occur—in more and more challenging situations in which she heretofore had expected panic attacks" (p. 22-23). These descriptions suggest that PI may operate according to principles closely aligned with ILM. Rather than altering the fear process itself, PI is creating a new, safer pathway that the mind can subsequently access.

It is important to note that while we argue that the premise of PI seems to be consistent with principles of CBT and exposure, the way it is incorporated into Fran's exposures differs from what is typically done in traditional CBT protocols. The closest parallels we identified within exposure-based treatments come from two sources. First, Hamburg's guidance to deliberately intensify panic symptoms resembles thought disengagement strategies in ACT-focused OCD treatment, where patients agree with and amplify intrusive thoughts to promote cognitive defusion. Just as within ACT exaggerating thoughts can create distance between self and cognition, PI may create distance between the individual and their physiological sensations. Second, the stance encouraged in the CBT theorist Reid Wilson's *Don't Panic: Taking Control of Anxiety Attacks* (2009) reflects a similar paradoxical spirit. Wilson encourages readers to embrace the attitude of: 'I'll become stronger by purposely facing what I am afraid of. It's OK that I'm anxious right now. I can handle these sensations. I can handle this uncertainty. I want this anxiety. I want this uncertainty' (Wilson, 2009, p. 200-201). While the practice of PI is not widely represented in anxiety treatment protocols beyond these few isolated examples, it may be more widely applicable, as it can simultaneously engage the processes of exposure, cognitive defusion, and willingness.

Our final thoughts regarding Fran's case concern Hamburg (2026)'s clinical decision-making in using hypnosis as a "booster" for Fran's treatment. Hamburg does not provide an

explicit rationale for implementing hypnosis rather than why additional PI sessions were not selected as the booster. This raises the question about what specific advantages hypnosis offers in this context compared with more exposure-based strategies and warrants further clarification. Another important consideration is that the messaging in the relaxation-focused hypnosis recordings Hamburg made for Fran appears to contradict the underlying message of PI. While PI encourages embracing uncomfortable anxiety sensations rather than attempting to control them, in the recording Hamburg suggested that Fran focus on relaxation, which could have inadvertently shifted the focus back toward attaining control of one's internal state to feel less anxious and more relaxed. This raises the question of whether the combination of the PI and the hypnosis recordings, as presented, were truly complementary or potentially at odds.

## "EMILY"

Turning to the case of Emily, a 54-year-old woman with aviophobia, we find Hamburg's (2026) characterization of CBT approaches somewhat incomplete, similar to his framing of CBT for panic disorder in Fran's case. Hamburg (2026) stated, "CBT approaches to aviophobia have focused not on the dread of an upcoming flight but on desensitizing the fear of the experience of flying itself; the reasonable assumption being that if clients had an easier time in the airplane, their dread would diminish accordingly" (p. 15). We disagree with this framing. In well-conducted CBT, treatment targets not only in-flight anxiety symptoms but also the anticipatory dread leading up to the flight, which often manifests as worry and rumination about the feared experience (e.g., Antony, Craske, & Barlow, 2006; Craske & Barlow, 2022). In traditional CBT, this anticipatory dread may be targeted through cognitive modification and exposure-based learning; in ACT, it may similarly involve exposure-based learning along with the above-mentioned cognitive defusion; and in both ACT and DBT, it may include cultivating mindfulness and non-distraction-based coping skills to foster acceptance of anxiety and reduce emotion-driven avoidance.

Another important point in our analysis concerns what Hamburg (2026) describes as PI in Emily's treatment, which appears structurally different from the intervention used for Fran. In Fran's case, PI involved paradoxically embracing rather than attempting to reduce her panic symptoms—deliberately attending to sensations of nausea and working to intensify them. In contrast, in Emily's case, Hamburg describes employing a paradoxical task that seems more consistent with Premack's principle, pairing a less preferred activity (flying) with a more preferred one (reading an enjoyable book), and thus pairing two paradoxical emotional states—dread and excitement. This raises the question of whether such a paradoxical task is conceptually equivalent to paradoxical intention or whether Hamburg may be using the terms interchangeably despite important theoretical and functional distinctions.

Our assessment of Emily's "paradoxical task" is that it may have functioned as an effectively crafted distraction intervention, in which Emily's anticipatory dread was offset by the excitement of anticipating her book, and her in-flight anxiety was diverted by the engagement of actually reading it. Perhaps another key ingredient in this task was a shift in Emily's threat appraisal of flying—particularly regarding the noises and sensations of turbulence—through the experiential in-flight exercise. Hamburg's hypnotic guidance, for instance, included the suggestion that "once she started to read the book, she would be very aware of all the unexpected sounds and movements the plane was making and that she would be irritated by their distracting her from her reading." Here, Hamburg appears to be facilitating a transformation in Emily's associative learning: in place of linking the sounds and movements of the plane to Emily's initial catastrophic fears of the plane crashing, Emily learns to associate the stimuli with the lesser threat, frustration that her reading was being disrupted. A tradeoff, we imagine, most aviophobes would gladly accept.

In his own reflection of Emily's treatment, Hamburg expressed uncertainty about the precise factors contributing to her improvement, stating, "my best guess is that the improvement was due to the paradoxical directive combined with the reassuring propositions, both of which Emily received repeatedly via the hypnosis." This explanation, however, feels somewhat incomplete, as it does not provide a clear rationale for why this specific combination proved effective nor whether the combination was required or if there was instead a single active mechanism. For example, it remains unclear whether the hypnotic delivery itself was essential to the treatment's effectiveness or whether similar benefits might have emerged through psychoeducation and the paradoxical task alone. Furthermore, the importance of how the reassuring messages about flying were delivered warrants consideration–was it important that they were conveyed through hypnosis, or might the extensive psychoeducation Emily received prior to the paradoxical task be sufficient on its own?

Notably, the inclusion of reassuring messaging within the hypnosis recordings appears to contradict core principles of exposure therapy, in which reassurance often functions as a safety behavior that reduces anxiety and prevents full expectancy violation. If a patient attributes perceived safety to the presence of reassurance (either from themselves or others), the patient may attribute safety to the reassurance rather than the actual experience of confronting the feared stimulus (Craske et al., 2014; Craske et al., 2018). In Emily's case, it is possible that the hypnosis recordings functioned as a subtle safety behavior, reducing anxiety in the moment while potentially limiting the potency of exposure-based learning, which may explain her continued use of benzodiazepines following treatment. Another plausible interpretation of what worked in Emily's treatment is that the paradoxical task of reading an enjoyable book functioned as an effective distraction or disengagement strategy, allowing Emily to shift her focus away

from the feared stimuli. This stands in contrast to Fran's task, which explicitly instructed her to direct her attention toward feared stimuli, sensations of nausea, potentially exacerbating discomfort rather than reducing it.

Moreover, mechanisms consistent with inhibitory learning theory may also explain the process underlying Emily's change, particularly in relation to the use of hypnosis and the paradoxical task. These components of Emily's treatment evoke parallels with the DBT "nightmare protocol," a technique used to reduce the frequency and intensity of recurrent nightmares through the use of imagery rehearsal (Linehan, 2015). In this approach, a fear-related image or memory is accessed and then layered with new, non-fear-based information to install corrective learning without necessitating full fear activation. Patients practice relaxation techniques, rewrite a more adaptive ending to the distressing narrative, and then repeat relaxation techniques again, effectively tapping into the same neural pathway while establishing new learning. From this perspective, the hypnosis recording paired with Emily's efforts to focus on non-feared stimuli (her book, her feelings of annoyance that her reading was being disturbed by the sounds of turbulence) used in Emily's in-flight experience might have operated as a fertile context for new learning—perhaps even a "blank slate" mindset for Emily—in which adaptive associations were installed without overwhelming fear activation.

In line with this framework, hypnosis might facilitate inhibitory learning by using attentional absorption, an altered state of consciousness characterized by a deep, focused awareness of a particular experience, leading to an increase in suggestibility (Geagea et al., 2024). This hypnotized state could reduce extraneous cognitive "noise," (e.g., cognitive distortions worsening anxiety and increased urges to avoid) allowing for greater focus and presence during exposure to feared stimuli. This heightened attentional absorption mirrors what is often encouraged during CBT exposure-based interventions—to remain fully engaged and present with the experience rather than avoiding or distracting oneself. By enhancing focused engagement while simultaneously lowering arousal through suggestions to relax or focus on non-feared stimuli, hypnosis may optimize the conditions under which new, non-fear-based associations can be encoded. Such a mechanism could help explain the apparent necessity of the hypnotic component when paired with the paradoxical task in Emily's case. However, these interpretations remain speculative and should be viewed in light of our own limitations: we, the writers, are not formally trained in hypnosis and are only modestly familiar with its theoretical foundations and clinical applications. Indeed, our thoughts are more exploratory hypotheses than authoritative conclusions and should be interpreted as preliminary attempts to conceptually link hypnosis with mechanisms of the ILM.

## REIMAGINING EXPOSURE WITH BOTH OPENNESS AND CAUTION

Hamburg presents two compelling case studies in which he employed unique therapeutic approaches that appeared to facilitate rapid clinical change, particularly when compared to the traditional trajectory of CBT-based treatments. His work offers thought-provoking examples of how creative interventions, including paradoxical tasks and hypnosis, might accelerate improvement. At the same time, these cases have prompted important questions for us, especially regarding the underlying mechanisms of action driving such change and how these approaches align with contemporary learning theories and behavioral models.

Approaching techniques such as PI and hypnosis with both humility and caution is essential. As clinicians committed to fostering meaningful behavioral change, we must balance openness to innovative interventions with a careful appraisal of the existing evidence. This balance is particularly important when interpreting rapid improvements such as those observed in Hamburg's cases.

Against this backdrop, Hamburg's use of PI—particularly in Fran's case—stands out as a distinctive and bold therapeutic maneuver. The specific directive to "try to make your panic symptoms worse" represents a striking departure from conventional CBT practice. While CBT often encourages patients to approach rather than avoid feared sensations, clinicians rarely instruct patients to deliberately intensify their anxiety or physiological arousal during an exposure. Hamburg's approach, therefore, challenged our assumptions about how exposure can be structured and delivered.

Conceptually, the PI intervention appears to align with the principles of CBT and the inhibitory learning model, yet it extends them in a creative way. By asking the patient to actively attempt to increase their anxiety, the therapist directly undermines the avoidance cycle and fosters a new learning experience: that anxiety itself is not dangerous, it cannot be fully controlled, and the individual can willingly say yes to even more discomfort–an empowering stance in and of itself that may help facilitate new safety learning. Hamburg's paradoxical approach may represent an evolution of exposure-based therapy that promotes deeper and potentially faster learning, and we hope that future research will directly compare traditional exposure protocols with PI-based exposure to examine whether this approach indeed yields enhanced outcomes and/or accelerates clinical change.

However, before this research can occur, "paradoxical intention" would need to be more clearly operationalized. As we noted, the PI intervention differed structurally across the cases: Fran's case embracing direct engagement with her panic symptoms, whereas Emily's case appearing to direct attention away from her panic and towards a more preferred activity. While both approaches may be clinically useful, clarifying the precise definition of "paradoxical

intention"—or perhaps, the different forms of paradoxical intention—would allow the technique to be better understood and more effectively researched.

Regarding hypnosis, one might ask whether we are overlooking a potentially powerful tool that could accelerate therapeutic progress. Of note, there is compelling evidence that hypnosis can reduce emotional distress and pain associated with medical procedures, such as surgeries and needle-related interventions (Rosendahl et al., 2023). Preliminary findings also suggest that hypnosis, when used as an adjunct to CBT, may enhance outcomes for anxiety and other mental health concerns (Ramondo et al., 2021). However, the evidence remains mixed overall (Rosendahl et al., 2023), and further rigorous investigation is needed before drawing strong clinical conclusions.

If future research substantiates its efficacy—particularly for producing the rapid change observed in these case studies—it would be worthwhile for clinicians to pursue formal training in hypnosis. It is also important to keep in mind that its limited use today may reflect more than just an absence of evidence; it may also be shaped by longstanding societal stigma and historical misrepresentations of hypnosis in popular media, which may have influenced both research priorities and clinical training (Weir, 2024). To our knowledge, no empirically validated mechanism of action for hypnosis has been established. Thus, our understanding of how it works remains incomplete. In this Commentary, we offered one possible conceptualization through the lens of inhibitory learning theory, proposing that hypnosis might facilitate focused attentional engagement and enhanced suggestibility to new, corrective learning.

Beyond further investigating hypnosis' utility in exposure interventions, future research would also need to clarify who is most likely to benefit from PI and/or hypnosis and how they can be most effectively integrated into evidence-based care. Notably, in Hamburg's two cases, his decision to employ hypnosis varied in both timing and purpose—used as a booster following extensive exposure work for Fran, and as a concurrent intervention alongside a paradoxical task for Emily. Such variability underscores the need for systematic investigation into the mechanisms and optimal conditions of its application. In addition, researchers and clinicians should also be cautious about the use of reassurance-based hypnosis before or during exposure tasks, as such reassurance may inadvertently function as a safety behavior that interferes with expectancy violation and inhibits corrective learning. Finally, while Hamburg's self-reported success rate of "at least 80%" is impressive, it must be interpreted with caution given the lack of information about how treatment outcomes were assessed—whether through clinician judgment, patient self-report, and/or standardized measurement.

In sum, Hamburg's work with Fran and Emily invites us to reflect more broadly on how we balance the pursuit of innovative therapeutic techniques that have the potential to rapidly alleviate our patients' suffering with the commitment to empiricism that ensures efficacy and

safety in psychotherapy. As we mentioned in the Abstract, Hamburg's novel approach with Fran and Emily is compelling because he treated their cases in just three sessions, a notable departure from traditional CBT protocols that typically require 6–20 sessions to see clinically meaningful change. That PI aligns with the principles of CBT—and particularly with inhibitory learning—is noteworthy. Not because it allows CBT to lay claim to a unique intervention implemented in a creative way, but because it allows the two approaches to build upon one another. Areas of conceptual and procedural overlap are opportunities to draw from shared research foundations, while remaining open to new empirical questions.

This attitude of openness to influence is essential within psychology research. Prior to the early 2000's, a robust research base supported the habituation model of exposure. Our willingness to revise this explanation enabled the transition into the inhibitory learning model, which has significantly changed our current understanding of anxiety and its treatment. While much of Hamburg's approach aligns with this model, we have also highlighted ways in which his methods challenge underlying assumptions regarding the most effective way to conduct exposures. A similar attitude of openness will benefit us as we consider these innovations. Over time, research will determine which outcomes are best explained by existing theories such ILM, and which point us in exciting new directions.

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