

CHAPTER 1

THE RATIONALE FOR INTEGRATING HYPNOSIS AND COGNITIVE BEHAVIOUR THERAPY IN THE MANAGEMENT OF EMOTIONAL DISORDERS

INTRODUCTION

This book adopts the position that there is an enhancement in treatment effect when cognitive behaviour therapy (CBT) is integrated with hypnosis in the management of emotional disorders. Although many clinicians have blended hypnosis with various psychotherapies, the approach to integration has ranged from being arbitrary and idiosyncratic to very systematic, rather than driven by a coherent integrated theory. As hypnosis is not a school of therapy and does not provide a theory of personality, psychopathology or behaviour change, hypnotherapists have combined their techniques with a variety of psychotherapies, for example CBT (e.g. Alladin, 1994, 2006, 2007a; Bryant *et al.*, 2005; Golden, 2006), multimodal therapy (Lazarus, 1973), psychoanalysis (e.g. Fromm & Nash, 1996) and rational emotive behaviour therapy (e.g. Ellis, 1986, 1993, 1996). To my knowledge, none of the writers has developed a coherent integrative model of psychotherapy that assimilates hypnosis with CBT.

I developed a theoretical or working model called the *Cognitive Dissociative Model of Depression* (Alladin, 1994, 2006, 2007a), which provides the rationale for combining hypnosis with CBT in the management of depression. From this model evolved *Cognitive Hypnotherapy*, a multimodal approach for treating depression, mainly consisting of CBT and hypnotic techniques (Alladin, 1994, 2006, 2007a). The cognitive hypnotherapy approach to integration is similar to the psychodynamically based integrative therapy developed and described by Gold and Stricker (2001, 2006). Gold and Stricker (2001, 2006) have developed an assimilative model of psychotherapy that integrates standard psychodynamic methods with other therapies 'when called

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for' in order to 'advance certain psychodynamic goals as well as address the target concern effectively' (Gold & Stricker, 2006, p. 12). In this chapter cognitive hypnotherapy is conceptualised as an assimilative model of psychotherapy.

Cognitive hypnotherapy uses CBT as the base theory for integration because the cognitive theory provides a unifying theory of psychotherapy and psychopathology, and it effectively integrates theory and clinical practice. Absence of a good theory can be problematic as it is likely to lack conceptual coherence (Bergin & Garfield, 1994). Another distinguishing characteristic of CBT is that it is technically eclectic. Although most of the techniques utilised in CBT are 'behavioural' or 'cognitive', it routinely combines techniques from various psychotherapies. Alford and Beck (1997, p. 90) write: 'any clinical technique that is found to be useful in facilitating the empirical investigation of patients' maladaptive interpretations and conclusions may be incorporated into the clinical practice of cognitive therapy'. However, in CBT the techniques are not chosen haphazardly. They are selected in the context of cognitive case formulation that is used to guide the practice of CBT for each individual case (Needleman, 2003; Persons, 1989; Persons & Davidson, 2001; Persons, Davidson & Tompkins, 2001). Evidence suggests that matching of treatment to particular patient characteristics increases outcome (Beutler, Clarkin & Bongar, 2000). Alford and Beck (1997, p. 91) went on further to say;

The technically eclectic nature of cognitive therapy has been described previously as follows: 'By working within the framework of the cognitive model, the therapist formulates his [*sic*] therapeutic approach according to the specific needs of a given patient at a particular time. Thus, the therapist may be conducting cognitive therapy even though he is utilizing predominantly behavioral or abreactive (emotion releasing) techniques' (Beck *et al.*, 1979, p. 117). Techniques can be selected from other psychotherapeutic approaches, provided that the following criteria are met: (1) The methods are consistent with cognitive therapy principles and are logically related to the theory of therapeutic change; (2) the choice of techniques is based on a comprehensive case conceptualization that takes into account the patient's characteristics (introspective capacity, problem-solving abilities, etc.); (3) collaborative empiricism and guided discovery are employed; (4) the standard interview structure is followed, unless there are factors that argue strongly against the standard format (Beck, 1991a).

As CBT is technically eclectic and adopts multiple approaches to case formulation and treatment, it offers an excellent framework for integrating hypnotic and cognitive strategies with a variety of syndromes. It is hoped that the integrated approach described in this chapter will provide a clear understanding of how to use hypnotic techniques to enhance treatment effect and how to

use hypnosis as an adjunct treatment in the context of CBT. Before discussing the rationale for integrating hypnosis with CBT in the management of emotional disorders, theories of psychotherapy integration are reviewed to provide readers with some background information on the psychotherapy integration movement.

PSYCHOTHERAPY INTEGRATION MOVEMENT

For decades the field of psychotherapy was marked by deep division and segregation of theories and methods. This sentiment is eloquently described by Gold and Stricker (2006, pp. 3–4):

Psychotherapists of one orientation or another have been loath to learn from their colleagues. Our collective behavior seems to have been governed by a powerful xenophobic fear and loathing that caused immediate and reflexive dismissal of approaches to psychotherapy that were different than one's own. When psychotherapists of one orientation did in fact take notice of the work of another school of psychotherapy, they typically did so with disdain and hostility. The clinical and research literatures were compiled primarily with reports meant to demonstrate that the writer's preferred brand of psychotherapy clinically outperformed all others, or that the author's theory was the best in terms of theoretical accuracy and sophistication.

Fortunately, there have been some pioneers in the field who tried to integrate different forms of psychotherapy. For example, French (1933) attempted to synthesise ideas from classical conditioning within psychoanalytic theory. Dollard and Miller (1950) integrated the central ideas about unconscious motivation and conflict with the concepts drawn from learning theories; and Wachtel (1977) integrated psychoanalysis with behaviour therapy. During the last decade of the 20th century, interest in the psychotherapy integration movement was at its peak and it culminated in the formation of the Society for the Exploration of Psychotherapy Integration, the founding of the *Journal of Psychotherapy Integration* in 1991, and the publication of two handbooks on psychotherapy integration: *Handbook of Psychotherapy Integration* (Norcross & Goldfried, 1992) and *Comprehensive Handbook of Psychotherapy Integration* (Stricker & Gold, 1993). These handbooks covered most of the important integrative therapies available at that time and went beyond the exclusive focus on the synthesis of psychoanalytical and behavioural models. The current trend in integrative therapies is to 'combine cognitive, humanistic, experiential, and family systems models with each other and with sophisticated psychoanalytic, behavioural and humanistic components of treatment in ever more complex permutations' (Gold & Stricker, 2006, p. 8). This chapter blends hypnosis with CBT and proposes *cognitive hypnotherapy* as an assimilative model of psychotherapy for the management of emotional disorders.

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Norcross and Newman (1992) have identified eight factors that have promoted psychotherapy integration in the past 20 years:

1. There has been a proliferation in the number of schools of psychotherapy.
2. Lack of unequivocal empirical support for the superiority of any single psychotherapy.
3. The inability of any psychotherapy theory to completely explain and predict psychopathology.
4. The exponential increases in short-term psychotherapies.
5. Increase in communication between clinicians and scholars.
6. Lack of support for long-term psychotherapy from third-party payers.
7. Recognition of common factors in all psychotherapies that are related to outcome.
8. Growth of journals, conferences and professional organizations dedicated to psychotherapy integration.

MODELS OF PSYCHOTHERAPY INTEGRATION

Psychotherapy integration can be defined as the 'search for, and study of, the ways in which the various schools or models of psychotherapy can inform, enrich, and ultimately be combined, rather than to a specific theory or method of psychotherapy' (Gold & Stricker, 2006, p. 8). From the current psychotherapy integration literature, four models of integration can be identified, including *technical eclecticism*, *common factors approach*, *theoretical integration* and *assimilative integration*. Each of these models of psychotherapy integration is briefly reviewed before describing Cognitive Hypnototherapy, an assimilative model that combines CBT with hypnotic techniques.

Technical Eclecticism Integration Model

Technical eclecticism, loosely referred to as eclectic psychotherapy, is an empirically based approach that advocates selectively combining the best techniques, regardless of their theoretical origin, and applies them in such a way as to maximise the therapeutic results for a specific client in as short a time as possible (Lampropoulos, 2001). Technical eclecticism can be approached haphazardly, arbitrarily, idiosyncratically or very systematically, where the techniques are chosen, based on clinical knowledge and research findings, to match the patient's needs. Multimodal therapy (Lazarus, 1992, 2002) and prescriptive psychotherapy (Beutler *et al.*, 2002) are the two well-known versions of technically eclectic psychotherapy. *Multimodal therapy* was developed by Lazarus, who became disenchanted with the limits of then traditional behaviour therapy, and hence decided to develop a broad-spectrum behaviour

therapy, supplemented by cognitive, experiential and imagery-based interventions. *Prescriptive psychotherapy*, developed by Beutler *et al.* (2002), is a flexible and empirically driven system in which the therapist matches the patient's concern with the most efficacious interventions, drawn from a variety of therapeutic orientations. Although technical eclecticism allows the flexibility to draw techniques from different schools of therapy, the model presents some serious problems. First, since none of the integrative therapies is related to any theory of personality and psychopathology, a framework for explaining and predicting human behaviour and change is lacking. Secondly, eclecticism is often practised as if a therapeutic technique can be easily disembodied from its contextual framework and readily transported to another context without consideration of its new psychotherapeutic context (Lazarus & Messer, 1991). Thirdly, it is very problematic to evaluate technical eclecticism. Because of the myriad interactions involved in empirical eclecticism, it is very difficult to determine the relative effectiveness of each treatment component included.

Common Factors Approach Integration Model

The common factors approach to psychotherapy integration is based on Rosenzweig's (1936) seminal discovery that all therapies share certain change processes, irrespective of their theoretical orientation. Therapists who operate within the common principles of change across different therapies look for common factors that may be most important in the treatment of their patients. For example, a common principle in many forms of psychotherapy consists of helping clients to become aware of and challenge their self-criticism. The common factors approach to psychotherapy integration has generated considerable research, produced several lists of proposed common factors and facilitated a rapprochement between different therapies (Lampropoulos, 2001). However, due to many serious methodological issues, recently there has been no further development in research and practice on the common factors approach.

One of the main problems with this approach relates to the common principles themselves. Although a common factor may appear similar on the surface, on closer inspection important differences may be represented. For instance, the common factors related to clients' awareness of self-criticism mentioned above are understood and accomplished very differently in the context of diverse psychotherapies. Within the CBT context, self-criticism is seen as maladaptive thinking that needs to be recognised, controlled and eliminated via cognitive restructuring. By contrast, in gestalt therapy, self-criticism is considered to be an aspect of the self that must be recognised and then integrated with other parts of the self, which can be achieved by the 'empty chair' technique (Safran & Messer, 1997).

Theoretical Integration Model

In this form of integration, different theories are combined in an attempt to construct a new and superordinate theoretical framework that can meaningfully guide research and practice. The best example of this kind of integration is Wachtel's *cyclical psychodynamics* (Wachtel, 1977, 1997), which assimilates psychoanalytic and behavioural theories within an interpersonal psychodynamic framework. The model acknowledges and uses reinforcement and social learning principles, thus allowing the therapist to use behavioural, cognitive, systems and experiential interventions in the context of psychodynamic therapy.

Lampropoulos (2001) has articulated four weaknesses related to the theoretical integration model of psychotherapy:

- (a) Although the goal of this model is to integrate as many theories as possible, the existing models have succeeded in combining only two or three theories.
- (b) The focus of the existing theoretical integration models is on specific psychological disorders only, thus neglecting other diagnostic categories.
- (c) Because of their inherent theoretical differences and contrasting worldviews, integration presents great difficulties.
- (d) Theoretical integration lacks systematic empirical validation.

Assimilative Integration Model

In this mode of psychotherapy integration the therapist maintains a central theoretical position but incorporates or assimilates techniques from other schools of psychotherapy (Gold & Stricker, 2006). It is the most recent model of psychotherapy integration described in the literature, drawing from both theoretical integration and technical eclecticism. This approach to integration is well illustrated by the psychodynamically based integrative therapy developed and described by Gold and Stricker (2001, 2006). In this approach, 'therapy proceeds according to standard psychodynamic guidelines, but methods from other therapies are used when called for, and they may indirectly advance certain psychodynamic goals as well as address the target concern effectively' (Gold & Stricker, 2006, p. 12).

Messer (Lazarus & Messer, 1991; Messer, 1992) argues that when techniques from different theories are incorporated into one's preferred theoretical orientation, both the host theory and the imported technique interact with each other to produce a new assimilative model. Assimilative integration is considered to be the best model for integrating both theory and empirical findings to achieve maximum flexibility and effectiveness under a guiding theoretical framework (Lampropoulos, 2001). The cognitive hypnotherapy approach to treating emotional disorders described in this book is conceptualised as an assimilative integration model of psychotherapy.

COGNITIVE HYPNOTHERAPY AS AN ASSIMILATIVE INTEGRATION MODEL OF PSYCHOTHERAPY

Traditionally the practice of hypnosis has embraced a psychoanalytic framework, although Freud abandoned hypnosis and went on to develop free association. Like other schools of therapy, 'classical' hypnotherapists have also been resistant to diluting hypnotherapy with behaviour therapy or CBT. Chapman (2006) has identified several barriers that have impeded the integration of CBT with hypnosis:

- CBT practitioners have tended to use relaxation training or imagery procedures rather than hypnosis. CBT therapists often wonder: 'How is relaxation and imagery training different from hypnosis?' or 'What can hypnosis offer beyond relaxation or imagery training?'
- Training programmes for CBT have not taught clinical hypnosis or emphasised the role of hypnosis in therapy.
- Practitioners from other theoretical models, for example psychodynamic therapists, have embraced hypnosis but have not endorsed formal CBT strategies, although they often employ techniques used by CBT therapists (Golden, 1994).
- Differing views of the concept of the unconscious exist among different schools of therapy. Behaviour therapy has traditionally rejected the role of the unconscious, while other therapies, such as psychodynamic therapy, have readily embraced the unconscious.
- Lack of agreement exists over the definition of hypnosis.
- Lack of agreement exists over the definition of CBT.

To this list we can also add:

- Hypnosis does not provide a theory of personality, psychopathology and behaviour change.
- Empirical validation of hypnosis techniques is in its infancy.

Nevertheless, some clinicians have attempted to combine hypnosis with behaviour therapy (e.g. Clarke & Jackson, 1983; Kroger & Fezler, 1976; Lazarus, 1973) and hypnosis with CBT (e.g. Alladin, 1994, 2006, 2007a; Ellis, 1986, 1993; Golden, 1986, 1994, 2006). To my knowledge, none of these writers has formally attempted to combine hypnosis with CBT within any of the four psychotherapy integration models described above. Previously, I described the *cognitive-dissociative* model of depression (Alladin, 1994, 2006), recently revised and renamed the *Circular Feedback Model of Depression* (Alladin, 2007a), to establish the theoretical rationale for utilising cognitive hypnotherapy, hypnosis combined with CBT, in the management of depression (Alladin, 1989, 1994, 2006, 2007a). In this chapter, cognitive hypnotherapy is formally conceptualised as an assimilative model of psychotherapy for emotional disorders.

It is only fitting to consider cognitive hypnotherapy as an assimilative integration model of psychotherapy since it meets the six criteria for assimilative

integration laid down by Lampropoulos (2001), including (a) empirical validation of host theory; (b) evidence-based imported techniques; (c) empirically based assimilation; (d) sensitivity around assimilation; (e) coherent assimilation; and (f) empirical validation of assimilated therapy.

Empirically Validated Theory

Both CBT and hypnotherapy comprise several empirically validated components. One of the requirements for integrative assimilation is that some of the components of the host theory of therapy should be empirically validated, or at least empirically informed. A good scientific theory should meet a number of criteria, including internal consistency, parsimony of explanatory constructs, testability and scope of clinical application (Alford & Beck, 1997). CBT meets all these criteria and it provides an excellent paradigm for integrative clinical practice, as it constitutes a unifying theory of psychotherapy and psychopathology. Theory is essential to clinical practice; without theory the practice of psychotherapy becomes a purely technical exercise, devoid of any scientific basis.

The cognitive theory of psychopathology and psychotherapy views *cognition* to be the key to psychological disorders. Alford and Beck (1997, p. 14) define cognition as 'that function that involves inferences about one's experiences and about the occurrence and control of future events' and state that cognitive theory 'suggests the importance of phenomenological perception of relationships among processes of identifying and predicting complex relations among events, so as to facilitate adaptation to changing environments'. CBT is the application of the cognitive theory of psychopathology to the individual case. Cognitive theory relates the various psychiatric disorders to specific cognitive variables and it includes a formal, comprehensive set of principles or axioms, including:

1. The *schemas* or cognitive structures regulate our psychological functioning or adaptation and give meaning to contextual relationship.
2. Assignment of meaning, whether at conscious or unconscious levels, activates behavioural, emotional, attentional or memory strategies for adaptation.
3. There is an interactive relationship between cognitive systems and other systems.
4. Each category of meaning has *cognitive content specificity* or the potential to produce specific patterns of emotion, attention, memory and behaviour.
5. Meanings do not always represent pre-existing components of reality but construction of a given context or goal, and are therefore subject to *cognitive distortions* or *bias* (dysfunctional or unadaptive meanings). Cognitive distortions can produce errors in either cognitive content (meaning) or cognitive processing (meaning elaboration), or in both.
6. Some individuals are vulnerable (predisposition or diathesis) to specific cognitive distortions. Specific cognitive vulnerabilities predispose individuals to specific syndromes.

7. Psychopathology results from *cognitive triad* or cognitive distortions related to the self, the world (environmental context) and the future (goals). Each psychological disorder manifests specific cognitive distortions associated with the components of the cognitive triad.
8. Two levels of meaning – *public meaning* and *personal meaning* – can be attached to any event. The public meaning of an event has few major implications for the individual, whereas the personal or private meaning has significant implications as the person is likely to access the cognitive triad.
9. Cognitive processing involves three levels of processing, including (a) pre-conscious, unintentional or automatic processing; (b) conscious processing; and (c) metacognitive processing, which includes ‘realistic’ or ‘rational’ responses. The conscious level of processing is predominantly utilised in CBT.
10. Schemas are *teleonomic* structures; that is, they facilitate adaptation of the individual to the environment. A given psychological state is therefore neither adaptive nor maladaptive in itself, but only in relation to the larger social or environmental context of the person.

Moreover, CBT provides a common language for psychotherapy integration. A survey of 58 members of the Society for the Exploration of Psychotherapy Integration carried out by Norcross and Thomas (1988) found the absence of a common language to be rated as the most severe impediment to psychotherapy integration. CBT constructs are compatible with divergent schools of psychotherapy. CBT uses ordinary language and concepts from cognitive psychology that are widely used by therapists from different/varying orientations. While ordinary language is applicable across several generations, cognitive concepts such as ‘schemas’, ‘scripts’ and ‘metacognition’ describe therapeutic phenomena observed across differing psychotherapies. According to Kazdin (1984, p. 163), the concepts of cognitive psychology ‘deal with meaning of events, underlying processes, and ways of structuring and interpreting experience. They can encompass affect, perception, and behaviour. Consequently, cognitive processes and their referents probably provide the place where the gap between psychodynamic and behavioural views is least wide.’

Evidence-Based Imported Techniques

The second criterion for integrative assimilation requires the techniques to be synthesised into the host theory to be empirically supported, or at least empirically informed, within the research guidelines proposed by the American Psychological Association (APA) Task Force (Chambless & Hollon, 1998). Hypnosis has been used, in one form or another, to relieve pain and suffering since prehistoric times. Review of the well-controlled empirical studies of the role of hypnosis in the treatment of a variety of medical and psychiatric conditions provides convincing evidence for the clinical efficacy of hypnosis (Alladin, 2007b; Lynn *et al.*, 2000; Pinnell & Covino, 2000). The effectiveness of hypnosis in the management of pain has been even more remarkable. A meta-analysis

of controlled trials of hypnotic analgesia demonstrates that hypnotherapy can provide relief for 75% of the patients studied (Montgomery, DuHammel & Redd, 2000). Other comprehensive reviews of the clinical trial literature indicate that hypnotherapy is effective with both acute and chronic pain (Elkins, Jensen & Patterson, 2007; Patterson & Jensen, 2003). The American Psychiatric Association recognises hypnosis as a legitimate therapeutic tool. It is therefore not surprising that hypnosis has been used as an adjunctive treatment with a variety of psychiatric conditions, including anxiety, depression, dissociative disorders, somatoform disorders, eating disorders, sleep disorders and sexual disorders.

Moreover, there is some empirical evidence for combining hypnosis with CBT. Schoenberger (2000), from her review of the empirical status of the use of hypnosis in conjunction with cognitive-behavioural treatment programmes, concluded that the existing studies demonstrate substantial benefits from the addition of hypnosis with cognitive-behavioural techniques. Similarly, Kirsch, Montgomery and Sapirstein (1995), from their meta-analysis of 18 studies comparing a cognitive-behavioural treatment with the same treatment supplemented by hypnosis, found that the mean effect size of the difference between hypnotic and non-hypnotic treatment was 0.87 standard deviations. The authors concluded that hypnotherapy was significantly superior to non-hypnotic treatment. Alladin and Alibhai (2007) demonstrated the additive effect of combining hypnosis with CBT in the management of chronic depression. The study also met criteria for *probably efficacious* treatment for depression as laid down by the American Psychological Association (APA) Task Force (Chambless & Hollon, 1998) and it provides empirical validation for integrating hypnosis with CBT in the management of depression. Similarly, Bryant *et al.* (2005) demonstrated hypnosis combined with CBT to be more effective than CBT and supportive counselling in the treatment of acute stress disorder.

Empirically Based Assimilation

The circumstances and rationale for selecting the techniques to be assimilated should be empirically guided. Alladin (2007a) has listed 19 strengths related to hypnosis that can be easily integrated with CBT. Those techniques that add strengths to hypnotherapy, and are empirically informed or supported, are listed below.

Hypnosis adds leverage to treatment

When used properly, hypnosis adds leverage to treatment and shortens treatment time (Dengrove, 1973). The rapid changes are attributed to the brisk and profound behavioural, emotional, cognitive and physiological changes brought on by hypnosis (De Piano & Salzberg, 1986). Hypnotherapists

routinely observe such rapid changes in their patients, which is succinctly documented by Yapko (2003, p. 106):

I have worked with many people who actually cried tears of joy or relief in a session for having had an opportunity to experience themselves as relaxed, comfortable, and positive when their usual experience of themselves was one of pain and despair.

Hypnosis serves as a strong placebo

For the majority of patients, hypnosis serves as a strong placebo. Lazarus (1973) and Spanos and Barber (1974, 1976) have provided evidence that hypnotic trance induction procedures are beneficial for those patients who believe in their efficacy. There is a considerable body of evidence that patients' positive attitudes and beliefs about a treatment can have a profound therapeutic effect in both medical and psychological conditions (Harrington, 1997). Such observations led Kirsch (1985, 2000) to develop the sociocognitive model of hypnosis, known as the *response set theory*. Kirsch provided considerable empirical evidence to support the hypothesis that the positive effect of hypnosis is due to the patients' positive expectancy. However, the studies on hypnotic induced analgesia conducted by Goldstein and Hilgard (1975) and Spiegel and Albert (1983) clearly indicate that hypnotic reduction of pain is not due to placebo, stress inoculation or changes in the level of endorphins. Moreover, there is a growing literature providing empirical evidence for the effectiveness of hypnotherapy with a variety of medical and psychological disorders (see Lynn *et al.*, 2000; Lynn & Kirsch, 2006; Yapko, 2003). Whether hypnosis works via a placebo effect or by influencing behavioural and physiological responses, the sensitive therapist can create the right atmosphere to capitalise on suggestibility and expectation effects to enhance therapeutic gains (Erickson & Rossi, 1979). Kirsch (1999, p. 216) stresses that the 'placebo effect is not something to be avoided, provided that it can be elicited without deception. Instead, therapists should attempt to maximize the impact of this powerful psychological mechanism.'

Hypnosis breaks resistance

Indirect hypnotic suggestions can be provided to break patients' resistance (Erickson & Rossi, 1979). For example, an oppositional (to suggestions) patient may be instructed (paradoxically) to continue to resist, as a strategy to obtain compliance.

Hypnosis fosters a strong therapeutic alliance

Repeated hypnotic experience fosters a strong therapeutic alliance (Brown & Fromm, 1986b). Skilful induction of positive experiences, especially when

patients perceive them to be emerging from their own inner resources, gives patients greater confidence in their own abilities and help to foster trust in the therapeutic relationship.

Hypnosis facilitates rapid transference

Because of greater access to fantasies, memories and emotions during hypnotic induction, full-blown transference manifestations may occur very rapidly, often during the initial stage of hypnotherapy (Brown & Fromm, 1986a). Such transference reinforces the therapeutic alliance.

Hypnosis induces deep relaxation

Hypnosis induces relaxation, which is effective in reducing anxiety, making it easier for patients to think about and discuss materials that they were previously too anxious to confront. Sometimes anxious and agitated patients are also unable to pinpoint their maladaptive thoughts and emotions. But once they close their eyes and relax, many of these same individuals appear to become more aware of their thoughts and feelings. Through relaxation, hypnosis also reduces distraction and maximises the ability to concentrate, which enhances learning of new materials. The relaxation experience is particularly helpful to patients who have comorbid anxiety. For example, many depressives experience anxiety; approximately 50–76% of depressives have comorbid anxiety disorder (see Dozois & Westra, 2004).

Hypnosis strengthens the ego

Ego strengthening is an approach whereby positive suggestions are repeated to oneself with the belief that these suggestions will become embedded in the unconscious mind and exert an automatic influence on feelings, thoughts and behaviour. Ego strengthening is incorporated in hypnotherapy to enhance patients' self-confidence and self-worth (Heap & Aravind, 2002). Alladin (1992) has pointed out that depressives tend to engage in negative self-hypnosis (NSH) and Araoz (1981, 1985) considers NSH to be the common denominator of all psychogenic problems. More recently, Nolen-Hoeksema and her colleagues (see Nolen-Hoeksema, 2002 for review) have provided empirical evidence that individuals who ruminate a great deal in response to their sad or depressed moods have more negative and distorted memories of the past, the present and the future. These ruminators or moody brooders then become increasingly negative and hopeless in their thinking, resulting in protracted depressive symptoms.

Ego-strengthening suggestions are offered to counter the NSH. Alladin and Heap (1991, p. 58) consider ego strengthening to be 'a way of exploiting the

positive experience of hypnosis and the therapist–patient relationship in order to develop feelings of confidence and optimism and an improved self-image’.

Hypnosis facilitates divergent thinking

Hypnosis facilitates divergent thinking by maximising awareness along several levels of brain functioning, maximising the focus of attention and concentration, and minimising distraction and interference from other sources of stimuli (Tosi & Baisden, 1984). In other words, through divergent operations the potential for learning alternatives is increased.

Hypnosis directs attention to wider experiences

Hypnosis provides a frame of mind where attention can be directed to wider experience, such as feelings of warmth, feeling happy and so on. Hypnosis provides a vehicle for exploring and expanding experience in the present, the past and the future. Such strategies can enhance divergent thinking and facilitate the reconstruction of dysfunctional ‘realities’.

Hypnosis allows engagement of the non-dominant hemisphere

Hypnosis provides direct entry into the cognitive processing of the right cerebral hemisphere (in right-handers), which accesses and organises emotional and experiential information. Therefore hypnosis can be utilised to teach restructure cognitive and emotional processes influenced by the non-dominant cerebral hemisphere.

Hypnosis enables access to non-consciousness processes

Hypnosis allows access to psychological processes below the threshold of awareness, thus providing a means of restructuring non-conscious cognitions.

Hypnosis allows integration of cortical functioning

Hypnosis provides a vehicle whereby cortical and subcortical functioning can be accessed and integrated. Since the subcortex is the seat of emotions, access to it provides an entry to the organisation of primitive emotions.

Hypnosis facilitates imagery conditioning

Hypnosis provides a basis for imagery training/conditioning. When the patient is hypnotised the power of imagination is increased, possibly because hypnosis, imagery and affect are all mediated by the same right cerebral

hemisphere (Ley & Freeman, 1984). Under hypnosis, imagery can be used for the following reasons:

- (a) systematic desensitisation (in their imagination the patient rehearses coping with in vivo difficult situations)
- (b) restructuring of cognitive processes at various levels of awareness or consciousness
- (c) exploration of the remote past
- (d) directing attention on positive experiences

According to Boutin (1978), the rationale for using hypnosis is that it intensifies imagery and cognitive restructuring. Lazarus (1999, p. 196) writes:

Clinically speaking, the use of the word *hypnosis* and the application of various hypnotic techniques appear to enhance the impact of imagery methods on susceptible clients. They also appear to augment the power of most suggestions. There seems to be a greater veridical effect when suggestible clients picture various scenes 'under hypnosis.'

Hypnosis induces dreams

Hypnosis can induce dreams and increase dream recall and understanding (Golden, Dowd & Friedberg, 1987). Dream induction provides another vehicle for uncovering non-conscious maladaptive thoughts, fantasies, feelings and images.

Hypnosis induces positive moods

Negative or positive moods can be easily induced under hypnosis and therefore patients can be taught, through rehearsal, strategies for controlling negative or inappropriate affects. Mood induction can also facilitate recall. Bower (1981) has provided evidence that certain materials can only be recalled when experiencing the coincident mood (mood-state-dependent memory). Bower's research into mood-state-dependent memory led him to propose the associative network theory, which states:

- (a) An emotion serves as a memory unit that can easily link up with coincident events.
- (b) Activation of this emotion unit can aid retrieval of events associated with it.
- (c) It primes emotional themata for use in free association, fantasies and perceptual categorisation.

Repeated hypnotic induction of positive mood can lead to the development of 'antidepressive' pathways (Alladin, 2007a; Schwartz, 1984). Goldapple *et al.* (2004) have provided functional neuroimaging evidence to show that CBT produces specific cortical regional changes in treatment responders.

Similarly, Kosslyn *et al.* (2000) have demonstrated that hypnosis can modulate colour perception. Their investigations showed that hypnotised subjects were able to produce changes in brain function (measured by PET scanning) similar to those that occur during visual perception. These findings support the claim that hypnotic suggestions can produce distinct neural changes correlated with real perception. Moreover, Schwartz *et al.* (1976) have provided electromyographic evidence that depressive pathways can be developed through conscious negative focusing. Schwartz's investigations led him to believe that if it is possible to produce depressive pathways through negative cognitive focusing, then it would be possible to develop anti-depressive or happy pathways by focusing on positive imagery (Schwartz, 1984). From the foregoing evidence it would not be unreasonable to infer that the positive affect and images, coupled with ego-strengthening suggestions, produced by the hypnosis and Positive Mood Induction Technique might have exerted some cortical changes in the brains of the depressives subjected to repetitive positive hypnotic experience. To verify the extent and locus of changes, further studies involving hypnotherapy and brain imaging are required.

Post-hypnotic suggestions

Hypnosis provides post-hypnotic suggestions, which can be very powerful in altering problem behaviours, dysfunctional cognitions and negative emotions. Often post-hypnotic suggestions are used for shaping behaviour. Barrios (1973) regards post-hypnotic suggestion to be a form of 'higher-order conditioning', which functions as positive or negative reinforcement to increase or decrease the probability of desired or undesired behaviours, respectively. Clarke and Jackson (1983) have utilised post-hypnotic suggestions to enhance the effect of in vivo exposure among agoraphobics. Yapko (2003) regards post-hypnotic suggestions to be a very necessary part of the therapeutic process if the patient is to carry new possibilities into future experience. Hence many clinicians use post-hypnotic suggestions to shape behaviour.

Hypnosis enhances training in positive self-hypnosis

Self-hypnosis training can be enhanced by hetero-hypnotic induction and post-hypnotic suggestions. Most of the techniques mentioned above can be practised under self-hypnosis, thus fostering positive self-hypnosis by deflecting preoccupation away from negative self-suggestions. Patients with various emotional disorders have the tendency to ruminate negatively, which can be considered to be a form of self-hypnosis (Alladin, 1994, 2006, 2007a; Araoz, 1981, 1985). For example, Abramson and his colleagues (Abramson *et al.*, 2002) have examined the relationship between cognitive vulnerability and Beck's theory of depression. They found cognitive vulnerability to underlie the

tendency to ruminate negatively and they posited that cognitively vulnerable individuals are at high risk of engaging in rumination. Depressive rumination involves the perpetual recycling of negative thoughts (Wenzlaff, 2004). Evidence indicates that negative rumination can lead to negative affect, depressive symptoms, negatively biased thinking, poor problem-solving, impaired motivation and inhibition of instrumental behaviour, impaired concentration and cognition, and increased stress and problems (for review, see Lyubomirsky & Tkach, 2004). Depressive ruminators, in particular, are caught in a vicious cycle. Due to their rumination they become keenly aware of the problems in their lives, but at the same time they are unable to generate good solutions to those problems and therefore they feel hopeless about being able to change their lives (Nolen-Hoeksema, 2002). Training in positive self-hypnosis provides a strategy for counteraction negative ruminations (Alladin, 2007a).

Hypnosis creates perceived self-efficacy

Bandura (1977) believes that expectation of self-efficacy is central to all forms of therapeutic change. The positive hypnotic experience, coupled with the belief that one has the ability to experience hypnosis and use it to ameliorate symptoms, give one an expectancy of self-efficacy. The perceived self-efficacy not only creates a sense of hope but also affects the treatment outcome (Lazarus, 1973).

Hypnotic techniques are easily exported

Hypnosis provides a broad range of short-term techniques, which can be easily integrated as an adjunct with many forms of therapy, e.g. with behaviour therapy, cognitive therapy, developmental therapy, psychodynamic therapy, supportive therapy and so on. Since hypnosis itself is not a therapy, the specific treatment effects will be contingent on the therapeutic approach with which it is integrated. Nevertheless, the hypnotic relationship can enhance the efficacy of therapy when hypnosis is used as an adjunct to a particular form of therapy (Brown & Fromm, 1986b).

Sensitivity Around Assimilation

The therapist should be sensitive to the assimilation process, as not all the techniques imported can be easily assimilated into one's theory without contradicting or opposing its central meaning and worldview (Messer, 1989). For example, the technique of regression commonly used in hypnotherapy contradicts one of the principal tenets of CBT. In hypnotherapy regression is often used to access unconscious experience (Alladin, 2007a, pp. 151–3) and it is readily accepted that one can have an affect without conscious cognition,

which is contradictory to the cognitive theory which holds that cognition precedes affect. The therapist needs to be very sensitive to the patient, particularly to a patient who is well versed in CBT, when introducing hypnotic regression to access unconscious cognitions, otherwise the patient will be confused and may question the credibility of the therapy or the integrity of the therapist. One of the ways of approaching hypnotic regression is to inform the patient:

Not always, but sometimes, it is possible for us to be upset in a situation without knowing why. This may sound contrary to what you learned from the CBT sessions. It is true that 99% of the time we are able to identify the cognitions related to the event or situation that upset us, but on rare occasions we can't identify the thoughts related to our feelings. Last Sunday is a good example – you indicated that you were upset at the wedding but don't know why, you could not identify your cognition. Hypnotic regression is an effective tool for accessing unconscious cognition related to an event or situation.

Coherent Assimilation

The assimilative integration process should be coherent or theoretically compatible with the major propositions and principles of the main guiding theory. This means that the final product of the assimilative integration is theoretically compatible with the host theory, without seriously altering it. Otherwise it might result in any of these three possibilities (Lampropoulos, 2001): a new theoretical integrative therapy is evolved; a multimodal or eclectic mode of therapy is produced; and a meaningless and contradictory hodgepodge of techniques is assembled. Hypnosis, not being therapy but a bunch of short-term strategies, is easily integrated with CBT without seriously altering the theoretical conceptualisation of CBT. Kirsch's (1993, p. 153) description of hypnosis in the context of CBT reinforces this point:

The use of hypnosis in cognitive-behavioral therapy is as old as behavior therapy itself. Wolpe and Lazarus (1966), for example, reported using hypnotic inductions instead of progressive relaxation with about one third of their systematic desensitization patients. From a cognitive-behavioral perspective, hypnosis provides a context in which the effects of cognitive-behavioral interventions can be potentiated for some clients. Specifically, hypnosis is likely to enhance the effects of cognitive-behavioral therapy among clients with positive attitudes and expectancies toward hypnosis.

Empirical Validation of Assimilated Therapy

Without empirical validation it is not possible to establish whether the importation of a technique into a host therapy has a positive impact on therapy, especially when techniques are decontextualised and placed in a new

framework. It is only through empirical validation that the creation and practice of ineffective and idiosyncratic assimilative integration can be avoided. Moreover, empirical validation may lead to re-evaluation of the assimilative model. Several studies (e.g. Alladin & Alibhai, 2007; Bryant *et al.*, 2005; Schoenberger *et al.*, 1997) and reviews (Flammer & Alladin, 2007; Kirsch, Montgomery & Sapirstein, 1995; Schoenberger, 2000) have demonstrated the effectiveness of combining hypnosis with CBT. However, all the studies have combined several hypnotic techniques with CBT. For example, Alladin and Alibhai (2007) utilised hypnotic relaxation, ego strengthening, expansion of awareness, positive mood induction, post-hypnotic suggestions and self-hypnosis with CBT in the treatment of depression. Without further studies using a dismantling design, there is no way of knowing which techniques were effective and which were superfluous.

COGNITIVE HYPNOTHERAPY AS AN ASSIMILATIVE INTEGRATION MODEL OF PSYCHOTHERAPY

From the reviews of the integrative models, it would appear that the assimilative model provides the best mode of psychotherapy integration. There are many reasons for assimilating hypnotic techniques with CBT.

1. CBT meets all the criteria for assimilative integration proposed by Lampropoulos (2001), including empirical evidence for the additive effect when CBT is combined with hypnotic techniques (Alladin & Alibhai, 2007; Bryant *et al.*, 2005; Kirsch, Montgomery & Sapirstein, 1995; Schoenberger, 2000; Schoenberger *et al.*, 1997).
2. Cognitive hypnotherapy allows CBT therapists to continue practising in the framework of their training, experience, investments and preferred theoretical orientations without losing the benefits of effective techniques generated from the area of clinical hypnosis. CBT therapists do not have to abandon their theoretical orientation nor do they have to change the beliefs around which they built their professional identity, self-esteem and professional credibility. Hypnosis provides a broad range of short-term techniques that can be easily integrated as an adjunct with CBT.
3. Cognitive hypnotherapy can equally be beneficial to therapists who practise clinical hypnosis within their own preferred theoretical orientations (e.g. psychodynamic approach). Since hypnosis does not provide a theory of personality, psychopathology and behaviour change, it seems logical to assimilate effective hypnotic techniques within an empirically based theory of psychotherapy such as CBT. Such an integrative approach is particularly suited when hypnosis is regarded as an adjunctive therapy.
4. In the assimilative integration of CBT and hypnosis, therapists faithful to each mode of therapy are able to transcend the limitations of their original theory by using highly effective but previously 'forbidden' techniques (Lampropoulos, 2001). Alladin (2007a) reviewed the strengths and limitations of CBT and hypnosis and concluded that the 'strengths of CBT and hypnotherapy can be combined to form a powerful treatment approach' (p. 54) for a variety of emotional disorders.

SUMMARY

After reviewing the well-known integrative theories of psychotherapy, the rest of the chapter focused on conceptualising cognitive hypnotherapy as an assimilated model of integrative psychotherapy. Cognitive hypnotherapy meets the criteria for an assimilative integrative model of psychotherapy. It is hoped that the application of the model with various clinical disorders will inform and guide clinicians on how to select treatment strategies, not haphazardly but based on case formulation of each individual case. However, the model should not be seen as a finished product, but an evolving process. Although it is important to evaluate and validate assimilative integrative therapies empirically, it is important to bear in mind that '*psychotherapy integration is synonymous with psychotherapeutic creativity and originality*' and thus 'many advances occur in the consulting room of individual therapists who cannot submit their work to large-scale research investigations' (Gold & Stricker, 2006, p. 13). Moreover, beyond blending techniques, clinicians should attempt to integrate patients' insight and feedback into their assimilative therapies.

