COGNITIVE HYPNOTHERAPY AS AN ASSIMILATIVE MODEL OF INTEGRATIVE THERAPY

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ABSTRACT

Integration, assimilation, and the overreaching concept of eclecticism have become attractive modes of thinking about models of psychotherapy and treatment. In this paper the current models of psychotherapy integration are briefly reviewed and the best fit model for integrating hypnotherapy with cognitive behaviour therapy (CBT) is described. Because CBT provides the best integrative lodestone, based on both sound theory and empirical foundation, it is chosen as the base or home theory for incorporation of hypnotherapy. Although hypnotherapy has been traditionally combined with other psychotherapies, the assimilation has not always been driven by a coherent theory of integration. The blending of hypnotic techniques with other therapies has vacillated from being very systematic to idiosyncratic. In this paper cognitive hypnotherapy (CH) is formally conceptualized as an assimilative model of psychotherapy. The assimilative approach to psychotherapy is the latest integrative psychotherapy model described in the literature and it is considered the best model for combining both theory and empirical findings to achieve maximum flexibility and effectiveness under a guiding theoretical framework. In this model of practice, integration of techniques is driven by case formulation and empirical findings. Moreover, the model provides an additive design for studying the summative effect of hypnotherapy when it is combined with other psychotherapies. The clinical and research implications of the assimilative model of hypnotherapy are discussed and the assimilative treatment protocol for somatization disorder is outlined to illustrate how hypnotic techniques can be assimilated with CBT in a structured mode to facilitate empirical validation.

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Key words: psychotherapy integration, eclecticism, assimilative model of psychotherapy, summative effect, additive design, cognitive hypnotherapy

INTRODUCTION

Hypnotherapy is practised either as a single-modality therapy (with simple conditions, e.g. removal of warts, reduction of acute pain) or as an adjunct therapy combined with other psychotherapies (i.e. part of a multimodal therapy with complex disorders such as depression or post-traumatic stress disorder). However, the blending of hypnotic techniques with other psychotherapies has not always been driven by a coherent theory of integration; the integration has ranged from being very systematic to idiosyncratic. The senior author, in the development of cognitive hypnotherapy (CH) (Alladin, 1994, 2006, 2007a) has sought to provide a coherent, theoretical perspective, reflective of integrationist principles and best assimilative practice standards in the pursuit of what works for patients. Cognitive behaviour therapy (CBT) is chosen as the base theory for integration because it is considered 'opportunistic' in its conceptual structure. Alford and Beck (1997) have stated that:

> *[A]ny 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. (1997: 90)*

Similarly, the psychodynamic tradition (Gold & Stricker, 2001, 2006) acknowledges that effective treatment ought to trump theory allegiance, that is, other therapies should be utilized 'when called for . . . to advance certain psychodynamic goals as well as address (the) target concern' (Gold & Stricker, 2006: 12). This incorporative shift from theoretical allegiance to 'what works' has, however, vacillated from haphazard or 'eclectic confused' (Norcross, 1987) to more orderly, conscientious, and evidence-based case management (Persons, 1989; Persons & Davidson, 2001; Persons et al., 2001; Needleman, 2003). It is in the latter sense that CH is advanced as an assimilative approach: technically and strategically eclectic. In order to do justice to the topic, a review of *psychotherapy integration* is undertaken, followed by discussion on *cognitive hypnotherapy in the light of both integration and empiricism*. Finally, an overview of *cognitive hypnotherapy as an assimilative model of psychotherapy* and its clinical implications are provided.

PSYCHOTHERAPY INTEGRATION MOVEMENT

For decades the field of psychotherapy was marked by deep division and segregation of theories and methods. This sentiment is eloquently captured by Gold and Stricker (2006):

> *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. (2006: 3–4)*

Fortunately, there had been some pioneers in the field who had ventured out of their theoretical confinement and attempted to blend other forms of psychotherapy in their clinical practice. For example, French (1933) attempted to incorporate ideas from classical conditioning within psychoanalytic theory. Dollard and Miller (1950) synthesized the central ideas of unconscious motivation and conflict with concepts drawn from learning theories and Wachtel (1977) assimilated psychoanalysis with behaviour therapy. During the last decade of the twentieth 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, apart from reviewing the well-known integrative therapies available at that time, went beyond the exclusive focus of 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, behavioral and humanistic components of treatment in ever more complex permutations' (Gold & Stricker, 2006: 8).

Norcross and Newman (1992) have identified eight factors that have promoted psychotherapy integration in the past twenty years, including (1) the proliferation in the number of schools of psychotherapy, (2) the 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) the increase in communication between clinicians and scholars, (6) the lack of support for long-term psychotherapy from third-party payers, (7) the recognition of common factors in all psychotherapies that are related to outcome, and (8) the growth of journals, conferences, and professional organizations that have been dedicated to psychotherapy integration. Most recently Stiles (2009: 9) has outlined three logical operations which apply to integrative and assimilative modelling of psychotherapy. These include 'deduction' (logical consistency and interconnection), 'induction' (applying observation to theory), and 'abduction' (creating, refining, and elaborating theory). Theories, models, principles of change, and so on, which are the received canons of the psychotherapy profession are questioned and examined—to what extent are they helpful in producing therapeutic change and desirable outcome, and how do we incorporate both unique and common aspects of the clients in our clinical work? In summary, the convergence of these factors has resulted in a therapeutic pluralism, where therapeutic allegiance (i.e. adherence to a particular orientation) is superseded by incorporation of diverse therapeutic techniques that work for clients (Wampold, 2001).

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: 8). From the current psychotherapy integration literature, four major models of integration are identified, including *technical eclecticism*, *common factors approach*, *theoretical integration*, and *assimilative or strategic integration*. Each of these models of psychotherapy

integration is briefly reviewed before examining the best fit integrative model for cognitive hypnotherapy.

TECHNICAL ECLECTICISM INTEGRATION MODEL

Technical eclecticism, loosely referred to as *eclectic psychotherapy*, is intended to be an empirically based approach, which advocates selectively combining the best techniques, regardless of their theoretical origin, and applying them in such a way as to maximize the therapeutic results for a specific client in as short a time as possible (Lampropoulos, 2001). However, in practice technical eclecticism has not always been approached systematically. Very often the integration of techniques in technical eclecticism occurs haphazardly, arbitrarily, or idiosyncratically. On the other hand, Lazarus (1992, 2002) and Beutler et al. (2002) have developed *multimodal therapy* and *prescriptive psychotherapy* respectively, two well-known versions of technically eclectic psychotherapy that are very coherent and empirically driven. Multimodal therapy (Lazarus, 1992, 2002) was conceptualized by Arnold Lazarus, who became disenchanted with the limits of 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 client's concern with the most efficacious interventions, drawn from a variety of therapeutic orientations.

Although technical eclecticism is set out to promote flexibility for drawing techniques from different schools of therapy, the model presents some serious problems. First, integrated therapies often overlook any theory of personality or psychopathology (e.g. combining hypnosis with eye movement desensitization reprocessing (EMDR)). In such instances a framework for explaining and predicting human behaviour and therapeutic change is lacking. Second, eclecticism is often practised as if a therapeutic technique can be easily disembodied from its contextual framework and readily transported without consideration of its new psychotherapeutic context (Lazarus & Messer, 1991). Third, evaluation of technical eclecticism has been problematic. Because of the myriads of interactions involved in empirical eclecticism, it is very difficult to determine the relative effectiveness of each treatment component included in the integration.

It is important to appreciate that while many, if not most, practitioners of hypnotherapy describe themselves as more or less 'eclectic', there is a distinction been an empirically based eclecticism and more circumstantially driven eclecticism. Often as new techniques and new ideas emerge, mental health professionals tend to add them to their toolbox of treatment techniques, without giving much consideration to the theoretical or scientific rationale for integration. For example, regardless of theoretical orientation, EMDR became a phenomenon based upon its (apparent) effectiveness. With many hypnotherapists this patchwork eclecticism stands however in juxtaposition to assimilative eclecticism or integration described in this paper.

COMMON FACTORS APPROACH INTEGRATION MODEL

The common factor 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. The common factors approach to psychotherapy integration has generated considerable research, produced several lists of proposed common factors, and has facilitated a rapprochement between different therapies (Lampropoulos, 2001). For example, therapeutic relationship, therapeutic alliance, and collaborative process have been shown to be robust factors in *all* effective treatment (Norcross & Goldfried, 1992). However, due to many serious methodological issues, recently there has been no further development in research and practice on the common factors approach to therapy integration. One of the main problems with this approach relates to the common principles themselves. Although a common factor may appear simple on the surface, upon closer look it may over-simplify important differences.

THEORETICAL INTEGRATION MODEL

In this form of integration, different theories are combined in an attempt to construct a new and supraordinate 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. This 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. Similarly, Linehan (1993) and Greenberg (2002) have employed diverse means under broad conceptualization to changeful ends in their empirically validated approaches to treatment.

Lampropoulos (2001) has levelled four weaknesses related to the theoretical integration model of psychotherapy. First, although the goal of this model of psychotherapy is to integrate as many theories as possible, the existing models have succeeded in combining only two or three theories. Second, the focus of the existing theoretical integration models has been on specific psychological disorders only (e.g. Linehan focuses on borderline personality disorder), thus neglecting other diagnostic categories or syndromes. Third, because of their inherent theoretical differences and contrasting worldviews, integration presents conceptual and philosophical difficulties. Fourth, theoretical integration lacks systematic empirical validation.

ASSIMILATIVE OR STRATEGIC 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 best illustrated by the *psychodynamically based integrative therapy* developed by Gold and Stricker (2001, 2006) and the *strategic eclectic* approach described by Beutler et al. (2001). In Gold and Sticker's 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: 12). Messer (Lazarus & Messer, 1991; Messer, 1992) emphasizes that when techniques from different theories are incorporated into one's preferred theoretical orientation both the host theory and the im-

ported technique interact with each other to produce a new assimilative model. Currently, 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). Although there are some similarities between assimilative and eclectic modes of integration, eclecticism places less emphasis upon indexed, efficacious psychotherapy, or theoretical abstraction. Instead technical eclecticism tends to emphasize pragmatic 'guiding principles' (Lampropoulos, 2001: 145) associated with change; thus co-opting theory or technique in the service of effective overarching principles (Beutler et al., 2001). In other words, assimilative shifts are not planned ahead of time; rather, they emerge at therapeutic choice points (Stricker & Gold, 2006), thus allowing therapeutic flexibility and creativity (Mahrer, 2007). The cognitive hypnotherapy approach for treating emotional disorders described in this article is conceptualized as an assimilative integration model of psychotherapy. It is named cognitive hypnotherapy because the home theory leans heavily on cognitive-behavioural theories, concepts, and interventions.

COGNITIVE HYPNOTHERAPY AS ASSIMILATIVE MODEL OF PSYCHOTHERAPY

Historically the practice of hypnosis has arisen from and embraced a psychoanalytic framework. Like other schools of therapy, 'classical' analytically driven hypnotherapists have been resistant to diluting hypnotherapy with behaviour therapy or cognitive behaviour therapy. 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 challenge hypnosis regarding the ways relaxation and imagery training differ from hypnosis and what hypnosis can offer beyond relaxation or imagery training.
- Training programmes for CBT have not taught clinical hypnosis or emphasized the role of hypnosis in therapy.
- Some practitioners from other theoretical models have embraced hypnosis but do not endorse formal CBT strategies (Golden, 1994).
- Behaviour therapy has traditionally rejected the role of the unconscious, while traditional/historical hypnosis has readily embraced the unconscious.
- There is a lack of agreement on the definition of hypnosis.
- And, ironically, there is as yet lack of agreement on the definition of CBT.

To this list, we can also add:

- Hypnotherapy is often reduced, in the mind of academicians, to a mono-dimensional stereotype.
- Hypnosis does not provide a theory of personality, psychopathology, and behaviour change.
- Empirical validation of hypnosis techniques is in its infancy.

Nonetheless, some clinicians have avoided the reflexive dismissal of other approaches to psychotherapy and have made attempts to combine hypnosis with behaviour therapy (e.g. Lazarus, 1973; Kroger & Fezler, 1976; Clarke & Jackson, 1983) and with CBT (e.g. Alladin, 1994, 2006, 2007a, 2007b; Ellis, 1986, 1993, 1996; Golden, 1986, 1994, 2006). However, to our knowledge, with the exception of Alladin (2008a), none of the writers have formally attempted to combine hypnosis with CBT within any of the four psychotherapy integration models described above. Previously, Alladin (1994, 2006) described the *cognitive-dissociative model of depression*, recently revised and renamed the *circular feedback model of depression* (Alladin, 2007a), to establish the theoretical rationale for utilizing cognitive hypnotherapy (hypnosis combined with CBT) in the management of depression (Alladin, 1989, 1994, 2006, 2007a, 2007b, 2008a, 2008b, 2009, 2010a, 2010b). Nevertheless, a coherent and rational frame of reference for empirically justifying such an integration was lacking. The earlier work to ground, justify, and base cognitive hypnotherapy within a theoretical frame of reference (Alladin, 1989, 1994, 2006, 2007a, 2008b) is expanded here under the assimilative/strategic integration banner. In this article, CH, as it meets the criteria for assimilative or strategic integration, is touted as an assimilative integrative model of psychotherapy.

CRITERIA FOR ASSIMILATIVE MODEL OF PSYCHOTHERAPY

For a psychological intervention to be recognized as an assimilative integrated model of psychotherapy, it has to meet the six criteria posited by Lampropoulos (2001). The six criteria include (1) empirical validation of host theory, (2) empirically based assimilation, (3) evidence-based imported techniques, (4) sensitivity around assimilation, (5) coherent assimilation, and (6) empirical validation of assimilated therapy. CH meets these six criteria and the next section reviews the evidence for each criterion.

EMPIRICAL VALIDATION OF HOST THEORY

CBT has borne the most empirically based scrutiny of any theoretical orientation of psychotherapy (Hunsley, 2007). First, at the level of efficacy it is clear that the general principles and specific practices of CBT satisfy the criteria associated with standards for validation: internal consistency, parsimony of explanatory contrast, testability/clinical trials, and scope of application (Alford & Beck, 1997). Second, because of its broad conceptual base, CBT has demonstrated flexibility and optimism in incorporating technical and theoretical concepts in practical and applicable ways. In this regard Kazdin (1984) states that 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 behavior. Consequently, cognitive processes and their referents probably provide the place where the gap between psychodynamic and behavioral views is least wide' (1984: 163).

EMPIRICAL SUPPORT FOR TECHNIQUES

A second criteria for assimilative integration or eclectism is some empirical or evidence base for 'imported' techniques, that is, the ideas being integrated ought to be satisfactory to American Psychological Association (APA) standards for empirical validation or evidence base (Chambless & Hollon, 1998; APA, 2006). Reviews of the well-controlled empirical stud-

ies of the role of hypnosis in the treatment of a variety of medical and psychiatric conditions provide convincing evidence for the clinical efficacy of hypnosis (Alladin, 2007c, 2007d, 2008a; 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 et al., 2000). Other comprehensive reviews of the clinical trial literature indicate that hypnotherapy is effective with both acute and chronic pain (Patterson & Jensen, 2003; Elkins et al., 2007). The American Psychiatric Association recognizes 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 (see Alladin, 2008a, 2008b). 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 et al. (1995), from their meta-analysis of 18 studies comparing a cognitive-behavioural treatment with the same treatment supplemented by hypnosis, found the mean effect size for the hypnotic treatment to be larger than the 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 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.

EVIDENCE-BASED RATIONALE FOR ASSIMILATION

The circumstances and rationale for selecting the techniques to be assimilated should be empirically guided and evidence based. Alladin (2007a, 2008a) 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 (DePiano & Salzberg, 1986). Hypnotherapists routinely observe such rapid changes in their patients, which is succinctly documented by Yapko (2003): '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' (2003: 106).

Hypnosis serves as 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 profound therapeutic effect with both medical and psychological conditions (Kirsch, 1990; 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; Yapko, 2003; Lynn & Kirsch, 2006). Whether hypnosis works via placebo effect or by influencing behavioural and physiological responses, the sensitive therapist can create the right atmosphere to capitalize on suggestibility and expectation effects to bolster therapeutic gains (Erickson & Rossi, 1979). Kirsch (1999) has stressed 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' (1999: 216).

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 hypnotic induction as a strategy to obtain compliance. Within the hypnotherapy context, Lynn et al. (1996) have recommended a prescription of permissiveness, parsimonious and easy therapeutic tasks, and preparation for setbacks to reduce resistance.

Hypnosis fosters strong therapeutic alliance:

Repeated hypnotic experience fosters strong therapeutic alliance (Brown & Fromm, 1986). 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 helps 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, 1986). Such transference reinforces the therapeutic alliance.

Hypnosis induces deep relaxation and lowers arousal:

Hypnosis induces relaxation, which is effective in reducing anxiety and 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 maximizes the ability to concentrate, which enhances learning of new materials. The relaxation experience is particularly helpful to patients who have co-morbid anxiety. For example, many depressives experience anxiety; approximately 50–76% of depressives have co-morbid anxiety disorder (see Dozois & Westra, 2004). Alladin and Alibhai (2007) and Dobbin et al. (2009) have found relaxation induced by self-hypnosis to be very beneficial to depressed patients.

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 automatic influence on feelings, thoughts, and behaviour. Ego-strengthening is incorporated in hypnotherapy to bolster 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) 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' (1991: 58).

Hypnosis facilitates divergent thinking:

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

Hypnosis directs attention to wider experiences and evokes psychophysiological correlates:

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 organizes emotional and experiential information. Therefore hypnosis can be utilized to restructure cognitive and emotional processes influenced by the non-dominant cerebral hemisphere.

Hypnosis allows access to non-consciousness processes:

Hypnosis provides 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 organization of primitive emotions.

Hypnosis facilitates imagery conditioning:

Hypnosis provides a basis for imagery training/conditioning. When the patient is hypnotized, 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 desensitization (in imagination 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; and (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) 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.' (1999: 196)*

Hypnosis induces dreams:

Hypnosis can induce dreams and increase dream recall and understanding (Golden et al., 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, and (c) primes emotional themata for use in free association, fantasies, and perceptual categorization.

Repeated hypnotic induction of positive mood can lead to the development of 'antidepressive' pathways (Schwartz, 1984; Alladin, 2007a). 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 hypnotized subjects were able to produce changes in brain function (measured by positron emission tomography (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. Their investigation led Schwartz (1984) to believe that if it is possible to produce depressive pathways through negative cognitive focusing, then it would be possible to develop antidepressive or happy pathways by focusing on positive imagery.

Post-hypnotic suggestions:

Hypnosis provides post-hypnotic suggestions (PHS) which can be very powerful in altering problem behaviours, dysfunctional cognitions, and negative emotions. PHS can also be used for shaping behaviour. Barrios (1973) considers PHS 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 utilized 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 PHS to shape adaptive and prosocial behaviours.

Hypnosis facilitates training in positive self-hypnosis:

Self-hypnosis training can be facilitated by hetero-hypnotic induction and post-hypnotic suggestions. Most of the techniques mentioned above can be practised under self-hypnosis, thus promoting positive self-hypnosis by deflecting negative self-suggestions. Patients with various emotional disorders have the tendency to ruminate negatively, which can be considered to be a form of negative self-hypnosis (Araoz, 1981, 1985; Alladin, 1994, 2006, 2007a). Abramson and his colleagues (Abramson et al., 2002) examined the relationship between cognitive vulnerability and Beck's theory of depression. They found cognitive vulnerability to underlie the tendency to ruminate negatively, which led them to hypothesize 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 (1) negative affect, (2) depressive symptoms, (3) negatively biased thinking, (4) poor problem-solving, (5) impaired motivation and inhibition of instrumental behaviour, (6) impaired concentration and cognition, and (7) 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, 2004). Training in positive self-hypnosis provides a strategy for counteracting negative ruminations (Alladin, 2007a).

Hypnosis creates perceived self-efficacy:

Bandura (1977) believes 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 impacts 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, for example, 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, 1986).

SENSITIVITY AROUND ASSIMILATION

Therapists 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 world view (Messer, 1989). Assimilation must not only honour fundamental efficacious evaluation of a theory or technique but the broader consideration(s) related to effectiveness variables. The concept of evidence-based practice (APA, 2006) reaches far beyond simple empirical validation of technique. Issues related to timing, motivation, patient characteristics, relationship dynamics, creativity, and so on emerge as robust factors equally supported by research. For example, orthodox CBT and hypnotic age regression present as strange bedfellows at first glance. Furthermore, there is much controversy around the efficacy of hypnosis relative to memory (Lynn et al., 2003). Nonetheless in response to patient characteristics—as motivational intervention, as a vehicle to strengthen ego or enhance treatment effect, as a means to stage treatment, as a means to lower resistance, as a means to honour patient expectancy, and so on—regression as a technique can be expropriated towards more cognitive or behavioural ends. Sensitive (and coherent) assimilation then is justified upon empirical grounds as opposed to more chaotic, 'shotgun' approaches.

COHERENT ASSIMILATION

The assimilative integration process should be coherent or theoretically compatible with the primary 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. An assimilative integration process ought to be able to account for technical expropriation without raising the theoretical nature of the host theory.

Such an approach does not simply try a lot of things until something works, but rather bases incorporation upon efficacy studies and effectiveness principles. Without such consideration three possibilities arise: (1) a new theoretical integrative therapy is evolved, (2) a multimodal or eclectic mode of therapy is generated, or (3) a meaningless and contradictory hodgepodge of techniques are assembled (Lampropoulos, 2001). Hypnosis, not being a therapy per se, but a collection of strategies, is easily integrated with CBT without changing the theoretical conceptualization of CBT. Kirsch's (1993) 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 (1990). (1993: 153)*

EMPIRICAL VALIDATION OF ASSIMILATED THERAPY

Without empirical validation or evidence-based principles it is not possible to either justify technique or establish whether the importation of a technique into a host therapy positively impacts treatment, especially when techniques are decontextualized and placed in a new framework. It is only through empirical validation that the creation and practice of ineffective and idiosyncratic assimilative integration or 'chaotic eclectism' can be avoided. Several studies (e.g. Schoenberger et al., 1997; Bryant et al., 2005; Alladin & Alibhai, 2007) and reviews (Kirsch et al., 1995; Schoenberger, 2000; Flammer & Alladin, 2007) have demonstrated the effectiveness of combining hypnosis with CBT. Studies examining the additive effect of hypnosis have usually combined several hypnotic techniques with CBT. For example, Alladin and Alibhai (2007) utilized hypnotic relaxation, ego-strengthening, expansion of awareness, positive mood induction, post-hypnotic suggestions, and self-hypnosis with CBT in the treatment of depression.

COGNITIVE HYPNOTHERAPY AS AN ASSIMILATIVE MODEL OF PSYCHOTHERAPY

From the reviews of the integrative models, it would appear that the assimilative model of psychotherapy provides the best approach for integrating hypnotherapy with CBT. Alladin (1994, 2006, 2007a, 2007b, 2008a, 2008b, 2009, 2010a, 2010b) refers to this integration as cognitive hypnotherapy. There are many reasons for assimilating hypnotic techniques with CBT.

1. CH 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 in the management of depression (Alladin & Alibhai, 2007), acute stress disorder (Bryant et al., 2005), and a variety of emotional disorders (Kirsch et al., 1995; Schoenberger et al., 1997; Schoenberger, 2000; Alladin, 2008b).

2. CH allows CBT therapists to continue practising in the frame 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 have 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. CH can be equally beneficial to therapists who practice 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 home 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, 2008a) 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' (2007: 54) for a variety of emotional disorders.
5. CH as an assimilative model of integrated psychotherapy provides an additive design (Allen et al., 2006) for studying the adjunctive effect of hypnosis when it is combined with a bona fide psychotherapy or medical intervention (see below).

EMPIRICAL VALIDATION OF COGNITIVE HYPNOTHERAPY AS AN ASSIMILATIVE TREATMENT

Although CH meets the criteria for an assimilative model of psychotherapy, it requires further empirical validation. Without empirical validation it is not possible to establish whether the importation of hypnotic techniques into CBT positively impact therapy, especially when the techniques are decontextualized and placed in a new framework. It is only through empirical validation that ineffective and idiosyncratic assimilation can be avoided. Moreover, empirical validation is important for the re-evaluation of the assimilative model itself.

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 treatment protocol, based on latest empirical evidence, provides an *additive design* for studying the summative effect of hypnosis. An additive design involves a strategy in which the treatment to be tested is added to another treatment to determine whether the treatment added produces an incremental improvement over the first treatment (Allen et al., 2006). In CH, the treatment protocols are specifically designed in a structured way to test for the clinical usefulness of adding a hypnotherapy component to CBT. Alladin (2008b) offers several well-structured assimilative protocols that can be easily validated. Some assimilative hypnotherapy protocols with conditions such as acute stress disorder (Bryant et al., 2005), depression (Alladin & Alibhai, 2007), and somatoform disorders (Moene et al., 2003) have already been validated. However, these studies need to be replicated and subjected to *second generation* studies, that

is, studies using dismantling design to evaluate the relative effectiveness of each imported technique (Alladin, 2008a). For example, Alladin and Alibhai (2007) in their CH protocol for depression imported several hypnotic techniques into CBT, including hypnotic relaxation, ego-strengthening, expansion of awareness, positive mood induction, post-hypnotic suggestions, and self-hypnosis. Without further studies (second generation studies), there is no way of knowing which techniques were effective and which were superfluous.

The assimilative protocols that have not been subjected to empirical validation are suitable for *first generation* studies. First generation studies involve either assessing the additive effect of imported techniques via the additive design, or comparing a single-modality hypnotherapy with another well-established therapy, for example, CBT for depression (Alladin, 2007a) or exposure therapy for post-traumatic stress disorder (Lynn & Cardena, 2007). An assimilative treatment protocol for somatization disorder derived from Alladin (2008a) is summarized below to illustrate how hypnotic techniques can be assimilated into CBT in a structured mode to facilitate empirical validation. This treatment protocol also demonstrates how multiple clinical concerns are addressed when treating such a complex syndrome as somatization disorder.

EXAMPLE OF A STRUCTURED TREATMENT PROTOCOL FOR SOMATIZATION DISORDER

Somatization disorder is characterized by multiple somatic complaints with no apparent physical cause for which medical attention is sought (Davison et al., 2005). As the disorder includes elements of dissociation, conversion, and somatization, hypnotherapy has been intuitively used as an adjunct in the management of the medically unexplained symptoms. Although there is no randomized clinical trial of hypnosis-based treatment for somatization disorder reported in the literature, Alladin (2008b) cites several reasons for combining hypnosis with CBT.

First, many early psychiatric luminaries such as Charcot, Janet, Breuer, and Freud successfully treated somatoform disordered patients with hypnosis and they noted the similarity between hypnotic response and somatization (Moene et al., 2003). Recent brain imaging studies have supported the proposition that there are common neurological processes shared by hypnotic responding and somatoform symptoms (Marshall et al., 1997; Halligan et al., 2000). Second, because there are similarities in the neurological mechanisms involved in hypnosis and somatoform disorders, somatization patients might be particularly responsive to hypnotic suggestions. It is well established that patients with somatoform disorders have high hypnotic capacity (Bliss, 1984; Maldonado, 1996a, 1996b) and therefore Maldonado and Spiegel (2003) have proposed that since the hypnotic phenomena may be involved in the aetiology of some somatoform symptoms, hypnosis can be used to control the symptoms. Third, somatoform symptoms can be elicited during hypnosis (Thornton, 1976), thus creating positive expectancy and bolstering the credibility of the hypnotic procedures. Hypnotic susceptibility, dissociation, and conversion play important roles in the aetiology of somatization disorder (see Alladin, 2008b). Within this conceptualization of somatization, it makes logical sense to use hypnosis to manage the symptoms. Fifth, hypnotherapy has been reported by many authors to be effective in the management of somatoform disorders (e.g. Frankel, 1994; Maldonado & Spiegel, 2003). Although, to date, no randomized controlled clinical trial of hypnotherapy for somatization disorder is reported in the literature, the hypnosis-based treatment utilized by Moene et al. (2003)

for conversion disorder can be easily adapted to the treatment of somatization. In their randomized controlled clinical trial of hypnosis-based treatment for motor type conversion disorder, Moene et al. (2003) found hypnosis to be effective in reducing motor disability and behavioural symptoms associated with motor conversion. The hypnotic techniques described by Moene et al. (2003) can be easily assimilated with the CBT treatment protocol for somatization disorder recently described by Woolfolk and Allen (2007). Woolfolk and Allen published a CBT manual for treating somatization disorder, based on three studies (see Woolfolk & Allen, 2007) that examined the efficacy of individually administered CBT with patients manifesting a diverse set of unexplained physical symptoms. The CBT was compared with standard medical care augmented by psychiatric consultations. Patients receiving CBT reported greater reductions in somatic complaints compared to comparison conditions.

CH for somatization disorder as described by Alladin (2008b) combines CBT and hypnotic strategies; and the treatment is extended over 16 weekly sessions of one hour each. CH for somatization disorder is specifically designed in a structured way to test for the clinical usefulness of adding a hypnotherapy component to the CBT protocol evaluated by Allen et al. (2006). The 16-week format of CH draws heavily from Woolfolk and Allen (2007) and comprises hypnotherapy, self-hypnosis, behaviour modification, cognitive restructuring, emotional awareness, positive mood induction, and interpersonal skills training. There are also several empirical reasons for combining hypnosis with CBT in the management of somatization disorder. Literature reviews (Schoenberger, 2000), meta-analysis (Kirsch et al., 1995), and empirical studies (Bryant et al., 2005; Alladin & Alibhai, 2007) have demonstrated that when hypnotherapy is combined with CBT in the management of emotional disorders, the effect size increases. Moreover, well-controlled studies of hypnotherapy in the management of a variety of medical conditions have demonstrated the clinical efficacy of hypnosis (Lynn et al., 2000; Pinnell & Covino, 2000; Alladin, 2007c, 2007d).

The effectiveness of hypnosis in the management of pain has been even more remarkable. For example, a meta-analysis of controlled trials of hypnotic analgesia demonstrates that hypnotherapy can provide relief for 75% of the patients studied (Montgomery et al., 2000). The treatment effect was largest for the patients who were highly suggestible to hypnosis. The National Institute of Health Technology Assessment Panel on Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia (1996) reviewed outcome studies on hypnosis with pain and concluded that there is strong research evidence that hypnosis is effective with chronic pain. Similarly, a meta-analysis review of contemporary research on hypnosis and pain management (Montgomery et al., 2000) documented that hypnosis meets the American Psychological Association criteria (Chambless & Hollon, 1998) for being an efficacious and specific treatment for pain, showing superiority over medication, psychological placebos, and other treatments. More recently, Elkins et al. (2007) reviewed 13 controlled prospective trials of hypnosis for the treatment of chronic pain, which compared outcomes from hypnosis for the treatment of chronic pain to either baseline data or a control condition. The data from the review indicates that hypnosis interventions consistently produce significant decreases in pain associated with a variety of chronic pain problems. Also, hypnosis was generally found to be more effective than non-hypnotic interventions such as attention, physical therapy, and education. Similarly, Alladin (2008b) and Hammond (2007) from their review of the literature on the effectiveness of

hypnosis in the treatment of headache and migraine concluded that hypnotherapy meets the clinical psychology research criteria for being a well-established and efficacious treatment for tension and migraine headaches.

SESSION 1

1. The first session is devoted to clinical assessment and goal setting.
2. A detailed clinical history is taken to formulate the diagnosis and identify the essential psychological, physiological, social, and environmental aspects of the patient's behaviours within a biopsychosocial framework.
3. A case formulation approach to clinical assessment is used (Alladin, 2007b, 2008b). The main function of the case formulation is to devise an effective treatment plan. Moreover, the case formulation approach allows the clinician to translate and tailor nomothetic (general) treatment protocol to the individual (idiographic) patient.
4. As many somatization patients have complex symptom histories, assessment should be seen as a process that occurs throughout the treatment.

It is important to set realistic goals to prevent 'another failure'. Most somatization patients have a long history of unexplained medical symptoms, repeated medical examinations, and lack of response to treatment. The patient is reassured that the treatment may not cure the condition, but it will help to ameliorate the symptoms.

SESSION 2

Session 2 focuses on (1) review of the week, (2) discussing rationale for treatment, (3) providing an overview of the treatment, (4) establishing rapport, (5) reviewing the patient's physical symptoms, (6) introducing the symptom-monitoring forms, and (7) assessing for hypnotic suggestibility.

SESSIONS 3–4

1. The week is reviewed and homework examined.
2. Hypnosis is introduced with a focus on induction, relaxation training, producing somatosensory changes, trance ratification (via eye and body catalepsy), ego-strengthening, post-hypnotic suggestions, and self-hypnosis training.
3. Homework is assigned (self-hypnosis CD, monitoring symptoms, and increasing physical activities).

SESSIONS 5–7

These three sessions concentrate on (1) reviewing the week, (2) reviewing homework, (3) introducing hypnotic strategies for symptom-amelioration (consisting of deep relaxation, symptom-transformation, dissociation of body parts, and complete dissociation), and (4) assigning homework. The main focus of these hypnotherapy sessions is to teach the patient how to utilize different hypnotic strategies to produce amelioration in symptoms.

SESSION 8

1. The main goal of this session is to teach self-hypnosis for symptom amelioration and promoting healing. Healing is promoted by asking the patient to (a) imagine the area of concern (e.g. the gut in a patient with irritable bowel syndrome (IBS) symptoms) is warming up due to increased blood circulation in the targeted area and (b) to visualize the extra blood flow is bringing in more oxygen and nutrition to the area, thus promoting healing.
2. Homework is a very important component of the treatment. At this stage, homework assignments include (a) daily completion of the symptom-monitoring form, (b) listening to the self-hypnosis CD every day, (c) practising the skills of transforming the symptoms (e.g. sharp pain transformed into a dull pain), (d) practising dissociating each part or the whole body, (e) practising warming up the targeted areas of concern, and (f) increasing physical activities.

SESSION 9

In this session the therapist has a joint session with the patient and his/her significant other.

1. The goals of this joint session are to (a) review the week and homework, (b) discuss the rationale for meeting with the patient's significant other, (c) plan joint activities, and (d) assign further homework. The goals for involving the significant other (domestic partner or spouse) in the treatment of somatization disorder include (a) obtaining of additional information about the patient, (b) gaining the support of the significant other for the treatment, (c) altering the behaviour of the significant other that may be reinforcing the patient's symptoms or illness behaviour, and (d) utilizing the significant other to facilitate some aspects of the treatment (e.g. the significant other can encourage the patient to increase physical activities).
2. The homework remains the same as previous session, but pleasurable conjoint activities with significant other are included.

SESSIONS 10–13

Patients with somatization disorder tend to have dysfunctional beliefs about their somatic sensations and their ability to perform effectively (Woolfolk & Allen, 2007). They can also have non-health-related dysfunctional thinking and themes such as perfectionist thoughts, catastrophic thoughts, over-estimation of possible negative outcomes, 'should' statements, and dichotomous thinking. Woolfolk and Allen (2007) believe these dysfunctional thoughts represent the somatizer's core beliefs of being inadequate or unlovable.

1. The next four sessions therefore focus on CBT. The objects of the CBT sessions are to help the patient identify and restructure their dysfunctional beliefs that may be triggering, exacerbating, and maintaining their symptoms. The CBT sessions are structured in the same format as with other disorders such as anxiety and depression. For a detailed account of CBT for depression within the context of CH see Alladin (2007a).

2. At this point in the therapy homework also involves recording, monitoring, and restructuring dysfunctional thinking.

SESSION 14

This session focuses on cognitive restructuring under hypnosis. Within the CH formulation, insight-orientated or exploratory hypnotic techniques are used when the patient does not respond to the usual CBT treatment protocol. Cognitive restructuring under hypnosis allows the therapist and the patient to explore intrapersonal dynamics and the unconscious origin or purposes of the symptoms. There are many insight-oriented hypnotic methods (e.g. Brown & Fromm, 1986; Watkins & Barabasz, 2008). The simplest and most widely used one is ideomotor signalling. Once the underlying cause of the somatization symptoms is established, the therapist helps the patient to deal with the non-conscious issue in a satisfactory conscious manner. The patient is encouraged to continue with the homework assigned in the previous sessions.

SESSION 15

This session is devoted to the second meeting with the significant other. This conjoint session reviews the grounds and prescription of strategies that were covered during the first conjoint session. This conjoint session concentrates mostly on communication and support.

SESSION 16

This session focuses on helping the somatization patient develop or improve interpersonal skills. Patients with somatization disorder often have multiple social problems and chaotic lifestyles characterized by poor interpersonal relationships and disruptive or difficult behaviour (see Abbey, 2006). The goal of this session is to help the patient objectively define some of these problems and to adopt a problem-solving strategy with these problems. Social skills training, behavioural activation, and mindfulness training can be utilized. Hypnotherapy is used to build self-esteem (via ego-strengthening and imaginal rehearsal), control anger, increase self-efficacy (forward projection), and catalyze the prosocial behaviours.

FOLLOW-UPS AND BOOSTER SESSIONS

As somatization disorder is a chronic condition and not yet curable, regular follow-up visits are essential for successful long-term care.

CLINICAL AND RESEARCH IMPLICATIONS

Although the conceptualization of CH as an assimilative model of psychotherapy advances the adjunctive role of hypnotherapy from the fringes of therapeutic activities to a more prominent position in the psychotherapy integration movement, much work remains to be done. Future progress will depend a great deal on what the hypnosis community chooses to do. This is only the first step to hypnotherapy gaining greater recognition as an empirically valid clinical intervention for enhancing treatment effect when combined with mainstream psychotherapies. For the field of clinical hypnosis to flourish and achieve this coveted sta-

tus of treatment enhancer with various disorders, clinical practice and research will have to be conducted within the context of the assimilative model of hypnotherapy.

1. Clinicians and investigators should take greater interest in integrative therapies rather than firmly holding on to a sectarian version of psychotherapy that was created generations ago.
2. Clinical assessment and treatment will need to be based on the assimilative model of hypnotherapy. Although the CH model described in this paper uses CBT as the base theory for assimilation, the model provides a template for assimilation of hypnosis into other mainstream psychotherapies. However, when developing new assimilative models it will be important to clearly delineate the models within the criteria proposed by Lampropoulos (2001) and the treatment protocols should be evidence based and fully described to allow for replication and empirical validation.
3. Clinical assessment needs to be carried out within the case formulation approach, paying particular attention to the current developments of the aetiology.
4. Treatment strategies should be based on individual case formulation and empirical evidence.
5. Baseline and outcome measures should be used.
6. Assimilative treatment protocols that have not been subjected to empirical validation should be subjected to first generation studies. First generation studies, as discussed above, involve either assessing the additive effect of imported techniques via the additive design, or allowing comparison of a single-modality hypnotherapy with another well-established therapy. For example, CBT for depression or exposure therapy for post-traumatic stress disorder as described by Lynn and Cardena (2007).
7. Assimilative hypnotherapy protocols that have already been validated need to be replicated and subjected to second-generation studies. These studies, by using dismantling designs, will be able to evaluate the relative effectiveness of each imported technique to a home theory (Alladin, 2008b). Through these studies the techniques will be refined by discarding superfluous imported techniques.

LIMITATIONS OF THE ASSIMILATIVE MODEL

While we have been encouraged to 'shop the market place' (Mahrer, 2007) and accept that 'many advances occur in the consulting room of individual therapists' (Gold & Stricker, 2006: 13) this does not mean free rein (Stiles, 2009). Clinicians ought to be encouraged to experiment with new integrative ideas—for example, the contemporary interface between cognitive therapy and Southern Buddhist teachings—and see each case as an 'N of 1' quasi single case design (Amundson & Gill, 2001). Simultaneously researchers ought to continue to explore the basis for success or failure in treatment in the largest or most specific sense. In this regard, we advocate for tentativeness, that is, an empirical scepticism regarding too much rigour. Gold and Stricker (2006) state:

> *Future progress in psychotherapy integration may be stalled or even be made impossible by overly strict demands for rigor and regularity in psychotherapy that emphasize conformity to manuals and guidelines at the expense of clinical experimentation and innovation. Pressure both within the profession of psychotherapy and from without*

> *(from government, insurance companies, and the public) for empirical support for the effectiveness of psychotherapy and for manuals that standardize psychotherapeutic practice are particularly relevant here. Although empirical support for psychotherapy is to be valued and pursued, many advances occur in the consulting room of individual therapists who cannot submit their work to large-scale research investigations. (2006: 13)*

Gold and Stricker (2006) also comment on the stalling of creativity when treatment becomes manualized. Moreover, beyond the blending of techniques, clinicians should attempt to integrate patients' insight and feedback into their assimilative therapies. It is hoped that the detailed and structured protocol will provide guidance to treatment and encourage evaluation of the adjunctive techniques.

SUMMARY

Wampold (2001) reminds us that 22% of the variance in treatment is indeterminant—as yet, or perhaps never to be, accounted for. We would suggest this is also applicable for the realm of assimilation under the gaze of critical, integrative, and empirical consideration. Again Gold and Stricker (2006) remind us that:

> *The essence of manualized psychotherapy (which is aimed at ensuring uniformity) runs counter to the spirit of practice of psychotherapy integration. In many ways, the term psychotherapy integration is synonymous with psychotherapeutic creativity and originality, and it is difficult to see how creativity can be accounted for and operationalized in a set of instructions, such as in a manual. (2006: 13)*

We believe and would hope that cognitive hypnotherapy, which is theory-driven—a good psychotherapeutic theory organizes the 'therapists' experience of their clients, giving meaning and interconnections to the clients' past, present and future' (Stiles, 2009: 10)—stands out as a tent big enough to serve the purposes of empirical investigation, creativity, innovation, and the principles of integrative assimilation.

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