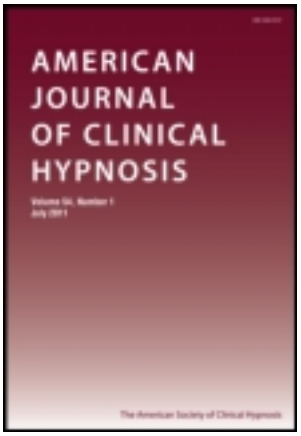

American Journal of Clinical Hypnosis
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/ujhy20

Cognitive Hypnotherapy for Anxiety Disorders

William L. Golden [a]
[a] Cornell Medical College, White Plains, New York, USA

Available online: 26 Mar 2012

To cite this article: William L. Golden (2012): Cognitive Hypnotherapy for Anxiety Disorders, American Journal of Clinical Hypnosis, 54:4, 263-274

To link to this article: http://dx.doi.org/10.1080/00029157.2011.650333

American Journal of Clinical Hypnosis, 54: 263–274, 2012

ISSN: 0002-9157 print / 2160-0562 online
DOI: 10.1080/00029157.2011.650333

Routledge
Taylor & Francis Group

Cognitive Hypnotherapy for Anxiety Disorders

William L. Golden
Cornell Medical College, White Plains, New York, USA

Cognitive hypnotherapy, also known as cognitive-behavioral hypnotherapy (CBH), is applied to the treatment of anxiety disorders. Specific techniques are described and illustrated. The research on CBH is discussed. CBH seems to be at least as effective as behavior therapy (BT) and cognitive-behavior therapy (CBT) treatments that employ imagery and relaxation techniques for anxiety disorders. However, more research is needed because of the lack of adequate studies comparing CBH with BT and CBT. Clinical implications and suggestions for future research are offered.

Keywords: anxiety, CBT, cognitive-behavioral hypnotherapy, cognitive-behavior treatment, cognitive hypnotherapy, hypnotherapy

Cognitive-behavior therapy (CBT) and hypnosis share a number of commonalities that make for a natural integration of the two approaches (Golden, 1983, 1985; Golden, Dowd, & Friedberg, 1987; Golden & Friedberg, 1986). Imagery and relaxation are common to both hypnosis and CBT. According to Barber and his associates, the same cognitive processes (focused thinking and imagining, expectations, and attitudes) are involved in hypnosis and CBT (Barber, 1979; Spanos & Barber, 1974, 1976).

The integration of hypnosis and behavior therapy (BT) can be traced back to Wolpe (1958). Systematic desensitization (SD) is an imagery-based BT technique that was developed by Wolpe (1958) for the treatment of fears and phobias. Although Wolpe (1958) originally used hypnosis for anxiety reduction during SD, he switched to Jacobson's (1929) progressive relaxation technique because many of his patients objected to being hypnotized. Nevertheless, Wolpe and Lazarus (1966) reported using hypnosis with SD in about one third of their cases.

Cognitive, behavioral, and hypnotic techniques provide the basis for cognitive hypnotherapy, also known as cognitive-behavioral hypnotherapy (CBH), which is the result of an integration of CBT and hypnotherapy. CBT itself is an integrated approach. One approach to CBT has been to add cognitive components to traditional BT techniques. Through their research, Goldfried and Meichenbaum (Goldfried, 1971; Meichenbaum, 1972) demonstrated that applying a coping skills approach to SD

Address correspondence to William L. Golden, 4 Ryder Road, Briarcliff, NY 10510, USA. E-mail: williamgolden@optonline.net

improved its efficacy. In the coping skills approach, patients learn to use relaxation techniques and coping self-statements for reducing their anxiety during SD.

Maladaptive thoughts are a focus of intervention in CBT and CBH. According to Araoz (1985) and Alladin (2007), negative self-hypnosis (NSH) is a destructive type of self-hypnosis that involves self-suggestions that cause emotional disturbance. NSH is the same phenomena that Ellis (1962) refers to as irrational self-talk; what Beck (Beck & Emery, 1985) refers to as automatic thoughts, and Nolen-Hoeksema (1991) calls it negative rumination or brooding. In CBT, cognitive-restructuring techniques are employed to modify maladaptive thoughts. Similar methods can be traced back to some of the early hypnotherapists (Bernheim, 1895; Prince & Coriat, 1907).

Applications of CBH in the Treatment of Anxiety Disorders

There have been a number of clinical applications of CBH in the treatment of anxiety disorders. The types of anxiety disorders have been diverse, such as generalized anxiety disorder (Golden, 2006), job interview anxiety (Golden et al., 1987), test anxiety (Boutin, 1978), airplane phobia (Golden, 1994, 2006; Golden et al., 1987), school phobia (Crawford & Barabasz, 1993), public speaking anxiety (Schoenberger, 1996), panic disorder (Golden, 1986b), agoraphobia associated with irritable bowel disorder (Golden, 2006, 2007), sexual performance anxiety (Golden et al., 1987), and post-traumatic stress disorder (Alladin, 2008; Cardeña, 2000).

Research on Hypnosis in the Treatment of Anxiety Disorders

Chambless and Ollendick (2001), on the basis of their reviews of the literature, have identified SD to be an empirically supported therapy (EST) in treating phobias and fears, including public speaking anxiety, social anxiety/phobia, and other specific phobias. CBT has also been identified by Chambless and Ollendick as an EST in the treatment of anxiety and phobias including generalized anxiety disorder, social anxiety/phobia, agoraphobia, panic disorder, and post-traumatic stress disorder (PTSD) (when used in combination with exposure therapy). Chambless and Ollendick identified hypnosis as an EST for recurrent headaches, irritable bowel syndrome, and obesity (when used in combination with CBT). However, they did not include hypnosis as an EST for the treatment of anxiety or phobias.

There have been studies that have attempted to examine whether hypnosis can enhance the effectiveness of BT or CBT. It is beyond the scope of this article to do a complete review of that literature. Several reviews of the literature have already been published covering hypnosis in the treatment of anxiety and phobias (Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000; McGuinness, 1984), as an adjunct to behavior therapy (Humphreys, 1986; Spinhoven, 1987), as an adjunct to CBT (Kirsch,

Montgomery, & Sapirstein, 1995; Schoenberger, 2000), and as a treatment for PTSD (see Alladin, 2008; Cardeña, 2000; Lynn & Cardeña, 2007). Several reviews have addressed the question of what patient variables enhance the effectiveness of hypnotherapy (Crawford & Barabasz, 1993; Lynn & Shindler, 2002; McGuinness, 1984).

In the reviews that examined the integration of hypnosis with BT (Humphreys, 1986; McGuinness, 1984; Spinhoven, 1987) only a few studies were identified demonstrating that the addition of hypnosis was superior to a nonhypnotic version of BT. Most of the studies included in these reviews suffer methodological flaws, such as small sample sizes, inadequate control groups, and lack of objective outcome measures. Humphreys (1986) concluded that there was not enough experimental evidence to establish that hypnosis enhances the effectiveness of BT. McGuinness (1984) concluded that the success of hypnosis in the treatment of phobias is largely the result of enhanced imagery and relaxation and subject variables such as hypnotizabilty and motivation. On the other hand, hypnotizability does not consistently predict therapeutic outcome for CBH treatments for anxiety (Schoenberger, 2000). Furthermore, Spinhoven (1987) concluded that the data is conflicted on the ability of hypnosis to enhance imagery and relaxation, and asserts that the benefit of hypnosis as an adjunct to BT is in its effect on patient expectations and treatment credibility. The consensus among the reviewers is that more research is needed.

Kirsch and colleagues (1995) in their meta-analysis of 18 studies in which CBT was compared to CBH (the same CBT treatment with hypnosis added) concluded that hypnosis enhances the effectiveness of CBT. However, only a few of the studies in the Kirsch et al. (1995) meta-analysis were relevant to anxiety disorders. Schoenberger (2000), on the basis of a review of the literature, concluded that while CBH treatments for anxiety were more effective than no treatment, there was only one study where it was found that a CBH treatment was more effective than a comparable CBT treatment for anxiety (Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997). In the Schoenberger et al. (1997) study, the CBH and the CBT were basically the same. The CBH treatment differed from the CBT in the labeling of the CBT techniques as hypnosis and included suggestions for improvement following the hypnotic induction. In a recent study, not included in any of the reviews on CBH, the relative effectiveness of SD with hypnosis was compared to SD with relaxation in the treatment of animal phobias (Forbes, 2007). The SD with hypnosis treatment included a hypnotic induction and suggestions that involved coping imagery. The SD without hypnosis included progressive relaxation instead of a hypnotic induction, and did not include the suggestions with coping imagery. The subjects receiving SD with hypnosis experienced greater anxiety reduction than the subjects receiving SD with progressive relaxation.

Spanos and Barber (1976) point out that most of the studies comparing hypnotic and nonhypnotic CBT treatments confound the assimilation of a hypnotic induction with the addition of fear-reducing suggestions. It may be the addition of the fear-reducing suggestions, or the coping imagery, and not the hypnotic induction procedure that is responsible for the increased effectiveness of SD. According to Spanos and Barber,

the reason why suggestions enhance the effectiveness of CBT techniques, such as SD, is because they provide the patient with a cognitive strategy. The reason why fear-reducing suggestions enhance the effectiveness of SD may be the same reason why coping self-statements and coping imagery enhance the effectiveness of SD. In support of the Spanos and Barber hypothesis, Woody and Shauble (1969) found that the addition of fear-reducing suggestions without a hypnotic induction enhanced the efficacy of traditional SD.

Fear-reducing suggestions and coping self-statements are both cognitive strategies that patients can use for reducing anxiety. As mentioned earlier, Meichenbaum (1972) demonstrated that adding coping self-statements and coping imagery during SD improved its efficacy. Likewise, there is some evidence that adding cognitive interventions to hypnotherapy increases its effectiveness. Boutin and Tosi (1983) found that rational stage directed hypnotherapy, which is a CBH approach that combines hypnosis and CBT strategies, was more effective than hypnosis alone in the treatment of test anxiety.

The integration of CBT and hypnosis provides a more effective treatment approach than either one alone, at least for some patients (Alladin, 2007; Alladin & Amundson, 2011). Patients' expectations about hypnosis may be one of the variables in determining its effectiveness. There is some evidence that patients with positive expectations and beliefs about hypnosis are the most responsive to treatments labeled and presented as hypnosis (Lazarus, 1973; Schoenberger et al., 1997). However, more research is needed to determine whether the enhanced effects observed in CBH are attributable to hypnotic induction, expectations, cognitive strategies, or a combination of these variables.

Therapeutic Interventions Used in CBH

Hypnotic Induction Procedures

Various relaxation and hypnotic induction techniques can be combined to create a procedure that is tailored to the needs and preferences of a given patient. The patient collaborates with the therapist in the decision making about which hypnotic induction and relaxation techniques to employ. Instead of using standardized images, patients are encouraged to create their own relaxation images. Getting patients involved increases the likelihood that they will be responsive and will follow through and use the techniques on their own as part of self-hypnosis. Individualized recordings are made for each patient for the purpose of facilitating self-hypnosis training. For detailed descriptions of various hypnotic induction procedures and deepening techniques, the reader is referred to Golden and colleagues (1987). For guidelines in selecting which hypnotic induction procedure to use with a particular patient, the reader is referred to Golden (1986a).

Self-Hypnosis

As part of self-hypnosis training, patients are taught to use hypnotic induction procedures, deepening techniques, and hypnotic suggestions. The author uses several methods for teaching self-hypnosis. In order to facilitate self-hypnosis, hypnotic inductions can be recorded for the patient to listen to at home. They are encouraged to practice self-hypnosis after listening to the recording several times. Alternatively, patients are given scripts that they can memorize or use for making recordings in their own voice. They are also taught the basic skills of hypnosis (relaxation, imagery, suggestion).

Patients are taught how to use self-hypnosis to prepare themselves for anxiety-producing situations. During self-hypnosis, they imagine coping with upcoming stressful events and apply hypnotic suggestion to reduce anxiety and build confidence. They are encouraged to apply their self-hypnosis skills during *in vivo* exposure.

Hypnotic Desensitization

The desensitization approach that the author uses involves 5 stages:

(1) Behavioral assessment and hierarchy construction,
(2) Hypnosis and relaxation training,
(3) Constructing hypnotic suggestions,
(4) Gradual exposure to feared situations through imagery and the use of therapeutic suggestions given during hypnosis, and
(5) *In vivo* exposure to feared situations.

Hierarchy Construction

SD provides patients an opportunity to confront their fears in a gradual manner. Care is taken to make sure that a patient experiences success with one step before proceeding to a next step. As part of behavioral assessment, the patient's fear or phobia is broken down to specific anxiety-producing situations. The situations are then rank ordered from least to most anxiety-producing, and are graded on a Subjective Units of Disturbance Scale (SUDS) from 1–100, where 100% is the most anxiety-provoking situation. In Table 1 is an example of an anxiety hierarchy that was used in the treatment of a patient (Tom) with public speaking anxiety, social anxiety, and a fear of vomiting in public. Tom had some motion sickness as a child and had one childhood experience where he vomited in his friend's parents' car. As an adult, although Tom experienced some nausea when anxious, he actually did not vomit in any of his feared situations. It was his fear of vomiting and his fear of social disapproval that made him anxious. The items and their SUDS ratings are presented in Table 1.

TABLE 1
Example of an Anxiety Hierarchy With SUDS Ratings

Situation	*SUDS*
1- Eating at home with friends	25
2- Eating in a restaurant with family	30
3- Eating in a restaurant with friends	35
4- Riding in an above-ground train	35
5- Bus, light traffic	40
6- Subway, short distance	40
7- Subway, long distance	45
8- Bus in heavy stop-and-go traffic	45
9- Taxicab ride, heavy traffic, with friend	50
10- Flying, experiencing turbulence	55
11- Business meetings	55
12- Eating with business associates	60
13- Meeting with new clients	65
14- Eating with new clients	70
15- Presenting his services to new clients	75
16- Giving a presentation, small audience	80
17- Giving a presentation, large audience	85

Cognitive Restructuring

In applying cognitive restructuring to hypnotherapy, the concept of negative self-hypnosis can be used to help patients to understand how their negative self-suggestions and frightening fantasies produce anxiety. They are taught to monitor and identify these cognitions. Patients are taught to replace their negative self-suggestions with hypnotic suggestions for anxiety reduction. The hypnotic suggestions can be applied during SD and self-hypnosis. The two-column method can be used for formulating hypnotic suggestions.

Two-Column Method

In using the two-column method, a page is divided in half. On the left side of the page, patients list their negative self-suggestions. Therapeutic suggestions are listed on the other side of the page. Table 2 shows an example of the two-column method used for generating some of the hypnotic suggestions for Tom, the patient with speech anxiety and a fear of vomiting described earlier.

Imagery Desensitization

After relaxation is induced, the therapist describes an item from the patient's hierarchy and repeats therapeutic suggestions that were developed utilizing the two-column

TABLE 2
Example of the Two-Column Method

Negative Self-Suggestions	*Hypnotic Suggestions*
1) Everyone will know I'm a fraud and I don't know what I'm talking about.	1) I've always gotten very good feedback on my presentations and I'm frequently told I'm very knowledgeable.
2) What if I vomit in front of people?	2) I've never vomited while giving presentations before. And now I have self-hypnosis and breathing techniques that will control anxiety and nausea.
3) People will lose respect for me if I vomit in front of them. They will think I'm weak.	3) I am assuming that people will condemn me, but I would be sympathetic if it happened to someone else. And while I think my fear is a weakness, I can acknowledge my strengths, including that I'm a very good speaker.

method described above. In addition, posthypnotic suggestions can be given. For example, prior to ending hypnosis, these suggestions were given to Tom, the patient whose hierarchy and two-column method were described above:

> And just as you are able to feel calm and in control while you imagine giving a presentation to a large audience, you will be able to do the same when you actually give the presentation . . . And you will remember that you have always gotten very good feedback on your presentations, and you are frequently told that you are very knowledgeable . . . You are a very good speaker . . . And now hypnosis and your breathing techniques will help you to feel more calm and more in control . . . your mind, your body, your stomach . . . calm and in control. And you will see, that as time goes on, and you give more presentations, you will feel even more confident, and more in control . . . And in a few moments, you will start to gradually return to the fully alert, wide-awake state . . . feeling more confident, feeling more in control . . . now starting to return to the fully alert, wide-awake state . . . feeling more confident . . . more calm . . . more relaxed . . . feeling more in control.

Before proceeding to the next hierarchy item, the therapist makes sure that the patient is ready to proceed. Making use of ideomotor signaling, the therapist can ask, "If you feel ready to proceed with the next item, you can let me know by gently nodding your head." If the patient indicates that he or she is experiencing anxiety, hypnotic suggestions for relaxation and rational thinking are given. In the case of Tom, the patient with the fear of vomiting, feelings of nausea were also monitored during SD. Slow diaphragmatic breathing was used whenever Tom reported experiencing nausea during SD. Diaphragmatic breathing has been found to be effective in reducing nausea and vomiting in addition to being a relaxation technique (see Golden, Gersh, & Robbins, 1992).

In Vivo Desensitization

In vivo assignments follow the successful completion of in-session hypnotic desensitization. Patients are instructed to gradually face their fears, and to practice self-hypnosis in preparation for those situations as well as during *in vivo* exposures.

Although *in vivo* exposure therapy is frequently employed as a treatment itself, there are many cases where *in vivo* exposure alone is insufficient for anxiety reduction. This is frequently the case when there is no phobic avoidance, such as in social anxiety (as opposed to social phobia) and generalized anxiety disorder (GAD). For example, Tom, the patient with speech anxiety and a fear of vomiting, was already having *in vivo* exposure. Tom's job required him to travel, go to meetings, and give presentations. He was becoming more anxious as a result of such exposure. He did not experience any anxiety reduction despite frequent travel on buses, trains, and airplanes. Tom continued to feel anxious when eating in public even though he did not avoid meals with friends. It is important for patients to experience anxiety reduction when undergoing imaginal and real-life exposure. Hypnosis provides anxiety reduction during imaginal exposure. Usually the anxiety reduction that they experience during imaginal desensitization generalizes to the real-life situations. Patients are also encouraged to use relaxation techniques and hypnotic suggestions during *in vivo* exposure, if needed.

In the case of Tom, through the combination of diaphragmatic breathing, relaxation, and suggestions he was able to imagine each of the anxiety-producing situations while remaining calm. He used self-hypnosis to replicate these experiences which were generalized to the real-life situations.

Flooding

In CBH, whenever possible, graded exposure to feared situations is preferred. However, there are many cases where graded exposure is unnecessary or is impractical. For example, there is not enough time to construct a finely graded anxiety hierarchy when an airplane phobic seeks treatment the day, or several days, before he or she needs to fly. Another example relates to phobic patients who report feeling the same amount of anxiety in all situations.

Flooding is a BT treatment that is similar to desensitization, in that both involve exposure to an anxiety-producing image or situation. However, flooding is quicker than SD because it typically does not include a graded hierarchy, relaxation, or other coping strategies. During traditional flooding, patients typically experience anxiety, sometimes high levels of anxiety. Therefore, adequate exposure time is needed in order to allow for the patient's anxiety to undergo extinction.

As an alternative, a CBT version of flooding can be used to keep the patient's anxiety down to a manageable level. Golden, Geller, and Hendricks (1981) found that a flooding procedure, that included relaxation and coping self-statements, was more effective than traditional flooding. When used in CBH, a hypnotic induction is used prior to exposing the patient to the images of the feared situations. Even when time constraints make it impossible for the development of a finely graded anxiety hierarchy, flooding can still be done in a step-wise fashion. The fear is broken down to at least a few items. Some therapists have used frightening images during flooding. However, frightening images can

intensify a patient's fear and cause sensitization (Golden, 1994). Realistic images are more likely to result in anxiety reduction, especially when used in combination with hypnotic induction procedures, relaxation techniques, and fear-reducing suggestions. Because the word "flooding" may frighten patients, the author prefers using terms such as visualization, or mental rehearsal when presenting the technique. See Golden (1994) for the CBH application of flooding in the treatment of an airplane phobic patient.

The CBH version of flooding is also very similar to a CBT technique called rational emotive imagery (REI) (Maultsby, 1975). When using REI, a patient imagines being in a stressful situation and practices using rational self-statements. In the case of a patient with anxiety about an upcoming job interview, the following rational self-statements can be used while the patient imagines being interviewed: "I have the qualifications and I'm ready for this interview. But even if I don't get this job, I'm not a failure or worthless. Eventually I'll get a job."

When using REI as part of hypnotherapy, a hypnotic induction is used prior to the imagery (Golden, 1983). Initially the therapist guides the patient. Later, the patient practices REI as part of self-hypnosis. One of the greatest advantages of using imagery techniques such as REI, visualization or mental rehearsal is that the therapist can be more flexible and intervene more quickly than with SD. It is very common for patients to begin therapy sessions with the "problem of the week" and want help with that issue as opposed to working on an item from a hierarchy. The therapist can shift to the patient's immediate concern and, during that session, use hypnosis, mental rehearsal, and fear-reducing suggestions to prepare the patent for the stressor that will be encountered that week.

Summary and Discussion

As discussed earlier, there are studies that have found CBH to be more effective than CBT without hypnosis. However, there are only a few studies comparing CBH with CBT, or BT, in the treatment of anxiety disorders. As noted in the various reviews of the literature on CBH, conclusions about the efficacy of CBH are difficult to reach because most of the studies suffer from methodological problems, lack appropriate control groups, and have small sample sizes. Furthermore, as pointed out by Spanos and Barber (1976), there is confounding in studies where components of a treatment package are combined, such as a hypnotic induction with the addition of fear-reducing suggestions. Future research needs to be done to examine the individual effects of adding a hypnotic induction, anxiety-reducing suggestions, and coping imagery to treatments such as SD.

CBH treatments may not be more effective than comparable CBT treatments. CBH does seem to be at least as effective as comparable BT and CBT treatments. Treatments that include hypnosis do not need to be superior to other treatments in order to have clinical value. As pointed out by Lazarus (1973), we should be examining what treatments are effective for which patients, for what problems, under what specific conditions.

Some clinical guidelines can be offered based on research examining individual differences. Imaginative involvement is a skill, or trait, that is correlated with hypnotic suggestibility (Spanos & Barber, 1974, 1976). Patient's expectations about hypnosis may be one of the variables in determining its effectiveness (Lazarus, 1973; Schoenberger et al., 1997). Hypnotherapy should therefore be considered for patients who have a moderate to high degree of imaginative skill and for patients with positive expectations and beliefs about hypnosis. Future research is needed to clarify the role of subject variables, such as hypnotizability, imaginative skills, and positive expectations and their interaction in determining treatment effectiveness. A few studies addressing these issues could possibly help in establishing CBH as an evidence-based treatment for phobias and anxiety.

References

Alladin, A. (2007). *Handbook of cognitive hypnotherapy for depression: An evidence-based approach*. Philadelphia, PA: Lippincott Williams & Wilkins.

Alladin, A. (2008). Cognitive hypnotherapy with post-traumatic stress disorder. In A. Alladin, *Cognitive hypnotherapy: An integrated approach to the treatment of emotional disorder* (pp. 81–124). Chichester, UK: John Wiley & Sons, Ltd.

Alladin, A., & Amundson, J. (2011). Cognitive hypnotherapy as an assimilative model of therapy. *Contemporary Hypnosis & Integrative Therapy*, *28*, 17–45.

Araoz, D. L. (1985). *The new hypnosis*. New York, NY: Brunner/Mazel.

Barber, T. X. (1979). Suggested ("hypnotic") behavior: The trance paradigm versus an alternative paradigm. In E. Fromm & R. E. Shor (Eds.), *Hypnosis: Developments in research and new perspectives* (2nd ed., pp. 217–271). New York, NY: Aldine.

Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York, NY: Basic Books.

Bernheim, H. (1895). *Suggestive therapeutics*. New York, NY: Putnam.

Boutin, G. E. (1978). Treatment of test anxiety by rational stage directed hypnotherapy: A case study. *American Journal of Clinical Hypnosis*, *21*, 52–57.

Boutin, G. E., & Tosi, D. J. (1983). Modification of irrational ideas and test anxiety through rational stage directed hypnotherapy RSDH. *Journal of Clinical Psychology*, *39*, 382–391.

Cardeña, E. (2000). Hypnosis in the treatment of trauma: A promising, but not fully supported, efficacious intervention. *International Journal of Clinical and Experimental Hypnosis*, *48*, 225–238.

Chambless, D. L., & Ollendick, T. H. (2001). Empirically supported psychological interventions: Controversies and evidence. *Annual Review of Psychology*, *52*, 685–716.

Crawford, H. J., & Barabasz, A. F. (1993). Phobias and intense fears: Facilitating their treatment with hypnosis. In J. W. Rhue, S. J. Lynn, & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp. 311–338). Washington, DC: American Psychological Association.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York, NY: Lyle Stuart.

Forbes, S. (2007). *Relative effectiveness of imaginal exposure with and without hypnosis in the treatment of specific animal phobias*. Master's dissertation, Department of Psychology, University College, London.

Golden, W. L. (1983). Rational-emotive hypnotherapy: Principals and techniques. *British Journal of Cognitive Psychotherapy*, *1*, 47–56.

Golden, W. L. (1985). Commonalities between cognitive-behavior therapy and hypnotherapy. *The Cognitive Behaviorist*, *7*, 2–4.

Golden, W. L. (1986a). Another view of choosing inductions. In B. Zilbergeld, M. G. Edelstein, & D. L. Araoz (Eds.), *Hypnosis: Questions and answers* (pp. 110–117). New York, NY: W. W. Norton & Co.

Golden, W. L. (1986b). An integration of Ericksonian and cognitive-behavioral hypnotherapy in the treatment of anxiety disorders. In E. T. Dowd & J. M. Healy (Eds.), *Case studies in hypnotherapy* (pp. 12–22). New York, NY: Guilford Press.

Golden, W. L. (1994). Cognitive-behavioral hypnotherapy for anxiety disorders. *Journal of Cognitive Psychotherapy: An International Quarterly*, *8*, 265–274.

Golden, W. L. (2006). Hypnotherapy for anxiety, phobias and psychophysiological disorders. In R. A. Chapman (Ed.), *The clinical use of hypnosis in cognitive behavior therapy* (pp. 101–137). New York, NY: Springer Publishing Co.

Golden, W. L. (2007). Cognitive-behavioral hypnotherapy in the treatment of irritable-bowel-syndrome-induced agoraphobia. *International Journal of Clinical and Experimental Hypnosis*, *55*, 131–146.

Golden, W. L., Dowd, E. T., & Friedberg, F. (1987). *Hypnotherapy: A modern approach*. New York, NY: Pergamon Press.

Golden, W. L., & Friedberg, F. (1986). Cognitive behavioural hypnotherapy. In W. Dryden & W. L. Golden (Eds.), *Cognitive-behavioural approaches to psychotherapy* (pp. 290–319). London, UK: Harper & Row.

Golden, W. L., Geller, E., & Hendricks, C. (1981). A coping-skills approach to flooding therapy in the treatment of test anxiety. *Rational Living*, *16*, 17–20.

Golden, W. L., Gersh, W. D., & Robbins, D. M. (1992). *Psychological treatment of cancer patients*. New York, NY: Pergamon Press.

Goldfried, M. R. (1971). Systematic desensitization as training in self-control. *Journal of Consulting and Clinical Psychology*, *37*, 228–234.

Humphreys, A. (1986). Review of the literature on the adjunctive use of hypnosis in behavior therapy: 1970–1980. *British Journal of Experimental and Clinical Hypnosis*, *3*, 95–101.

Jacobson, E. (1929). *Progressive relaxation*. Chicago, IL: University of Chicago Press.

Kirsch, I., Montgomery, G., & Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *63*, 214–220.

Lazarus, A. A. (1973). "Hypnosis" as a facilitator in behavior therapy. *International Journal of Clinical and Experimental Hypnosis*, *21*, 25–31.

Lynn, S. J., & Cardeña, E. (2007). Hypnosis and the treatment of post-traumatic conditions: An evidence-based approach. *International Journal of Clinical and Experimental Hypnosis*, *55*, 167–188.

Lynn, S. J., Kirsch, I., Barabasz, A. F., Cardeña, E., & Patterson, D. (2000). Hypnosis as an empirically supported clinical intervention: The state of the evidence and a look to the future. *International Journal of Clinical and Experimental Hypnosis*, *48*, 239–259.

Lynn, S. J., & Shindler, K. (2002). The role of hypnotizability: Assessment in treatment. *American Journal of Clinical Hypnosis*, *44*, 185–197.

Maultsby, M. C. (1975). *Help yourself to happiness through rational self-counseling*. Boston, MA: Marlborough House.

McGuinness, T. P. (1984). Hypnosis in the treatment of phobias: A review of the literature. *American Journal of Clinical Hypnosis*, *26*, 261–272.

Meichenbaum, D. H. (1972). Cognitive modification of test anxious college students. *Journal of Consulting and Clinical Psychology*, *39*, 370–380.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of Abnormal Psychology*, *100*, 569–582.

Prince, M., & Coriat, I. (1907). Cases illustrating the educational treatment of the psychoneuroses. *Journal of Abnormal Psychology*, *2*, 166–177.

Schoenberger, N. E. (1996). Cognitive-behavioral hypnotherapy for phobic anxiety. In S. J. Lynn, I. Kirsch, & J. W. Rhue (Eds.), *Casebook of clinical hypnosis* (pp. 33–49). Washington, DC: American Psychological Association.

Schoenberger, N. E. (2000). Research on hypnosis as an adjunct to cognitive behavioral psychotherapy. *International Journal of Clinical and Experimental Hypnosis*, *48*, 154–169.

Schoenberger, N. E., Kirsch, I., Gearan, P., Montgomery, P., & Pastyrnak, S. L. (1997). Hypnotic enhancement of a cognitive behavioral treatment for public speaking. *Behavior Therapy*, *28*, 127–140.

Spanos, N. P., & Barber, T. X. (1974). Toward a convergence in hypnosis research. *American Psychologist*, *29*, 500–511.

Spanos, N. P., & Barber, T. X. (1976). Behavior modification and hypnosis. In M. Hersen, R. M. Eisler, & P. M. Miller (Eds.), *Progress in behavior modification* (pp. 1–44). New York, NY: Academic Press.

Spinhoven, P. (1987). Hypnosis and behavior therapy: A review. *International Journal of Clinical and Experimental Hypnosis*, *35*, 8–31.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Oxford, UK: Pergamon Press.

Wolpe, J., & Lazarus, A. (1966). *Behavior therapy techniques*. New York, NY: Pergamon Press.

Woody, R. H., & Shauble, P. J. (1969). Desensitization of fear by video tapes. *Journal of Clinical Psychology*, *25*, 102–103.