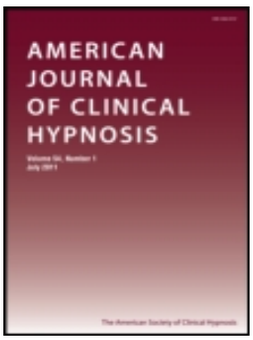

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Cognitive Hypnotherapy for Accessing and Healing Emotional Injuries for Anxiety Disorders

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Although anxiety disorders on the surface may appear simple, they often represent complex problems that are compounded by underlying factors. For these reasons, treatment of anxiety disorders should be individualized. This article describes cognitive hypnotherapy, an individual comprehensive treatment protocol that integrates cognitive, behavioral, mindfulness, psychodynamic, and hypnotic strategies in the management of anxiety disorders. The treatment approach is based on the self-wounds model of anxiety disorders, which provides the rationale for integrating diverse strategies in the psychotherapy for anxiety disorders. Due to its evidence-based and integrated nature, the psychotherapy described here provides accuracy, efficacy, and sophistication in the formulation and treatment of anxiety disorders. This model can be easily adapted to the understanding and treatment of other emotional disorders.

Keywords: affect bridge, anxiety, cognitive behavior therapy, hypnotherapy, integration, mindfulness, wounded self

Self-wounds model of anxiety disorders (SMAD) is based on Wolfe's (2005, 2006) integrated theory of anxiety disorders, which combines the best etiological theories and the most effective treatment of anxiety disorders. The focal point of Wolfe's theory is the concept of self-wounds, which in the most general sense can be defined as patients' chronic struggles with their subjective distress. The wounded self is akin to Jung's complex (Alladin & Amundson, 2016), Beck's negative self-schemas (Beck, Rush, Shaw, & Emery, 1979), Fonagy's foreclosure of mentalization (Spiegel, 2016a), and the wounded-self ego state from ego state therapy (Barabasz, Barabasz, & Christensen, 2016). According to the wounded self-perspective, each anxiety disorder consists of two interrelated factors: (1) an emotional conflict and (2) suppression of the re-experiencing of the trauma. The emotional conflicts are believed to be generated from early traumatic events (see Alladin, 2013 for review), while defense against re-experiencing of the trauma stems from the nature of the trauma and the specific cognitive-emotional-behavioral coping strategies used to protect self-wounds. From this perspective, the onset, development, exacerbation, and maintenance of anxiety symptoms are believed to

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emanate from two layers of psychological processes contrived by the wounded self. The first layer of this process comprises conscious awareness of symptoms resulting from cognitive distortions, cogitation with symptoms, rumination, and excessive worry, while the second layer involves implicit or unconscious interpretations of what the symptoms mean to the patient. Since SMAD embodies both explicit and implicit psychological processes in the etiology of anxiety disorders, any comprehensive treatment ought to include both conscious and unconscious therapies such as behavior therapy, cognitive therapy, psychodynamic psychotherapy, mindfulness-based therapies, etc., in the treatment of these disorders (Alladin, 2013, 2014a, 2016; Alladin & Amundson, 2016; Wolfe, 2005, 2006).

Nevertheless, not every patient with an anxiety disorder may require intense, complex and extended therapies, as symptoms severity and complexity vary with each patient. Wolfe (2005, 2006) has thus underlined the importance of focusing on either intermediary or ultimate treatment goals, or both. The core intermediary goal focuses on reducing or eliminating anxiety symptoms, while the ultimate goal is to heal self-wounds. Attainment of intermediary goal in some patients may be sufficient, in others it serves as a necessary prelude to the ultimate goal of healing self-wounds, that are hypothesized to generate anxiety symptoms. Thus Alladin (2013, 2014b, 2016) has incorporated hypnotherapy into Wolfe's (2005, 2006) integrative psychotherapy for anxiety disorders. He has argued that such a combination could be very beneficial as hypnotherapy offers a variety of strategies for accessing and restructuring unconscious experience (e.g., Ewin & Eimer, 2006; Hunter & Eimer, 2012), i.e., providing a powerful set of techniques for eliciting and healing the wounded self. Furthermore, as Wolfe's conceptualization of anxiety disorders is commensurate with an experiential model of psychotherapy (Wolfe, 2005, pp. 51–55); hypnotherapy, by virtue of being an experiential form of therapy, serves as a befitting adjunct to the psychotherapy of anxiety disorders (Alladin, 2006, 2013, 2014b, 2016).

Hypnotherapy, however, is not a unitary practice based on a single theory. It consists of a diverse set of strategies and techniques blended with the therapist's preferred model of psychotherapy (e.g., cognitive behavior therapy [CBT] or psychodynamic psychotherapy). For example, Alladin, (2013, 2014b, 2016) in his cognitive hypnotherapy (CH)—which combines hypnotherapy with CBT—has integrated Wolfe's (2005, 2006) psychotherapy for anxiety disorders. With the exception of the hypnotherapy component, Wolfe's integrated psychotherapy for anxiety disorders embodies similar elements contained in CH (e.g., relaxation training, exposure to fearful stimuli, cognitive restructuring, guided imagery training, emotional processing, etc.).

CH itself represents an integrated form of therapy. Clinical trials, meta-analyses and detailed reviews (for review, see Alladin, 2016, chap. 1; Alladin & Amundson, 2011) have all substantiated the additive (increase in effect size) value of combining hypnotic procedures with CBT for treating various emotional disorders. CH is also recognized as an assimilative model of integrative psychotherapy (Alladin, 2008, 2012; Alladin &

Amundson, 2011), which is considered to be the most effective model of psychotherapy integration, drawing from both theoretical integration and technical eclecticism (Gold & Stricker, 2006). More recently CH has also incorporated "third wave" therapies (e.g., acceptance, mindfulness) (Alladin, 2006, 2007, 2014b) in the treatment of anxiety disorders. For example, in Alladin (2016), I have incorporated acceptance and mindfulness strategies with CH in the treatment of each of the DSM-5 (American Psychiatric Association, 2013) anxiety disorders. The next sections describe the major components of CH for anxiety disorders.

CH for Anxiety Disorders

CH for anxiety disorders consists of four separate, but interrelated phases (Alladin, 2014b, 2016; Wolfe & Sigl, 1998), including (1) assessment, case conceptualization, and establishment of therapeutic alliance, (2) management of symptoms, (3) uncovering and healing of self-wounds, and (4) promotion of acceptance, mindfulness and gratitude. The treatment generally consists of 16 weekly sessions, which can be expanded or modified according to patient's clinical needs, areas of concern, and severity of symptoms. An additional 10 sessions may be needed for patients who wish to explore and restructure tacit causes of their symptoms. As a rule, uncovering work, which is regarded an advanced treatment procedure in CH, is introduced later in therapy. The four phases of CH are described in detail next.

Phase I: Assessment, Case Conceptualization, and Therapeutic Alliance

Before initiating CH, it is important for the therapist to take a detailed clinical history to formulate diagnosis and identify the essential psychological, physiological, and social aspects of the patient's anxieties and other difficulties. An efficient way to obtain this information within the context of CH is to take a case formulation approach as described by Alladin (2007, 2008). CH case conceptualization underlines the role of cognitive distortions, cogitation, rumination, excessive worry, negative self-hypnosis, maladaptive behaviors, and subjective meaning of symptoms in the understanding of a patient's anxiety disorder (see Alladin, 2006, p. 3; Alladin & Amundson, 2016, this issue, for schematic representation of SMAD). As CH targets both intermediary and ultimate treatment goals, at least in some patients, the therapy goes beyond standard CBT strategies. Therefore, when addressing ultimate treatment goals, in addition to assessing the relationship between events and cognitive distortions, the following psychodynamic processes (Gabbard & Bennett, 2006) are also explored in therapy:

- Careful evaluation of the stressor that triggered the anxiety.
- Assessment of whether the stressor produced a feeling of embarrassment, shame, humiliation, or loss of control.

- Assessment of whether the stressor reawakened self-wounds.
- Identification of the meaning attributed to the stressor by the patient.

Evidence suggests that matching of treatment interventions to particular patient characteristics increases outcome (Beutler, Clarkin, & Bongar, 2000). In formulating a case, the clinician develops a working hypothesis on how the patient's problems can be understood in terms of negative self-hypnosis (cogitation), cognitive-behavioral theories, wounded self, and lack of acceptance of personal distress. This comprehensive integration of the unique experience of the individual patient with a psychological disorder is a central process in effective therapy (Dudley, Kuyken, & Padesky, 2011). Milton Erickson stated: "Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior." (https://Erickson-foundation.org/biography/)

Establishment of Therapeutic Alliance

This component is not a discrete element of therapy; it forms part of the ongoing treatment. Therapeutic alliance is vitally important in psychotherapy (Norcross, 2002) as all effective psychotherapy is predicated on the establishment of a safe, secure, and solid therapeutic alliance (Wolfe, 2005). As the life histories of patients with anxiety disorders are often replete with experiences of betrayal, empathic failures, insecure attachments, and mistreatment (Wolfe, 2005), they may have some trust issues, which may impede therapeutic alliance (Alladin, 2014b). The negotiation of trust thus becomes the first undertaking of psychotherapy for healing the wounded self. By providing a trusting, empathic, genuine, nonjudgmental, and collaborative relationship (Castonguay & Beutler, 2006), a therapist fosters hope and positive expectations for change in patients (Dobson & Dobson, 2009).

Phase II: Management of Symptoms

The primary focus of this phase of therapy is to help patients with anxiety disorders achieve some measure of control over their symptoms and enhance their sense of self-efficacy. By achieving some control over their anxiety symptoms, patients start to feel more confident and hopeful about overcoming their fears and solving their basic life difficulties. To achieve these goals CH utilizes hypnotic and cognitive-behavioral strategies.

Hypnotherapy for Symptom Management

Four to six sessions of hypnotherapy are specifically targeted at symptoms management. Hypnotherapy components include (1) relaxation training, (2) demonstration of

the power of mind over the body, (3) ego-strengthening, (4) expansion of awareness, (5) modulation and regulation of symptoms, (6) self-hypnosis, and (7) post-hypnotic suggestions. Hypnotherapy may also be reintroduced later in therapy with patients who elect to pursue with uncovering work. The initial sessions of hypnotherapy, therefore, for some patients, serve as a preparatory phase for more complex therapy of exploring the roots of the anxiety disorder later in the therapy. As these hypnotic strategies for symptom management in anxiety disorders are described in detail elsewhere (Alladin, 2014b, 2016, chap. 2; Daitch, 2007, 2011; Lynn & Kirsch, 2006), they are not covered here; instead the objective here is to describe the integration of behavior therapy with hypnosis.

Hypnotherapy combined with behavioral therapies. As hypnotherapy primarily involves experiential, cognitive and imaginal therapies in the office, it is important to transfer the learning from this setting to real life situations. To facilitate this process, the next phase of therapy focuses on blending cognitive-behavioral strategies, namely systematic desensitization (SD) and in vivo exposure, with hypnotherapy. SD has been found to be an effective component of therapy for anxiety disorders for achieving positive treatment outcome (Antony & Barlow, 2002). Clinical and experimental evidence demonstrate SD to be an effective treatment for reducing, and in some cases eliminating, simple phobias (Antony & Barlow, 2002).

Hypnosis aided systematic desensitization (HASD). Although exposure therapy has been found to be very effective with specific phobia (Follette & Smith, 2005), some patients feel too anxious to tolerate this treatment. They feel more secure working with SD, which could be used as a preparatory step for later in vivo exposure therapy. The SD procedure is based on the principle of reciprocal inhibition. It can be defined as anxiety being inhibited by a pleasant feeling or response (e.g., relaxation), which is incompatible with the feeling of anxiety (Wolpe, 1990). The operating components of SD include (1) relaxation training, (2) the construction of a hierarchy of anxiety evoking events associated with the target condition being treated, and (3) imaginal exposure to anxiety evoking situations. The fear evoking events are rank-ordered into a hierarchy of subjective units of distress (SUD) from least evoking to most evoking anxiety (see Table 1). Table 1 shows Mandy's fear hierarchy for using the public washroom in the local mall (see Alladin, 2016, chap. 4). The SUD represents subjective distress rated on a scale of 0–100, 0 representing no anxiety, while 100 stands for the worst anxiety. The patient is exposed to the imagery from the hierarchy, one image at a time, under relaxation, until all images have been presented and the patient had tolerated each without reporting anxiety (Iglesias & Iglesias, 2013). When anxiety is experienced during imaginal exposure, the image is terminated and a relaxed state is induced. With continued exposure to each image, the patient's level of anxiety weakens progressively, until the patient no longer experiences anxiety in response to the fearful stimuli (Wolpe, 1990).

TABLE 1
Systematic Desensitization Hierarchy of Fear of Using Public Washroom

Item	*Fear rating in SUD (0–100)*
Asking for location of washroom in shopping mall	20
Looking for the washroom in the mall	30
Looking at the washroom from a distance	40
Standing in front of the washroom	50
Standing at the entrance of the washroom	60
Going inside the washroom but not using it	70
Opening the washroom door and looking inside	80
Going inside the washroom, door open, not using it	85
Sitting in the washroom, door closed, not using it	90
Being inside the locked washroom	95
Being inside the locked washroom, using it	100

In CH, the relaxation component of SD is replaced by hypnosis, and hence, this treatment approach is referred to as HASD (Iglesias & Iglesias, 2013). A number of reports in the literature support the effectiveness of combining hypnosis with SD in the treatment of specific phobias (Glick, 1970). More specifically, HASD has been found to be effective with odontophobia (Moore, 1990), non-accidental driving phobia (Iglesias & Iglesias, 2013), agoraphobia (Surman, 1979), phobia of a laundry product (Deiker & Pollock, 1975), and fear of recurrent distressing dreams (Surman, 1979).

Gradual in vivo exposure therapy. Exposure in vivo therapy involves repeated confrontation with the feared objects or situations. It has been found to be efficacious with a variety of anxiety disorders (Follette & Smith, 2005). Based on learning theory, exposure therapy is conceptualized to function as a form of counter-conditioning or extinction. Exposure therapy was initially used with SD by Wolpe (1958). Since his seminal work, exposure therapy for anxiety disorders has continued to evolve. Today it comprises a set of techniques designed to help patients confront their feared objects, situations, memories, or images in a therapeutic manner, both literally and virtually (DeAngelis, 2012; Wiederhold & Wiederhold, 2005). Research suggests that using avatars in therapy, business consulting and training may be as effective as their real-life counterparts, and may have other benefits as well.

Notwithstanding its effectiveness, as mentioned before, in vivo exposure therapy has many disadvantages in terms of compliance, drop-outs, symptoms exacerbation, and emotional disturbance (Golden, 2012). It is estimated that approximately one in four patients who initiates treatment drops out (Hofmann & Smits, 2008). Until virtual technology is more widely available, these concerns need to be addressed. To prepare patients for this treatment, CBT, cognitive processing therapy, acceptance and commitment therapy (ACT), eye movement desensitization and reprocessing (EMDR)

(Shapiro, 1995), couple therapy, and have been incorporated with exposure therapy (see Alladin, 2016, chap. 2). Golden (2012) has recommended that in vivo therapy be carried out only after successful completion of in-session hypnotic desensitization. Therefore, in CH, the general rule is to introduce patients to HASD (Iglesias & Iglesias, 2013) before initiating in vivo exposure therapy.

CBT. CBT is used to help patients with anxiety disorder reevaluate the meaning of their fears and symptoms, and to reframe their distorted beliefs associated with maladaptive emotions such as guilt, shame, embarrassment, and anger. In CH, CBT is viewed as a conscious strategy for countering negative self-hypnosis in order to circumvent the negative affect or the symptomatic trance state (Yapko, 1992). The CBT component of CH for this purpose can be extended over four to six sessions. However, the actual number of CBT sessions is determined by the needs of the patient and the severity of the presenting symptoms. As CBT protocols and specific treatment strategies for each anxiety disorder are fully described in several excellent books (e.g., Alladin, 2016; Beck, Emery, & Greenberg, 2005; Clark & Beck, 2010) and a detailed description of the sequential progression of CBT within the CH framework is provided elsewhere (Alladin, 2007, 2008), they are not described in detail here. However, the following CBT transcript adapted from Alladin (2008, pp. 107–110, 2016) illustrates how Roger was guided to reexamine and alter his maladaptive belief of the world ("the world is unsafe") which stemmed from his traumatic experience (saw many innocent people killed and maimed in a war zone).

Therapist:	Roger, what do you mean by "the world is unsafe?"
Roger:	You can't go out there; you may get killed.
Therapist:	What do you mean by "out there?"
Roger:	Well, you can't go out in the street without getting killed or mugged.
Therapist:	So, let me get it right what you are saying. You believe that if you go out in the street, you will either get killed or mugged.
Roger:	Yes.
Therapist:	How much do you believe in the belief that you will get shot or mugged when you go out in the street?
Roger:	Totally, one hundred percent.
Therapist:	What kind of a thinking error is this?
Roger:	All-or-nothing thinking, magnification, and I'm overgeneralizing.

(This transcript is from Roger's third session of CBT. From his previous sessions of CBT and homework assignments, Roger was well-versed in the types of cognitive distortions anxious people ruminate with).

Therapist: So you are aware that your thinking is inaccurate.
Roger: Yes, but I can't help it. I know I live in a fairly safe neighborhood, but my mind keep going back to East Europe. I get confused. My mind keeps going back as if I'm still there. It's so crazy.
Therapist: Do you see the connection between your thinking and your negative reaction?
Roger: Yes, it's so dumb. Whenever I think of going out, I think of the dangerous situations we faced in East Europe, people getting shot, arrested, and blown up. But this is so dumb, I know I am not going to get attacked or shot going to a store in Canada.
Therapist: So your thinking gets confused. When you think of going out to the local store you think you are in East Europe.
Roger: Yes, but I can't help it.
Therapist: Having the thoughts that you are in East Europe and exposed to dangers are not intentional on your part. You don't think this way on purpose. As a result of your traumatic experiences, your mind has developed many associations with the fearful and dangerous situations you were in. Also you learned to think automatically about danger, even in situations where there is no danger. Does this make sense to you?
Roger: Yes, but how do I get out of this?
Therapist: As we talked before, we use disputation or reasoning? Suppose you are thinking of going to the store and the thought crosses your mind that you will get mugged or shot, how would you reason with this statement?
Roger: I can remind myself that I'm not in East Europe, my assignment is over. I am at home now, and this is a safe environment.
Therapist: That's excellent. You have to separate "then" from "now." You have to reason that you are in a safe environment now, even if your thinking keeps going back to East Europe.
Roger: I guess I always knew my thinking was wrong, but the feelings are so real that you begin to go along with your feeling, rather than thinking with your head. Funny, this is what cops are taught to do.
Therapist: What kind of a thinking error is this, when you are thinking with your feeling?
Roger: Emotional reasoning. You are right, I need to use my head more than my feeling.
Therapist: That's right, you have to continue to assess the link between your thinking and your feeling. Try to identify the cognitive distortion and then reason with it.

Following this session Roger was able to modify his maladaptive beliefs and, consequently, he started to go out more often and to different places in the city.

Phase III: Hypnotherapy for Eliciting and Healing Self-Wounds

Once a patient has achieved sufficient ego-strength (Frederick & McNeal, 1999; Hammond, 1990, chap. 5; Hartland, 1971), ample emotional stabilization (Brown, Scheflin, & Hammond, 1998) and some measure of control over his/her anxiety symptoms from either hypnotherapy or CBT, or a combination of the two, the therapist has to make a decision about the next stage of intervention. For those patients who have improved and believe that they had met their goals, the therapy is considered complete and it is duly terminated. For those patients who wish to explore the roots of their anxiety, they continue with the next phase of therapy, which involves (1) uncovering and (2) healing of tacit self-wounds.

Hypnotherapy provides an assortment of methods for uncovering unconscious roots of emotional disorders (Alladin, 2013, 2016; Brown & Fromm, 1986; Ewin & Eimer, 2006; Watkins, 1971; Watkins & Barabasz, 2008; Yapko, 2012). In CH four hypnotic techniques are routinely used for accessing and healing tacit self-wounds, including (1) direct suggestions, (2) hypnotic age regression, (3) affect bridge, and (4) hypnotic exploration. Once the implicit meaning of the fear and the underlying self-wounds are elicited by a particular uncovering technique, the therapy normally segues into healing. In other words, accessing and healing often occur in the same session, as described under hypnotic exploration technique (HET).

Direct Hypnotic Suggestions

While the patient is in deep trance, the therapist may suggest: "You are in such a deep hypnotic trance that you may remember the root cause of your anxiety." This simple approach, coupled with a solid therapeutic alliance and no resistance from the patient, may be sufficient to elicit tacit meaning of fear and underlying self-wounds. However, this approach may not work with patients whose self-wounds are well-defended and suppressed deeply.

Hypnotic Age Regression

Age regression is defined as an intensified absorption in and experiential utilization of memory (Yapko, 2012, p. 344). It can be classified into two general categories: revivification and hypermnesia. In revivification, a patient is guided back in time to relive an episode in life as if it is happening in the here-and-now. In hypermnesia, the patient simply remembers an experience as vividly as possible. Age regression is structured deliberately to engage patients with anxiety disorders in some memory that may have relevance to their symptoms. However, it should be noted that not all patients with anxiety disorders may suffer underlying traumas or emotional injuries. Golden (1994) recommended using regression with patients who request it and expect it to be superior to other methods of treatment. Moreover he suggests deployment of age regression when the patient is in a deep trance. Finally, though the patient may uncover specificity in relation to memory or experience that is logically connected in their mind to the anxiety today, the therapist is cautioned that a "narrative truth might not equate to/with an actual historical truth" (Spence, 1982).

Affect Bridge Technique

The affect bridge technique (Watkins, 1971) is a popular hypnotic procedure for tracing the origin of an inappropriate feeling or emotion in the present. The affect bridge technique is based on the psychological fact that emotions, feelings or affect can

activate, drive, or intensify recall (Watkins, 1971; Watkins & Barabasz, 2008; Yapko, 2012). The concept of state dependent memory (Rossi & Cheek, 1988) is applicable here. This concept states that memories are often more easily retrieved and recalled when a person is in an emotional and physical state similar to the one he/she was in when the memory was first encoded. Therefore, current emotions and feelings can serve as our connections, or bridge, to the past. The utilization of affect bridge technique with anxiety disorders can be divided into three sequential steps:

1. *Elicitation of a negative feeling associated with anxiety*: While the patient is in a deep hypnotic trance, the therapist suggests that the patient feels an emotion or feeling (e.g., fear) that is linked to existing fear or anxiety.
2. *Amplification of that feeling*: The patient is encouraged to intensify the anxiety or fear as the therapist counts from 1 up to 10.
3. *Recalling the first time that feeling was experienced*: Then the therapist, by counting 10 to 1, guides the patient back to the first time, or an earlier time, when the patient first felt that fear or feeling.

Once the bridge between anxiety and underlying self-wounds are elicited, the treatment segues into healing self-wounds as described in the next section.

HET

The HET incorporates Wolfe's Focusing Technique (WFT; Wolfe, 2005, 2006; Wolfe & Sigl, 1998) and Alladin's hypnotic accessing technique (Alladin, 2013, pp. 11–14). WFT is a form of imaginal exposure, or a type of affect bridge without hypnosis, for uncovering and healing self-wounds. HET combines both exploration (e.g., affect bridge technique) and healing (e.g., split-screen technique) and it can be summarized under the following sequential steps:

- The patient is inducted into a deep hypnotic trance.
- The experience is ratified by ego-strengthening suggestions (e.g., "this shows you can relax," "you can let go, but still being aware of everything").
- The patient is encouraged to become fully aware of the whole range of affect, cognition, physiological reaction, sensations and behaviors (syncretic cognition), presently experienced.
- Then the therapist suggests that the patient recall the most recent occurrence of anxiety or other negative affect experienced by the patient.
- Once the anxiety is recollected, the feeling is amplified as the therapist counts from 1 to 10. Importantly, the patient is guided to focus on the whole experience (syncretic cognition) rather than on a single affect.
- While experiencing syncretic cognition, the patient is directed to identify the implicit meaning of his/her anxiety or fear, particularly the underlying self-wounds.

Once the implicit meaning of the fear and the underlying self-wounds are established, HET segues into guided-imagery procedures to explore the network of interconnected ideas, feelings, and associations that constitute the implicit meaning of anxiety. Then the patient is guided to (1) differentiate between accurate and inaccurate self-views and (2) learn to tolerate painful realities.

Differentiate Between Accurate and Inaccurate Self-Views

The patient is guided to differentiate between painful self-views that are based on facts and those that are based on inaccurate opinions. The empty-chair dialogue or the split-screen technique can be used here. The empty chair technique is a Gestalt therapy role-playing strategy (Perls, Hefferline, & Goodman, 1951; Woldt & Toman, 2005) for reducing intra- or interpersonal conflicts (Nichol & Schwartz, 2008). In this procedure, the patient is directed to talk to another person who is imagined to be sitting in an empty chair beside or across from the patient. The imaginary person can be a family member or any relevant person with whom the patient is afraid of being honest in expressing strongly charged emotions, either negative or positive. By imagining the other person sitting in the empty chair in the safety of the therapy situation, a patient is able to experiment with the experience and expression of various emotions, including anger (Greenberg, Rice, & Elliott, 1993). Moreover, it helps patients experience and understand their feelings and thinking more fully.

The split screen technique (Alladin, 2008; Cardeña, Maldonado, van der Hart, & Spiegel, 2000; Lynn & Cardeña, 2007; Spiegel, 1981) is used to help patients detoxify the meaning of their anxiety. The split screen technique is a hypnotic strategy that makes traumatic or painful memories or experience more bearable. When in a deep hypnotic trance, following ego-strengthening suggestions, the patient is asked to imagine sitting in front of a large TV or cinema screen, which is vertically split in two halves, consisting of a right side and a left side. The patient is first instructed to imagine experiencing symptoms of anxiety on the left side of the screen. Then the patient is directed to focus on the right side of the screen, where he/she imagines coping with the symptoms by using self-hypnosis, self-talk, or other procedures that have been learned in therapy. Creating coping image on the right side of the screen helps patients build confidence that they could deal with the symptoms rather than catastrophizing about them and labeling themselves as weak or incompetent.

Learning to Tolerate Painful Realities

The patient is encouraged to tolerate painful experience and realities rather than avoiding them. They are coached to develop a remediation plan to transform their liabilities into strengths. In CH, these goals are achieved through behavioral rehearsal, the empty-chair dialogue, or the split-screen technique. Behavioral rehearsal is a

technique specifically used in behavior therapy. It involves rehearsing behavioral patterns, which were initially introduced by the therapist, until they are ready to be practiced in real-life situations. Behavioral rehearsal is usually used in therapy to modify or improve interpersonal skills and social interactions. Other strategies that can be used to help patients learn to deal with painful realities include attachment-focused techniques (Spiegel, 2016a, 2016b), Kohutian-based tactics (Kluft, 2016), affect tolerance (Brown & Fromm, 1986), multimodal behavior therapy (Lazarus, 1976) and the Behavior, Affect, Sensation, and Knowledge procedure (Braun, 1988a, 1988b).

Phase IV: Promoting Acceptance, Mindfulness, and Gratitude

Accumulating evidence suggests that patients with anxiety disorders have (1) heightened reactivity to internal experiences; (2) the tendency to view thoughts as self-defining indicators of truth rather than transient reactions; (2) poor understanding of emotions; (3) negative reactivity to emotions; (4) habitual use of maladaptive regulation patterns such as avoidance, suppression, and substance use to deal with their emotional dysregulation; and (5) significant impediments in their lives, which occur either through behavioral avoidance, or through inattention to present moment, because of their indelible worries and rumination about the past or the future (see Alladin, 2012, chap. 2; Roemer, Williston, Eustis, & Orsillo, 2013). It is thus important to target emotional distress, fear of emotions, and problematic emotional regulation in the treatment of anxiety disorders to enhance response to therapy. Acceptance and mindfulness-based therapies (AMBT) specifically target these areas of concern. In the past 20 years, a variety of third-wave psychological therapies such as mindfulness-based stress reduction (MBSR; Kabat-Zinn (1990), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) and ACT (Hayes, Strosahl, & Wilson, 1999) have been applied to diverse psychosocial problems (Abbey, 2012; Hofmann, Sawyer, Witt, & Oh, 2010). Because of their overarching similarities, Alladin (2016) has categorized all these new approaches under AMBT (Alladin, 2016).

AMBT have been found to help patients with anxiety disorder develop a wise and accepting relationship with their internal cognitive, emotional, and physical experience, even during times of intense fear or worry (Greeson & Brantley, 2009; Vøllestad, Nielsen, & Nielsen, 2012; Yapko, 2011).). These strategies, through the cultivation of wise responsivity, rather than automatic reactivity, enable patients to establish a radically different relationship with their inner experience and outer events. This was supported by a recent study, which demonstrated that emotional well-being depended less on frequency of negative emotions, but more on how one related to these emotions as they occurred (Sauer-Zavala et al., 2012). These studies clearly indicate that reactivity to emotional experience (fear of emotions and anxiety sensitivity) interferes with emotional regulation, while acceptance (wise responsivity) promotes emotional well-

being. Based on these findings, Roemer et al. (2013) have recommended that the treatment of anxiety disorders should be targeted at (1) fear of emotions, (2) problematic emotion regulation pattern, and (3) distress, as this approach has been found to enhance treatment outcome. A variety of acceptance and mindfulness-based strategies are applied to anxiety disorders to help the patients learn to observe their symptoms without overly identifying with them or without reacting to them in ways that aggravate their distress (Alladin, 2014b, 2016; Herbert & Forman, 2014; Roemer, Erisman, & Orsillo, 2008; Roemer & Orsillo, 2013).

A recent meta-analysis by Hofmann et al. (2010) showed AMBT to produce significant reductions in anxiety and depressive symptoms in a wide range of clinical problems. The treatments were particularly effective with social anxiety disorder (SAD), generalized anxiety disorder (GAD), and obsessive-compulsive disorder (OCD). AMBT were also found to significantly improve quality of life among patients with GAD (Craigie, Rees, & Marsh, 2008; Roemer & Orsillo, 2007) or SAD (Kocovski, Fleming, & Rector, 2009). There are also some evidence that AMBT helps patients relate differently to their internal experiences, resulting in decreased emotional reactivity and reduced experiential—and behavioral avoidance (Roemer & Borkovec, 1994; Wegner, 2011; Wolgast, Lundh, & Viborg, 2011). Or as Erickson once said, when asked to define hypnosis, he replied that is was the capacity to think deeply and differently about oneself, one's life and one's experiences. Moreover, mindfulness practice has been found to modulate structural and functional brain plasticity (e.g., Tang & Posner, 2013) and improve executive functioning in patients with anxiety and depression (Teper, Segal, & Inzhicht, 2013; Roemer & Orsillo, 2013).

For the present purpose six overlapping groups of AMBT components for the management of anxiety disorders are briefly described, including (1) cultivating awareness, (2) cognitive distancing, (3) promoting acceptance, (4) clarifying values, (5) expressing gratitude, and (6) nurturing psychophysiological coherence. The integration of these six components in the treatment of anxiety disorders is deemed to produce a fundamental shift in perspective (*re-perceiving*), that is, they lead to a re-evaluation of patient's constructed reality (Alladin, 2014b, 2016). Strategies based on these six treatment components are briefly described next.

Cultivating Awareness

There are many strategies for cultivating increasing awareness of one's ongoing stream of experience. Some of the commonest techniques include (1) mindfulness meditation, (2) mindful hypnosis, (3) concentrative meditation, (4) walking meditation, (5) eating meditation, (6) attention training, (7) compassion meditation, and (10) loving kindness meditation. Since these techniques are described in other publications (e.g., Kabat-Zinn, 2013; Orsillo & Roemer, 2011; Segal, Williams, & Teasdale, 2012), they are not discussed here.

Cognitive Distancing

Cognitive distancing strategies are used to help patients with anxiety disorder distance away from their worrying and fearful thoughts. Cognitive distancing can be seen as an extension of cognitive self-monitoring routinely practiced in CBT. While in CBT cognitive distortions are recorded on paper or noted mentally with the goal of identifying and restructuring them, in AMBT cognitive distancing strategies are used with the purpose of recognizing that thoughts are distinct from the self and that they may not be true. Specifically, AMBT train patients to visualize thoughts from a distance, for example, as floating on a leaf going downstream. This training produces cognitive defusion, or the ability to separate thoughts from the self. Cognitive defusion can be achieved by (1) using metaphors, (2) recognizing bias in thinking, (3) hearing thoughts (self-talk), and (4) seeing thoughts as images. A similar technique called Heart Joy, developed by Lankton (2008, pp. 45–50) can also be used to create cognitive distancing and a sense of emotional well-being.

Promoting Acceptance

One of the core interventions in AMBT relates to fostering an open, accepting, nonjudgmental, and welcoming attitude toward the full range of subjective experience. The most common strategies for promoting acceptance include (1) psychoeducation, (2) acceptance exercise, and (3) exposure exercises. As these strategies are described in detail in Alladin (2016, chap. 6), the salient features of promoting acceptance are listed below:

- Focusing on here and now.
- Observing emotional experiences and their contexts non-judgmentally.
- Separation of secondary emotions from primary emotions (e.g., not to get upset for feeling upset; not to get anxious for feeling anxious). Learning to tolerate distress rather than fighting it (flow with it).
- Adopting healthy and adaptive means to deal with anxiety and chronic distress, rather than resorting to short-term reduction measures such as over-medication, alcohol, or substance abuse.
- Toleration of painful experience. Tolerance of frustration.
- Re-contextualizing meaning of suffering, e.g., from "this is unbearable" to "let me focus on what I can do."
- Exercising radical acceptance—ability to welcome those things in life that are hard, unpleasant, or very painful (e.g., accepting a loss).
- Embracing good or bad experience as part of life.
- Willing to experience the reality of the present moment, e.g., believing that "things are as they should be."

- Purposely allowing experiences (thoughts, emotions, desires, urges, sensations, etc.) to unfold without attempting to block or suppress them.
- Realizing that anxiety is not caused by object or situation itself, but by the perception of it, coping abilities, and level of spirituality.

Clarifying Values

Clarification and articulation of one's values are considered to be important in AMBT. As values give meaning to one's life, they often establish the direction one chooses to take in therapy. In this sense, values largely determine whether a patient is willing to commit to the behavioral and emotional challenges that he/she may have to face in the course of therapy. Clarification of patient's values thus becomes an essential ingredient in the development and sustenance of motivation for change (Herbert & Forman, 2014). This can be illustrated by the case of Emma, a 32-year-old homemaker, with three young children. Emma had a fear of contamination by "germs." Whenever she touched an object outside her house she had the compulsion to wash her hands. Similarly, if any of her children touched something outside the house they had to wash their hands. As a result, her children were deprived of going out and they were not allowed to the playgrounds. Although Emma was motivated to get better, and she attended her CBT sessions with her therapist regularly, she struggled with response prevention and exposure therapy. The introduction of the concept value in therapy had a significant effect on Emma. She was encouraged to list the values a good mother should have toward her children and then to compare her own behaviors toward her children regarding going out and playing in the parks. She was shocked that her behaviors did not match her values as a good mother. This realization helped her to tolerate her anxiety while the children played in the parks and playgrounds. In other words, the clarification of her values as a good mother motivated her to come to terms with her fear of contamination.

Expressing Gratitude

Sense of gratitude is used as a means to cultivate acceptance in patients with anxiety disorder. Gratitude is a feeling or attitude in acknowledgment of a benefit that one has received or will receive. Recent studies suggest that people who are grateful have higher levels of subjective well-being, are happier, less depressed, less stressed out, and more satisfied with their lives and social relationships (Kashdan, Uswatte, & Julian, 2006; McCullough, Emmons, & Tsang, 2002; Wood, Joseph, & Maltby, 2009). Grateful people also have higher levels of control over their environments, personal growth, purpose in life, and self-acceptance (Wood et al. 2009). Moreover, they have more positive ways of coping with difficulties they experience in life, being more likely to seek support from other people, reinterpret and grow from experience, and spend more

time planning how to deal with a problem rather than ruminating about it (Wood, Joseph, & Linley, 2007). Furthermore, grateful people have less negative coping strategies, being less likely to try to avoid or deny their problems, or blame themselves, or cope through maladaptive means such as substance use (Wood et al., 2007). Grateful people sleep better, which appears to be related to less indulgence in negative rumination and more involvement in positive thoughts just before going to sleep (Wood, Joseph, Lloyd, & Atkins, 2009).

Strategies commonly used in psychotherapy, particularly in CH, to promote expression of gratitude in patients with anxiety disorder include gratitude education and gratitude training.

Gratitude education explores broad generalizations about different cultural values and beliefs, and Western and non-Western expectations of life and achievement. Patients are also encouraged to read the book *The Narcissism Epidemic: Living in the Age of Entitlement* (Twenge & Campbell, 2009). This book provides a clear account of how high expectations, preoccupation with success, and sense of entitlement can set us up for failure. The idea behind the education is to help patient with anxiety disorder understand that values are human-made, subjective, and culturally determined. This comparative understanding of societal values help patients reexamine their own meaning of success and failure and help them to focus on what they have (gratitude) rather than ruminating with what they do not have. As some patients with anxiety disorder—because of their cogitation with symptoms, avoidance behaviors and suffering—do not know how to be grateful, the therapist may have to provide gratitude training.

Gratitude training involves carrying out one of the listed gratitude tasks each day:

- Writing gratitude letters.
- Writing a gratitude journal.
- Remembering gratitude moments.
- Making gratitude visits to people one is grateful to.
- Practicing gratitude self-talk.

Nurturing Psychophysiological Coherence

The sixth component of AMBT targets integration of various subsystems in the body. There is abundant research evidence from neuroscience that heart-focused positive emotional state synchronizes the entire body system to produce psychophysiological coherence (McCraty, Atkinson, Tomasino, & Bradley, 2009; McCraty & Tomasino, 2006). Guided by these scientific findings, Alladin (2014a, 2016) has developed the *Breathing With Your Heart* technique to help patients with anxiety disorders generate coherence (harmony) of the entire system (mind, body, brain, heart, and emotion). This technique integrates both Western (complex information center) and Eastern (big mind) concepts of the heart to produce psychological well-being. The Heart Joy technique

(Lankton, 2008, pp. 45–50), mentioned before, can also be used to nurture emotional harmony. Moreover, the Institute of HeartMath (www.heartmath.org) provides biofeedback equipment to professionals and consumers for training in heart-rate variability, which helps to cultivate psychophysiological coherence. The breathing with your heart technique consists of two phases: (1) heart education, and (2) breathing with your heart training assisted by hypnosis. In the education phase the patient is given a scientific account of the role of heart and positive emotions in the generation of psychophysiological coherence, which promotes healing, emotional stability, and optimal performance. The similarities and the differences between Western and Eastern theories of mind and "heart" are also discussed to expand patients' perspective on emotional well-being.

The heart-mind-body training helps patients with anxiety disorders cope with aversive feelings activated by fearful objects or situations, or other stressors. By breathing with the heart, patients with anxiety disorders are able to shift their attention away from their mind (thinking) to their heart (feeling). When a person feels good in his/her heart, the person experiences a sense of comfort and joy because he/she validates reality by the way he/she feels and not by the way he/she thinks (Fredrickson, 2002; Isen, 1999). Logic does not always equate good affect, but feeling good in one's heart, especially when associated with a sense of gratitude, invariably creates positive affect (Welwood, 1983). The following transcript from a session with Irene (Alladin, 2014a, pp. 298–299) illustrates how the technique can be introduced in therapy. Prior to this session, Irene had several sessions of hypnotherapy; therefore, she already had some training in hypnosis and deep relaxation. It is advisable to introduce this technique later in therapy, when the patient had sufficient training in CBT, hypnosis and AMBT. The script begins with Irene being in a deep hypnotic trance. Irene was a high school student, who became fearful of skating, agoraphobic and depressed because she could not ice-skate competitively (resulting from a bad fall she had while skating):

Therapist:	You have now become so deeply relaxed, that you begin to feel a beautiful sensation of peace and relaxation, tranquility, and calm flowing throughout your mind and body. Do you feel relaxed both mentally and physically?
Irene:	Irene nods her head up and down (ideomotor signals of "head up and down for YES" and "shaking your head side to side for NO" were set up prior to starting the breathing with your heart technique).
Therapist:	Now I would like you to focus on the center of your heart (pause for 30 seconds). Can you imagine this?
Irene:	Irene nods her head.
Therapist:	Now I would like you to imagine breathing in and out with your heart (pause for 30 seconds). Can you imagine this?
Irene:	Irene nods her head.
Therapist:	Continue to imagine breathing in and out with your heart (she was allowed to continue with this exercise for 2 minutes; the therapist repeated at regular intervals "Just continue to imagine breathing with your heart" as she did the exercise). Now I would like you to slow down your breathing. Breathe in and out at 7-second intervals.

Breathe in with your heart . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 and now breathe out with your heart . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7. And now as you are breathing in and out with your heart I want you to become aware of something in your life that you feel good about, something that you feel grateful for (pause for 30 seconds). Are you able to focus on something that you are grateful for in your life?

Irene: Irene nods.

Therapist: Just become aware of that feeling and soon you will feel good in your heart.

Irene: Irene nods.

Therapist: Just become aware of this good feeling in your heart (pause for 30 seconds). Now I would like you to become aware of the good feeling in your mind, in your body and in your heart. Do you feel this?

Irene: Irene nods.

Therapist: Now you feel good in your mind, in your body, and in your heart. You feel a sense of balance, a sense of harmony. Do you feel this sense of harmony?

Irene: Irene nods.

Therapist: From now on whenever and wherever you are, you can create this good feeling by imagining breathing with your heart and focusing on something that you are grateful for. With practice you will get better and better at it. Now you know what to do to make your heart feel lighter.

Irene found this technique extremely helpful. It reminded her of her achievements, successes and resources that she had rather focusing on what she did not have or lost. She indicated that the "heart-breathing" technique, although it seemed "weird" initially, it provided a "neat method" for restoring inner balance.

Summary

Anxiety disorders represent complex problems that are often further compounded by comorbidity and socio-cultural factors. As there is no one treatment that fits every patient, there is an urgent need for clinicians to continue to develop more effective and comprehensive treatments for anxiety disorders. The main purpose of this article was to integrate cognitive, behavioral, mindful, psychodynamic, and hypnotic strategies in the management of anxiety disorders. The wounded self-framework provided the rationale for such integration. This protocol provides a variety of treatment interventions for anxiety disorders from which a therapist can choose the "best-fit" strategies for a particular patient. Each case formulation guides the clinician to select the most effective and efficient treatment strategies for his or her patient. Number of sessions and the sequence of the stages of CH will be determined by the clinical needs of each individual patient. Although most of the techniques described are scientific and evidence-based, there is a need to study the effectiveness of the multifactorial treatment protocol described in this article. Moreover, to refine the treatment package, it will be important to continue to study the relative effectiveness of each of the treatment components described.

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