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

Paradoxical Intention: Everywhere and Nowhere All at Once

Clair Cassiello-Robbins[a,b,d] & Jacqueline R. Bullis[c]

[a] Triangle Area Psychology Clinic, Durham NC

[b] Unified Protocol Institute, Boston MA

[c] McLean Hospital, Belmont MA

[d] Correspondence regarding this article should be sent to: Clair Cassiello-Robbins, 45 Milford Street, Boston, MA, 02118.
Email: clair@unifiedprotocol.com

ABSTRACT

We provide commentary on the article *Paradoxical Intention (PI) Combined with Hypnosis in the Rapid Treatment of Anxiety Disorders: The Cases of "Fran" and "Emily,"* by Sam Hamburg (2026). We highlight strengths of the article, including its effort to identify the active elements of treatment, as well as its use of case observations in an effort to advance the field of psychology. We also discuss several areas of weakness, including the use of unclear definitions of "success" in treatment, focus on habituation-based exposure, and lack of acknowledgement of research-supported treatments that include principles of paradoxical intention within their intervention.

Keywords: paradoxical intention; anxiety; Cognitive Behavior Therapy (CBT); Unified Protocol (UP); transdiagnostic treatment; clinical case study; case study

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We are delighted to have been asked to comment on this paper about the application of paradoxical intention to two cases of anxiety disorders. First, we want to commend the author on thinking creatively and critically about the active elements of treatment, or the specific intervention procedures delivered with the intent to cause therapeutic change—in this instance, paradoxical intention. If psychology is to improve treatment outcomes, it is imperative that we better understand how and for whom specific therapeutic interventions work. In the absence of well-defined active elements of treatment, efforts to identify mechanisms of change will continue to fall short.

In addition, we have long been proponents of using case observations and systematic data collection from individuals to inspire scientific advancements in the treatment of psychological conditions. Indeed, we have both used and published on the methods of single-case experimental

design (SCED), which involved rigorous data collection from an individual and the use of these data to understand the drivers of intra-individual change. These methods are often overlooked in favor of larger, randomized controlled trials despite their strong internal validity and ability to identify mechanisms of change in psychotherapy (Barlow, Nock, & Hersen, 2009).

However, despite our enthusiasm for these underrepresented methods of examining psychological phenomenon, there are several components of this article that we believe merit critical evaluation. First, we will comment on elements of the design itself, then speak to some of the author's comments about paradoxical intention as an intervention, and conclude with a brief review of an alternative approach to the conceptualization and treatment of the two cases presented within his article.

CONFLATION OF APPROXIMATE NUMBERS FOR RESULTS

While we are enthusiastic supporters of small n studies (indeed one of us helps run a website dedicated to improving the understanding of small n studies; statsof1.org), we find that this article conflates approximate numbers and ill defined "successes" for data driven results. Comments such as claiming an 80% success rate, without a clear delineation of what is considered "success" does not actually create an 80% success rate. Case studies are certainly valuable for highlighting rare clinical cases or treatments and providing the seeds for advancement of psychological treatment, and SCEDs can be utilized to link behavior or symptom change to the application of specific active elements of treatment. However, to claim an 80% success rate, the definition of success needs to be both clearly defined and ideally substantiated using less subjective indices of improvement (e.g., independent evaluation, validated measures of symptom severity, repeated measurement and, ideally, follow-up assessments, etc.).The clinical observations provided by the author are certainly valuable, and at the same time, cannot replace more systematic data collection.

COGNITIVE BEHAVIORAL CONCEPTUALIZATION OF PANIC DISORDER

As psychologists who practice cognitive behavioral therapy (CBT), conduct and publish research on CBT, and who train practitioners globally in CBT case conceptualization and treatment, we would like to note some places where the author's description of CBT for panic disorder diverges from our own. CBT models of panic disorder do include an acknowledgment of a biological vulnerability, along with the appreciation that anxiety sensitivity (i.e., a fear of anxiety-related physical sensations) is a robust dispositional risk factor for the experience of panic attacks, both in-vivo and in response to biological challenges (e.g., carbon dioxide inhalation), and the development of panic and related anxiety disorders. It is also important to note the difference between the experience of a panic attack and the development of panic disorder; not everyone who experiences an uncued panic attack will go on to suffer from panic

disorder. Although the reasons why someone does develop panic disorder following the experience of one or several panic attacks may not have as clear of a pathogenesis as Rocky Mountain spotted fever, we do know it is at least a combination of a generalized biological vulnerability, catastrophic interpretations of the physical sensations themselves, and reliance on avoidant coping strategies that contribute to development of panic disorder.

While the author asserts that CBT is singularly focused on the fear of physical sensations and neglects the "dread" that many people suffering from panic disorder experience, CBT does in fact view the anticipation of future attacks to be central to both understanding and treating panic disorder. Specifically, patients with panic disorder experience anticipatory (i.e., future-oriented) anxiety about the possibility of experiencing another panic attack and its consequences in addition to fear of the physical sensations themselves; CBT for panic disorder targets both of these maintaining factors.

FOCUS ON HABITUATION-BASED EXPOSURE

Perhaps even more importantly, the author makes several incorrect assertions about exposure and CBT and ignores recent advancements in the field of exposure therapy. The author refers several times throughout the paper to desensitization and habituation. However, more recent research has elucidated a better understanding of the mechanisms by which exposure therapy work, which has in turn led to refinements in the field of how to deliver exposure therapy to optimize its outcome. Whereas habituation was the dominant theory of how exposure therapy worked for decades, we now better understand it to work through a process referred to as to as inhibitory learning (Craske et al., 2014). Whereas habituation-based exposure focuses on reduction in emotional intensity over time through repeated exposure to the emotion-provoking stimulus, inhibitory learning focuses on the learning that an individual obtains by engaging with the emotion-provoking stimulus. In inhibitory learning, reduction of emotional distress or intensity is not required for exposure to be effective. Instead, what matters most is that the individual learns something about their ability to tolerate the stimulus and associated emotions, regardless of change in the intensity of the experience. Indeed, as we detail in the next section, paradoxical intention is necessary for this type of exposure and has been included in several cutting edge interventions.

Moreover, this mischaracterization of exposure perpetuates myths about exposure that might make both patients and providers hesitant to engage in these interventions. For example, some people do not habituate (Arch & Craske, 2009). By defining habituation as "success" in exposure, many patients and providers might feel that exposure has failed if habituation has not occurred. Such "failures" could reduce willingness to engage in exposure in the future. Additionally, habituation-based exposure does not always produce lasting change (Craske & Rachman, 1986; Craske & Mystkowski, 2006), which can also make it seem as though exposure therapy has failed. A common barrier to providers utilizing exposure therapy, a first-line

treatment for anxiety and related disorders, is that many patients and providers report concern that exposure will be too distressing to be helpful (Moses et al., 2023). When success is defined by reduction in distress, experiencing intense emotion that does not habituate would be considered a failure. However, if success is defined by trying a new activity and learning something new, then experiencing intense distress and coping, is considered success. By teaching individuals that they can tolerate their emotions, and these emotions are in fact safe to experience, inhibitory learning exposure empowers individuals and their providers to broaden the definition of success in exposure therapy beyond simply habituation or desensitization.

While there are certainly valid questions to raise about exposure therapy, and it is certainly not the appropriate intervention for everyone and every presenting problem, we find the mischaracterization of exposure here one that may contribute to unhelpful attitudes or beliefs about the practice of exposure.

ASSERTION THAT PARADOXICAL INTENTION IS UNDERUSED

Finally, and most importantly, the author asserts that paradoxical intention is rarely, if ever, used in psychological treatment. However, we disagree. We find that paradoxical intention has made its way into the collective wisdom of our society. For example, these lyrics from the King and I, written by Rogers and Hammerstein, demonstrate this principle.

Whenever I feel afraid
I hold my head erect
And whistle a happy tune
So no one will suspect I'm afraid
While shivering in my shoes
I strike a careless pose
And whistle a happy tune
And no one ever knows I'm afraid
The result of this deception
Is very strange to tell
For when I fool the people
I fear I fool myself as well

More importantly in this context, this principle has also found its way into the collective wisdom of psychology. In fact, it is entirely unsurprising to us that the author noted paradoxical intentions have been most often reported successful in the literature with insomnia, conversion reactions, obsessive-compulsive disorder, social anxiety disorder, panic disorder, agoraphobia, and so on, as these are all disorders for which the current first-line treatments are exposure-based.

So, while the term itself is no longer commonly used, the principle is embedded in many of our evidence-based psychological treatments. In particular, Carl Izard wrote that the most

efficient way to change an emotion is to change its action tendency (Izard,1977). At this point in time, many (if not most) evidence-based psychological interventions include components that are consistent with paradoxical intention. Indeed, most CBT-based treatment contain elements of acting alternative or opposite to their initial action tendencies. Here we offer the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2017) as one such an example of a treatment that integrates the principles of paradoxical intention.

The UP is an emotion-focused treatment that addresses emotional disorders. Here the term emotional disorder is a functional term, as opposed to a diagnostic term. Emotional disorders refers to any clinical presentation with the following characteristics 1) the presence of frequent, intense emotions, 2) judgement of or aversion to the experience of these emotions (e.g., the perception of emotions as bad, unacceptable, or uncontrollable), and 3) reliance on avoidance-based coping strategies that provide short-term relief from the experience of emotions but perpetuates difficulty managing emotions in the long-term (Bullis et al., 2019). This definition is based on an accumulation of research highlighting the shared etiological and maintenance mechanisms relevant to difficulties managing the experience of strong emotions across diagnostic boundaries.

This definition of emotional disorders lends itself to paradoxical intention interventions on its own. That is, if avoidance-based coping is perpetuating difficulty managing strong emotions, then approaching and experiencing (often even intensifying) the experience of emotions would disrupt the cycle maintaining a patient's difficulties. And indeed, the UP contains several treatment elements that include paradoxical intention.

In brief, the UP is comprised of eight treatment modules. In module one, patients engage in motivational enhancement exercises by setting behaviorally specific treatments goals and completing a decisional balance exercise to explore the pros and cons of engaging in treatment versus not. Module two targets the model of emotional disorders directly by providing psychoeducation about the function of emotions and teaching patients to break down their experience into thoughts, physical sensations, and behaviors. It also helps patients understand the short- and long-term consequences of their behavior in order to identify ineffective behaviors that are maintaining their symptoms and might benefit from change. In module three, mindfulness skills are introduced to increase emotion awareness; patients learn to apply non-judgmental present-focused attention to the experience of their emotions through a series of emotion-focused mindfulness exercises. Module four introduces cognitive flexibility skills to encourage patients to find alternative interpretations for unhelpful patterns of thinking about both specific situations and their beliefs about emotions. Module five teaches patients to engage in alternative actions for ineffective behaviors. In module six, patients engage in interoceptive exposure to learn to experience and tolerate the physical sensations associated with strong emotions; more recent research has contributed to our understanding that interoceptive exposures

are beneficial for patients beyond those with panic disorder (Boswell et al, 2013). Module seven focuses on emotion exposure; patients purposefully engage in emotion-provoking situations as a way to learn more about their ability to tolerate strong emotions. Finally, in module eight, relapse prevention activities are conducted to help patients prepare to practice skills independently once treatment is terminated.

It is modules five, six, and seven that most explicitly use paradoxical intention. Engaging in alternative actions involves paradoxical intention as patients are encouraged to engage in behaviors that are counter to their typical action tendencies. Because their typical action tendencies involve avoidance, suppression, or escape, alternative actions require patients to choose behaviors that keep them in contact with and/or intensify their emotions. Further, in module six (interoceptive exposure) patients purposefully produce, experience, and intensify physical sensations that they find distressing or aversive. The goal here is not necessarily habituation, but that patients learn they are able to tolerate the experience of these intense sensations and that it is safe for them to do so. Finally, in module seven, which focuses on emotion exposure, patients purposefully approach situations that produce strong emotions and even engage in efforts to intensify their emotional experience by combining exposures (e.g., conducting an in-vivo exposure after completing interoceptive exposure to intensify physical sensations). Inhibitory learning models of exposure are based on the expectation violation that occurs between a patient's predicted or feared outcome and their actual experience during the exposure, so a patient may be explicitly encouraged to engage in strategies to bring anxiety or distress up if they notice it has declined substantially while engaging in the exposure.

The two cases described in this paper could also be conceptualized and treated using the UP. If we revisit the case conceptualization provided by this treatment, it applies to both patients. First, Fran described feeling intense anxiety (it is possible she also experienced other emotions intensely, but this was not described in the case study). She also appeared to interpret the emotion as dangerous (e.g., thinking that nausea is a sign of a heart attack). Finally, she was engaging in efforts to escape and avoid the emotion. Fran created an "axis of safety" and limited the distance she would travel from home. She also avoided large stores and other places she felt would be difficult to escape. While this avoidance likely provided short-term relief, it was limiting her life in the long-term. Additionally, this avoidance was reinforcing Fran's belief that the anxiety was dangerous.

Emily's case also appears to fit well within the UP case conceptualization. She describes feeling intense fear and anxiety and indicates that she experiences these emotions as aversive. While she does not directly state this in the provided quotes, Emily's behavior indicates that she finds the emotions problematic by relying on benzodiazepines to try to eliminate the emotion. The medication also serves to allow her to escape and avoid the emotions associated with flying. While benzodiazepines provide short-term relief in the form of an almost instantaneous reduction

in anxiety, they pose several long-term challenges. They can become habit forming and discontinuing the medication can be quite challenging. Additionally, similar to other types of avoidance, these medications reinforce the idea that the person themselves cannot manage the emotion and need to rely on medication instead.

Thus, both cases appear to fit well within the described UP model and would be candidates for UP treatment. This treatment typically involves progressing sequentially through the aforementioned modules. More or less time can be spent in each module depending on the needs of the patient. To highlight the place of paradoxical intention in the UP, we will discuss how two UP modules could be applied to these patients.

For Fran, module six would be particularly relevant. Fran would first engage in psychoeducation about the role of physical sensations in the experience of strong emotion. Then she would engage in exercises to specifically induce the physical sensations she was distressed by. For example, she might drink seltzer quickly to induce nausea. She might also breathe through a thin straw to produce shortness of breath and chest tightness (which are often associated with her worst fear of a heart attack). By inducing these physical sensations on purpose, she would learn that the sensations are tolerable and she can navigate the experience of them (i.e., the focus would be on the new learning that occurred via an expectation violation, not habituation). In module seven, Fran would actually engage in many of the activities described in the case study. She would go places such as large stores to learn about her ability to experience the emotions associated with these experiences. She might also engage in interoceptive exposures in these locations to intensify her experience (which was not done in the case study). Through these exposure exercises she would learn that she can navigate the emotions without relying on escape or avoidance behavior.

For Emily, module five would help her build her insight into how many of her behaviors were paradoxically increasing her anxiety about flying. For example, white knuckling through the experience and relying on benzodiazepines both provide short-term relief and increase anxiety over time. Emily would then develop alternative actions for these behaviors such as leaving benzodiazepines at home or using mindful emotion awareness instead of white knuckling. These alterative behaviors would increase her anxiety at first, but would also increase her confidence in managing anxiety over time. In module seven, Emily would be able to use her planned flights for work as exposure practice. She would be encouraged to get on the plane while implementing her alternative actions. By engaging in these exposures, she would be able to learn that she can tolerate the emotions she experiences while anxious.

The author of this paper suggests that there are not systematic treatment procedures available in psychology, but we would disagree. We believe the UP is an example of a treatment that provides a set of active treatment elements that can be broadly applied, while still being personalized to each individual and their experience. Indeed, studies show that the UP is

effective at reducing the symptoms of a wide range of emotional disorders (Cassiello-Robbins et al., 2020; Longley & Gleiser, 2023; Sakiris & Berle, 2019). Further, the procedures applied in the UP are derived from decades of research aimed at understanding the mechanisms that produce and maintain difficulty managing strong emotions.

The case studies provided by Hamburg could also attribute much of their success to elements that are present in the UP. For example, Emily did engage in exposure practice. And Fran engaged in some alternative action practice by reading while flying. However, there are elements of these cases that have less research support. For example, the addition of hypnosis to exposure therapy is not well explored and it is unclear whether hypnosis procedures would come to function as avoidance behavior over time.

A valid question and/or criticism might be that the UP is a much longer treatment than that provided by Hamburg. However, research suggests that patients who complete UP treatment often maintain their gains for years after treatment is complete (Bullis et al., 2023). Additionally, by completing more thorough exposure procedures, it is possible Emily and Fran would have derived greater benefit. For example, it is possible that Emily would have experienced even greater treatment "success" if she had the opportunity to fly without reliance on her safety behaviors. By continuing to take the benzodiazepine while flying, Emily was reinforcing unhelpful beliefs about the danger of anxiety and her inability to cope with it, which likely is what maintained her continued anxiety surrounding flying. However, at the end of the day this is an empirical question that may one day be tested via research.

In conclusion, we believe that in many ways what the author described as diametrical opposition between CBT and paradoxical intention is better characterized by more similarities than differences (although some differences do persist, particularly in the conflation of fear with anxiety). Our hope is that the author feels heartened to learn that there are indeed many of us out there applying similar principles to the treatment of panic and anxiety disorders, albeit using a different name and slightly different implementation, and that he may feel inspired to incorporate some of the research on inhibitory learning into his own work and of course, report back.

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