COGNITIVE HYPNOTHERAPY AS A TRANSDIAGNOSTIC PROTOCOL FOR EMOTIONAL DISORDERS

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Abstract: This article describes cognitive hypnotherapy (CH), an integrative treatment that provides an evidence-based framework for synthesizing clinical practice and research. CH combines hypnotherapy with cognitive-behavior therapy in the management of emotional disorders. This blended version of clinical practice meets criteria for an assimilative model of integrative psychotherapy, which incorporates both theory and empirical findings. Issues related to (a) additive effect of hypnosis in treatment, (b) transdiagnostic consideration, and (c) unified treatment protocols in the treatment of emotional disorders are considered in light of cognitive hypnotherapy.

Emotional disorders in this article refer to a spectrum of psychological conditions including anxiety, depression, dissociation, somatization, and trauma-related problems. A person with an emotional disorder is characterized by a tendency to experience precipitous increases in negative affect in response to environmental stimuli and to interpret the subsequent experience as being harmful (Andrews, 1990, 1996; Brown & Barlow, 2009; Payne, Ellard, Farchione, Fairholme, & Barlow, 2014; Sauer-Zavala et al., 2012). The unification of emotional disorders as transdiagnostic syndrome is based on findings from recent research that suggest that (a) emotional disorders share similar etiological pathways or pathophysiological processes in the genesis and presentation of symptoms, (b) there are high rates of comorbidity among emotional disorders (Wilamowska et al., 2010), and (c) psychological treatments targeting a specific emotional disorder often lead to improvements in comorbid disorders (Barlow et al., 2011; T. A. Brown, Antony, &

Barlow (1991, 2000, 2002; Suarez, Bennett, Goldstein, & Barlow, 2009), in his triple vulnerability theory, has described in detail how a set of vulnerabilities or diatheses can interact to produce anxiety and mood disorders. The triple vulnerability theory incorporates three sets of predisposition that interact to produce symptoms: (a) generalized biological vulnerability, (b) generalized psychological vulnerability, and (c) specific psychological vulnerability emerging from early learning. Much of the research on generalized biological and psychological vulnerabilities has focused on the core temperamental dimension of neuroticism (also labeled negative affect, behavioral inhibition, or trait anxiety), which is an enduring tendency to experience negative affect (T. A. Brown, Chorpita, & Barlow, 1998; Gershuny & Sher, 1998; Kasch, Rottenberg, Arnow, & Gotlib, 2002; Watson, Clark, & Carey, 1988). A generalized biological vulnerability involves nonspecific genetic contributions to the development of neuroticism, as well as early life experiences that contribute to a generalized psychological vulnerability, or diathesis leading to negative, unpredictable, or uncontrollable emotional response. This diathesis in developmental years in turn leads to the progression of neuroticism later on in life.

Barlow et al. (2011) have developed the unified protocol (UP) as a result of evidence that treatments targeted at specific emotional disorders often lead to improvements in comorbid conditions (Brown et al., 1995; Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Payne et al., 2014; Tsao et al., 1998, 2002). Decades of research on cognitive and behavioral treatment for anxiety and depression and findings on adaptive emotional regulation (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Gross & Anthony, 2006) support the assimilative UP model. Similarly, cognitive hypnotherapy has emerged as a vehicle for assimilation and an incorporation of evidence-based treatment models, in similar UP format.

Cognitive Hypnotherapy as Unified Treatment for Emotional Disorders

Cognitive hypnotherapy (CH) embodies an integrated psychotherapy based on a transdiagnostic treatment model (Alladin, 2012b; Alladin & Amundson, 2011). Its main goals entail reduction in patient reactivity to internal or external cues or “triggers” and the acquisition of skills related to affect regulation. CH is deemed a major evidence-based submodality of modern hypnotherapy (e.g., Alladin, 2012b; Byom & Sapp, 2013). It gained greater impetus since the publication of the influential meta-analysis by Kirsch, Montgomery, and Sapirstein (1995),
which examined 18 studies that compared cognitive behavior therapy (CBT) with CBT + hypnosis in the treatment of various disorders. The treated disorders included anxiety, duodenal ulcer, hypertension, insomnia, obesity, pain, public speaking anxiety, self-concept and athletic performance, and snake phobia. The mean effect size across the studies was .87 standard deviations, indicating that hypnosis significantly increased the efficacy of CBT (Byom & Sapp, 2013). The clients treated for obesity (eight studies) showed the largest effect sizes and, according to Byom and Sapp (2013), “the average client receiving cognitive-behavioral hypnotherapy benefited more than at least 70% of clients receiving cognitive-behavioral treatment alone” (p. 2). Similarly, Flammer and Bongartz (2003) from their meta-analysis of 57 randomized clinical trials that compared patients treated exclusively by hypnosis to either an untreated control group or a group of patients treated by conventional medical procedures found a medium effect size of $d = .56$, indicating superiority of treatment in hypnosis groups.

More recently, the additive effect of CH has been demonstrated with anxiety disorders (Golden, 2012), acute stress disorder (Bryant, Moulds, Gutherie, & Nixon, 2005), bulimia nervosa (M. Barabasz, 2012), chronic pain (Elkins, Johnson, & Fisher, 2012; Jensen, 2013), depression (Alladin & Alibhai, 2007), insomnia (Graci & Hardie, 2007), migraine headache (Hammond, 2007), posttraumatic stress disorder (Lynn & Cardeña, 2007), obesity (Byom & Sapp, 2013), psychosomatic disorders (Flammer & Alladin, 2007), and somatoform disorders (Alladin, 2008; Moene, Spinhoven, Hoogduin, & Van Dyck, 2003). Moreover, CH meets criteria for the assimilative model of integrative psychotherapy, which incorporates both theory and empirical findings (Alladin, 2008, 2012b; Alladin & Amundson, 2011).

Although hypnotherapy has not been directly tested as a unified treatment for emotional disorders, some disorder-specific studies clearly indicate its positive impact on comorbid disorders. For example, Alladin and Alibhai (2007) in their CH trial with depression found the treatment to produce significant reduction in both anxiety and depression scores (measured by the Beck Anxiety Inventory and the Beck Depression Inventory, respectively), although the treatment was targeted at depression. Similarly, Dobbin, Maxwell, and Elton (2009) found relaxation training (via self-hypnosis) to be effective in the management of depression among primary care depressed patients. Furthermore, A. Barabasz, Barabasz, Christensen, and French (2013) and Christensen, Barabasz, and Barabasz (2013) found ego-state therapy targeted at post-traumatic disorder to be effective in reducing symptoms of depression.

The major components of CH as a unified treatment for emotional disorders are briefly described here. For a more detailed description of the stages and the components of CH, refer to Alladin (1994, 2007, 2008, 2012a, 2015). CH generally consists of 20 weekly sessions that can be
expanded or modified according to the patient’s clinical needs, areas of concern, and severity of presenting symptoms. CH for emotional disorders can be broadly divided into two separate but overlapping phases of treatment. The first phase, mainly consisting of hypnotherapy and CBT, is targeted at symptom management. The second phase, if needed, focuses on uncovering and healing the underlying cause of the emotional disorder. For some patients, the initial phase of the therapy may be sufficient, while for others it serves as a preparation for more complex therapy, exploring the roots of the emotional disorder. The first phase of the treatment usually consists of hypnotherapy and CBT. The second phase of CH involves deep hypnotherapy strategies (e.g., affect bridge and split-screen techniques) of a more dynamic nature.

Case Formulation and Therapeutic Alliance

CH case conceptualization underlines the role of cognitive distortions, negative self-instructions, irrational automatic thoughts and beliefs, schemas, and negative ruminations or negative self-hypnosis in the understanding of a patient’s emotional disorder. An efficient way of obtaining this information within the context of CH is to take a case formulation approach as described by Alladin (2007, 2008). A case formulation approach allows a clinician to tailor nomothetic (general) treatment protocol, derived from randomized clinical trials, to the status of individual (idiographic) patient.

Status refers to the competency or aptitude of the patient relative to treatment. Such attention—to neither under nor overwhelm the patient—is essential in effective alliance (Norcross, 2002). Dose specific titration of treatment, that is, how much, how little, how quickly, etc., is central to effective treatment in general and in CH particularly.

In the first phase of CH, hypnotherapy is specifically targeted at symptom management. The hypnotherapy components include (a) relaxation training, (b) demonstration of the power of mind over the body, (c) ego-strengthening, (d) expansion of awareness, (e) modulation and regulation of symptoms, (f) self-hypnosis, (g) positive mood induction, and (h) posthypnotic suggestions. These components are briefly reviewed here. For a more detailed description and recent review of these components see Alladin (2015).

Relaxation Training

One of the major reasons for using hypnosis with emotional disorders is to cultivate the relaxation response. The relaxation response can be defined as a set of integrated physiological mechanisms and “adjustments” that are elicited when an individual engages in a repetitive mental or physical activity and passively ignores distracting thoughts (Esch, Fricchione, & Stefano, 2003). Patients with emotional disorders
experience high levels of tension, nervousness, and steep physiological reactivity (e.g., Beck & Emery, 1985, 2005; D. A. Clark & Beck, 2010). Even depressed patients experience high levels of anxiety either due to comorbid anxiety (Dozois & Westra, 2004) or a lack of confidence to effectively handle life challenges. For these reasons, depressed patients often derive significant benefit from simply learning to relax (Dobbin et al., 2009). There is extensive evidence that relaxation alone or in combination with other therapies is beneficial to both normal and multiple clinical populations, including emotional disorders (Elkins, 2013; Walsh, 2011). Relaxation training appears to be well suited for the treatment of diffuse anxieties (Borkovec & Weerts, 1976) and it represents one of the most used nonpharmacological approach in anxiety management worldwide (Barrows & Jacobs, 2002), as a bona fide anxiolytic treatment in itself (Ost, 1987) or as an adjunct to more complex therapies such as systematic desensitization (Goldfried, 1971) and CBT (Beck & Emery, 1985, 2005; D. A. Clark & Beck, 2010). For decades, relaxation training has been shown to attain many of the same benefits as benzodiazepines but without the side-effect profile of medication (Stahl & Moore, 2013). Various hypnotic induction techniques are utilized to induce relaxation (see Elkins, 2013).

Demonstration of the Power of the Mind

Hypnosis provides a powerful means for producing syncretic cognition (Alladin, 2006, 2007), which consists of a mixture of cognitive, somatic, perceptual, physiological, visceral, and kinesthetic changes. Hypnotic induction and modulation of syncretic cognition offer patients with emotional disorders direct and compelling evidence that they can alter their subjective experience. Most importantly, the ability to produce novel and diverse experiences associated with hypnosis sponsors expectant faith; hope that negative affect can be managed.

Ego-Strengthening

Bandura (1977) provided experimental evidence that self-efficacy, the expectation and confidence of being able to cope successfully with various situations, is one of the key elements in the effective treatment of psychological disorders. Ego-strengthening suggestions are offered to patients with emotional disorders to promote confidence and self-efficacy. The goals of ego-strengthening suggestions are to reduce anxiety and depression and to gradually restore the patient’s self-confidence in his or her ability to cope effectively with problems and distress (Hartland, 1971). While in deep hypnotic trance, patients are encouraged to visualize acquiring the skill of “letting go” and not cogitating with their symptoms while feeling anxious or depressed. The following reflects a CH approach:
• “As a result of this treatment and as a result of listening to your Self-Hypnosis CD, every day you will feel calmer and much more relaxed.”
• “Although you are aware of your concerns and your worries, you will be able to put everything on hold and let go. This shows that you can relax and let go even if you are aware of everything. You don’t need to empty your mind to be able to relax.”

After the first hypnotherapy session, patients are given a self-hypnosis CD to listen to at home as homework (see “Self-Hypnosis Training” for further details).

**Expansion of Awareness**

Patients with emotional disorders tend to be preoccupied with negative affect and the consequences of their symptoms (Papageorgiou & Wells, 2004), resulting in the narrowing down of their range of experience. Neisser (1967) viewed marked constriction in the range of behaviors and self-attributions as characteristic of psychopathology. Hypnosis offers a powerful vehicle for expanding awareness and amplifying positive experience. For example:

You have now become so deeply relaxed that you begin to feel a beautiful sensation of peace and tranquility, relaxation and calm, following all over your mind and body. Giving you such a pleasant, and such a soothing sensation all over your mind and body, that you feel completely relaxed, totally relaxed both mentally and physically. And yet you are aware of everything, you are aware of all the sound and noise around you, you are aware of your thoughts and your imagination, and yet you feel so relaxed, so calm and so peaceful. This shows that you have the ability to relax, the ability to let go, and the ability to put everything on hold.

Now you can become aware of all the good feelings you are experiencing. You feel calm, peaceful, relaxed and very, very comfortable. You may also become aware of feeling heavy, light, or detached, or distancing away from everything, becoming more and more detached, distancing away from everything, drifting into a deep, deep hypnotic state.

From the expansion of awareness training, patients discover that they have the ability to relax and the capacity to experience different feelings and sensations. The induction of such a positive syncretic experience gives patients with emotional disorders the confidence that they could learn to “flow” with their emotions, distress, and concerns.

**Posthypnotic Suggestions**

Posthypnotic suggestions are routinely delivered during hypnotherapy to counter problem behaviors, negative emotions, dysfunctional cognitions, negative self-hypnosis (NSH), and negative self-affirmations. Based upon the triple vulnerability theory (Barlow, 1991, 2000, 2002; Suarez, Bennett, Goldstein, & Barlow, 2009), patients
with emotional disorders are predisposed to reflexively ruminate with negative self-suggestions, particularly after experiencing a negative affect (e.g., “I will not be able to cope.”). This can be regarded as a form of NSH; negative posthypnotic suggestion that maintains the anxious or depressive cycle. To break this reflexive pattern of thinking, it is important to counter the NSH. Yapko (2003) points out that positive posthypnotic suggestions serve as a necessary part of the therapeutic process if the patient is to carry out new possibilities into future experiences based on the hypnosis session.

Self-Hypnosis Training

Apart from learning to relax, the self-hypnosis component of CH is also devised to create positive affect and to counter negative self-suggestion (NSH). At the end of the first hypnotherapy session, the patient is provided with an audio CD, which contains (a) a Relaxation and Counting Method for induction and deepening of hypnosis, (b) expansion of awareness (aware of internal and external stimuli), (c) ego-strengthening suggestions, and (d) posthypnotic suggestions. The homework assignment of listening to the Self-Hypnosis CD daily offers continuity of treatment between sessions and creates a setting for the patient to learn self-hypnosis.

To further consolidate their skill of generalizing self-hypnosis to real-life situations, patients with emotional disorders are introduced to the clenched-fist technique (Stein, 1963), an anchoring cue:

From now on, whenever you wish to feel just as you are feeling now, all you have to do is to clench your preferred fist and anchor your mind to this experience. Moreover, from now on, whenever you feel anxious, you can tame the feeling by clenching your fist and anchoring your mind to this experience . . . and with practice you will get better and better at it.

Anchoring is experientially ratified by hypnotic imaginal rehearsal training and reinforced by posthypnotic suggestions. Most patients find the clenched-fist technique concrete and “portable”; however, it is one of many potential discriminatory cues for distress reduction.

Positive Mood Induction

Nolen-Hoeksema (2004) and Papageorgiou and Wells (2004) have found anxious and depressed patients to be preoccupied with repetitive catastrophic thoughts and negative images. These ruminations can easily become obsessional in nature and further sensitize the anxiety and depressive neuropathways, thus impeding therapeutic progress and symptomatic relief (Monroe & Harkness, 2005; Post, 1992). To counter negative ruminations and to prevent kindling of maladaptive neuropathways, the positive mood induction technique is used in CH (Alladin, 1994, 2006, 2007, 2012a).
The positive mood induction technique involves systematic focusing on positive experiences. The patient is encouraged to make a list of 10–15 pleasant or positive experiences and then to focus on the list, one item at a time for about 30 seconds, three to four times a day. The technique is initially practiced (with three items from the list) in hypnosis in the therapist’s office. When in hypnosis, the patient is instructed to focus on one of the positive experiences from his or her list, which is then amplified with suggestions from the therapist. This technique is similar to the “expansion of awareness training” described earlier. However, to develop antianxiety or antidepressive neuropathways, more emphasis is placed on producing somatosensory changes and concomitant physiological changes, rather than merely focusing on affective experience. The procedure is repeated with at least three positive experiences from the patient’s list. Posthypnotic suggestions are provided so that the patient will be able to re-experience positive mood easily while practicing with the list at home. To consolidate the technique and to activate positive kindling, the patient is encouraged to practice with the list of positive experiences at home three to four times a day.

Cognitive Behavioral Therapy (CBT)

CBT is the most widely studied psychosocial treatment for emotional disorders. A vast number of controlled trials have consistently demonstrated CBT to be effective in the reduction of acute symptoms of anxiety and depression and its effect is comparable to pharmacological treatment (e.g., Butler, Chapman, Forman, & Beck, 2006; D. A. Clark & Beck, 2010; Iddon & Grant, 2013). The central premise of the cognitive theories of emotional disorders is the formation of dysfunctional schemas (i.e., attitudes and assumptions) generated from previous experience, which may lay dormant until they are activated by thematic events. Negative early experience is one of the three predispositions identified by the triple theory of emotional disorders (e.g., Barlow, 2002). Therefore, teaching these patients to recognize and examine negative beliefs and information-processing proclivities have been found to produce relief from their symptoms and to enable them to cope more effectively with life’s challenges (e.g., D. A. Clark & Beck, 2010; Ellard et al., 2010; Payne et al., 2014).

Cognitive distortion in patients with emotional disorders can be regarded again, as a form of negative self-hypnosis (NSH), suitable to attention through clinical hypnosis and positive posthypnotic suggestions. The following description of a depressed patient recorded by Beck, Rush, Shaw, and Emery (1979) captures this element:

In milder depressions the patient is generally able to view his negative thoughts with some objectivity. As the depression worsens, his thinking
becomes increasingly dominated by negative ideas . . . and [he or she] may find it enormously difficult to concentrate on external stimuli . . . or engage in voluntary activities . . . the idiosyncratic cognitive organization has become autonomous . . . [so] that the individual is unresponsive to changes in his immediate environment. (Beck et al., 1979, p. 13)

This example of negative rumination and consequent dysphoric responses can be considered analogous to the concepts of negative trance state spoken of above (Yapko, 1992, 1997). Within the CH perspective, CBT is viewed as a conscious strategy for countering NSH in order to circumvent the negative affect or the symptomatic trance state (Alladin, 1994, 2007, 2008, 2012a; Yapko, 1992). The CBT component of CH for this purpose can be extended over four to six sessions. However, the actual number of CBT sessions is determined by the needs of the patient and the severity of the presenting symptoms.

Hypnosis-Aided Systematic Desensitization

Although imaginal exposure can be helpful in building confidence to deal with avoidance behaviors, some patients may still feel too anxious to face real anxiety-provoking situations. One of the ways to overcome this obstacle is to use systematic desensitization (SD) as a preparation before introducing patients to exposure in vivo (Golden, 2012). The CH approach is referred to as hypnosis-aided systematic desensitization (HASD) (Iglesias & Iglesias, 2014). A number of reports in the literature support the effectiveness of combining hypnosis with SD in the treatment of specific phobias (e.g., Glick, 1970).

Traditional hierarchies related to anxiety, a review of subjective units of discomfort (SUDs), and hypnosis are all used to establish a counterveiling/counterconditioning state of mind. Additionally, to help patients become further disengaged from their worries and negative reactivity, they are introduced to imaginal exposure therapy (Wolpe, 1958; Wolpe & Lazarus, 1966), which is considered an important component of CH for emotional disorders (Golden, 2012). While in deep hypnosis, patients are directed to focus on their worries, uncertainties, and reactivity. Then they are instructed to utilize their self-hypnosis skills to relax and calm down whenever they experience any anxiety or depression associated with their recurring thoughts and worries. The goal is not to control their symptoms; the focus is on learning to tolerate their distress.

Based on findings from acceptance and mindfulness-based therapies (AMBT), the focus of exposure therapy is not to control the symptoms of emotional disorders but to teach patients techniques to deal with their symptoms or to learn to surf over them (Alladin, 2014a, 2014b, 2015). Research indicates fears, anxiety, and depression are partly generated by overly rigid attempts to avoid or control the emotional experience
of fear and anxiety (e.g., Butler et al., 2006; Greeson & Brantley, 2009; Roemer, Williston, Eustis, & Orsillo, 2013). The toleration of fear, anxiety, and depression is therefore considered a critical component in the psychological treatment of emotional disorders (Campbell-Sills et al., 2006; L. A. Clark, 2005; Morita, 1998; Wegner, 1994; Wenzlaff, 2005; Wenzlaff & Grozier, 1988; Wilson, Lindsey, & Schooler, 2000). Hence, the goal of exposure therapy should not be on the immediate reduction of negative emotion but rather learning to tolerate distress and discomfort. The mental rehearsal in trance provides patients a safe milieu to learn to face their worrying thoughts and associated reactivity, rather than catastrophizing or cogitating about them. With depression for example, this protocol raises awareness of underlying emotions and feelings, expands affective range and increases motivation for change (Brown & Fromm, 1990) leading to “anti-depressive pathways” (Alladin, 2007), positive as opposed to negative associations or dissociations.

**Gradual In Vivo Exposure Therapy**

Exposure in vivo is a key component of CBT for overcoming avoidance behaviors (Chambless, 1985; Follette & Smith, 2005; Hazlett-Stevens, 2006).

CH involves a step-by-step approach to conquering anxiety or distress elicited by certain specific situations or objects. The patient draws on his or her relaxation skills, self-hypnosis, cognitive coping, and related CH components strategies to manage the discomfort associated with the successive exposure steps.

**Healing Self-Wounds—a Second Phase**

Patients often seek to pursue additional treatment upon initial symptom reduction. In CH, this second phase of treatment is more psychodynamic and growth oriented (Yerushalmi, 2003).

The concept of the wounded self is well described in CH (see Alladin, 2013b, 2014a, 2014b, 2015; Wolfe, 2005, 2006). It is an active metaphor around which to structure treatment and hypnotherapy provides an array of methods for uncovering and restructuring unconscious causes or roots of emotional disorders. Hypnotic techniques for accessing tacit self-wounds include (a) direct suggestions, (b) hypnotic age regression, (c) affect bridge, (d) hypnotic exploration in CH, (e) cognitive restructuring under hypnosis, (f) editing and deleting the “unconscious file,” (g) the split-screen technique, and (h) the empty-chair technique (Alladin, 2012a, 2013a, 2014b, 2015; D. P. Brown & Fromm, 1986; Ewin & Eimer, 2006; Watkins, 1971; Watkins & Barabasz, 2008; Yapko, 2012). For the present purpose, the affect bridge, the split-screen, and the empty-chair techniques will be described and illustrated in the case of Fred:
After 10 sessions of CBT and hypnotherapy, Fred noticed significant improvement in his affect. He felt less anxious, depressed, and worried, and he was less preoccupied with uncertainties about his future. Nevertheless, he still had some anxieties and depression and felt the need to produce “deeper changes” inside him.

Fred had always felt fretful and anxious. Though the pronounced symptoms related to his presenting status of GAD [generalized anxiety disorder] had been addressed, this lack of confidence became target for Phase 2 attention. In initial exploration using the affect bridge technique (Watkins, 1971), Fred deduced that his loss of self-confidence was related to comparison(s) to his father in his youth; that his more reserved and introverted personality and social presence was “not good enough.” Although he engaged all his life in compensatory activities, this self-wound of inadequacy and self-doubt persisted. Once identified, the wound of doubt, inadequacy, and fear for capacity related to comparisons to his father became the basis for treatment to deconstruct this anxiety.

Deconstruction of Meaning in Anxiety, Depression, and Worry

The split-screen technique (Alladin, 2008; Cardeña, Maldonado, van der Hart, & Spiegel, 2000; Lynn & Cardeña, 2007; Spiegel, 1981) was used to help Fred breakdown the meaning of his anxiety, depression, and worry. This hypnotic strategy utilizes an “adult ego state” to assist a “weak ego state” in dealing with distress-provoking situations. Treatment also unites the two ego states to work together as a team when the self is threatened, rather than splitting from each other when stressed out. The following therapy transcript adapted from Alladin (2015) illustrates how the split-screen technique was used with Fred to help him deal with the toxic meaning of his emotional disorder. The transcript began while Fred was in a deep hypnotic trance.

Therapist: Now I would like you to imagine sitting in front of a large TV or cinema screen, which is vertically split in two halves, consisting of a right side and a left side. Can you imagine this?

Fred: [Raises his “YES” finger. Ideomotor signals were already set up—raising his right index finger represented “YES” and raising his left index finger indicated “NO”.

Therapist: Imagine the right side of the screen is lighting up as if it’s ready to project an image. Imagine yourself being projected on the right side of the screen, just as you are now. Feeling very relaxed, very comfortable, in complete control, and aware of everything. And now become aware of the things you have achieved, things that you are proud of. Do you feel these good feelings?

Fred: [After a moment, his “YES” finger went up.]

Therapist: That’s very good. Do you feel the sense of achievement?

Fred: [His “YES” finger went up.]

Therapist: Are you thinking about your achievement related to having been promoted to Team Leader in your company? [Fred had disclosed this information to the therapist in previous sessions.]
Fred: [His “YES” finger goes up.]
Therapist: Just focus on the good feelings and become aware that you made it to this senior position despite your anxiety and depression. This proves to you that you have a strong side, a successful side, a side that can rescue you from difficulties and help you to succeed. We are going to call this part of you the “adult side” or your “adult ego state.” Is that acceptable to you?
Fred: [He raises his “YES” finger.]
Therapist: Leave this side of yourself on the right side of the screen and imagine yourself being projected on the left side of the screen now. On the left side of the screen imagine yourself being in a situation that cause anxiety or depression for you. Can you imagine this?
Fred: [His “YES” finger goes up.]
Therapist: Now become aware of all the feelings that you are experiencing. Don’t be afraid to let all the negative feelings come over you, because soon we will show you how to deal with them. Become aware of all the physical sensations that you are feeling. Become aware of all the thoughts that are going through your mind and become aware of your behaviors. Can you feel these?
Fred: [His “YES” finger goes up.]
Therapist: Become aware of the whole experience and we are going to call this part of you the “weak part of you” or the “child ego state” as we discussed before. Is this acceptable to you?
Fred: [His “YES” finger goes up.]
Therapist: Now imagine, your “adult ego state” is stepping out from the right side to the left side of the screen. Can you imagine this?
Fred: [He raises his “YES” finger.]
Therapist: Imagine your adult ego state is reassuring your “child ego state.” He is telling your child ego state not to be afraid because he is here to help him out and guide him how to deal with his fears, worries, and depression. From now on, the child part of you doesn’t have to handle difficulties on his own, he can work as a team with the “strong part” of you. Imagine the adult part of you is telling the weak part of you that in therapy he has learned many strategies for dealing with anxiety and depression that he can teach you. Imagine he is demonstrating the weak part of you how to relax, how to let go, and how to reason with fearful, depressing, and worrying thoughts. Continue to imagine this until you feel the “weak part” of you feels reassured and now he knows what to do when feeling upset or distressed. Imagine your weak part feels protected and empowered knowing that he is not alone; he can get help from the adult ego state whenever the need arises. The weak part also realizes that the strong part is of part of your self [sic]. So from now on you can both work as a team. Is this acceptable to you?
Fred: [His “YES” finger goes up.]

Fred found the split-screen technique very helpful. It reminded him of the strategies that he had learned in therapy, and it served as useful mental rehearsal training for coping with his emotional difficulties.
Differentiating Between Accurate and Inaccurate Self-Views

The self-wound can sponsor global or specific contextual negative self-appraisal (Alladin, 2013a, 2014a, 2015; Beck et al., 1979; Bowlby, 1973; Wolfe, 2005, 2006). This sense of doubt or inadequacy with Fred led to not only compensatory attempts at achievement but maladaptive coping strategies such as behavioral avoidance, excessive worries, rumination with cognitive distortions, and preoccupation with his symptoms and then protecting himself from facing situations that were perceived to produce distressing affect. Unfortunately, these indirect strategies did not minimize his distress; instead, they reinforced his painful core beliefs about his self. These strategies kept Fred from facing his fears and self-wounds head on, resulting in the perpetuation of his symptoms. It is important to appreciate that whether reality is based on or a product of psychic conjecture on the part of the patient, treatment seeks to confront the feared emotions as opposed to avoiding them.

The empty-chair technique, which is a Gestalt therapy role-playing strategy (Perls, Hefferline, & Goodman, 1951; Woldt & Toman, 2005), was utilized for reducing personal fears, self-doubts, negative self-appraisal, and intra- or interpersonal conflicts (Nichols, 2008).

In this procedure, while in deep hypnosis, Fred was directed to talk to his father, whom he imagined sitting in an empty chair in the therapist’s office, across from him. By imagining his father sitting in the empty chair in the safety of the therapy situation, Fred was able to express various strong feelings about himself and his father that he had been harboring inside him since he was a teenager. This procedure consisted of two interrelated parts. During the first part of the procedure, Fred talked to his father, while his father was silent. In the second part, the father spoke to Fred and then they both talked to each other in turn.

In this exercise, the therapist, like a creative editor, assists the patient in creative dialogue and narrative. For Fred this narrative became one of paternal indictments regarding his father, then paternal clarification in his “father’s” response from the other chair and then a dialogue of reconciliation. The thesis—“My father wasn’t there for me”—is met by the antithesis—“I am proud you admired me as your father and proud of your own accomplishments”—and results in a new synthesis—“I didn’t know you were upset, son, and I am sorry” and “as your son I can feel proud of my own accomplishments.”

In addition to the empty-chair technique, as homework, Fred was encouraged to write down a full description of his idealized, unrealistic self-expectations and his more realistic or actual self in a realistic and reconciliation inventory.

As result, Fred realized (a) that his ideal self was constructed by a set of cognitive distortions, (b) that his father was not responsible for his emotional injury, (c) that not achieving his ideal self did not mean he was a
failure, (d) that his father did not perceive him to be a failure, (e) that people would not consider him to be failure if he did not reach the ideal self, and (f) finally that he could live a “normal life” and experience satisfaction with his real self.

**Summary**

This article describes a unified treatment protocol for emotional disorders: cognitive hypnotherapy. Such an integrative approach provides a variety of treatment interventions for emotional disorders distilled from decades of research on effective cognitive, behavioral, and hypnotherapeutic treatments for anxiety, mood, and trauma-based disorders. Based on case formulation, the therapist can choose the “best-fit” strategies for each individual patient with an emotional disorder. The number of sessions and the sequence of the stages of CH are determined by the clinical needs of each individual patient. However, the central tenet across all these treatment strategies is to help patients with emotional disorders reduce negative reactivity to emotions and distress-provoking situations. This is achieved by teaching patients skills to effectively manage and regulate negative emotions (Sauer-Zavala et al., 2012). The goals of CH are not different from those of UP described by Barlow and his colleagues and other integrative, assimilative approaches. Such unification in treatment appears to promise much both to research and practice.

**References**


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**Kognitive Hypnotherapie als ein Transdiagnostisches Protokoll für emotionelle Erkrankungen**

**Assen Alladin und Jon Amundson**

**Abstract:** Dieser Artikel beschreibt Kognitive Hypnotherapie (CH) als eine integrative Behandlungsform, die einen evidenzbasierten Rahmen bietet, um klinische Praxis und Forschung zusammenzuführen. CH kombiniert Hypnotherapie mit Kognitiv Behavioraler Therapie im Management emotioneller Erkrankungen. Diese verbundene Version klinischer Praxis erfüllt die Kriterien für ein assimilatives Modell integrativer Psychotherapie, welche sowohl Theorie als auch empirische Ergebnisse beinhaltet. Fragen, die mit (1) dem additiven Effekt von Hypnose bei der Behandlung, (2) transdiagnostischen Erwägungen und (3) vereinten Behandlungsprotokollen bei
der Behandlung emotioneller Erkrankungen verknüpft sind, werden im Licht kognitiver Hypnotherapie untersucht.

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L’hypnothérapie cognitive comme protocole transdiagnostique de troubles émotionnels

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Résumé: Cet article décrit l’hypnothérapie cognitive (HC) comme un traitement intégratif qui fournit un cadre factuel pour faire la synthèse de la recherche et de la pratique clinique. L’HC allie l’hypnothérapie à la thérapie cognitivo-comportementale dans la gestion de troubles émotionnels. Cette version mixte de la pratique clinique répond aux critères d’un modèle d’assimilation de la psychothérapie intégrative de la théorie et des résultats empiriques. Les questions liées à 1) l’effet additif de l’hypnose dans le traitement; 2) les considérations transdiagnostiques; et 3) les protocoles de traitement unifiés des troubles émotionnels sont examinés à la lumière de l’hypnothérapie cognitive.

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La hipnoterapia cognitiva como un protocolo transdiagnóstico para los trastornos emocionales

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Resumen: Este artículo describe la hipnoterapia cognitiva (HC), un tratamiento integrador que provee un marco conceptual basado en evidencias para sintetizar la práctica y la investigación clínica. La HC combina la hipnoterapia con la terapia cognitivo-conductual para el manejo de los trastornos emocionales. Esta versión combinada de práctica clínica alcanza los criterios para un modelo asimilativo de psicoterapia integradora, que incorpora tanto teoría como resultados empíricos. A la luz de la HC, se consideran cuestiones relacionadas con (1) el efecto aditivo de la hipnosis en el tratamiento, (2) consideraciones transdiagnósticas, y (3) protocolos unificados de tratamiento para el manejo de trastornos emocionales.

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