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Hypnosis and mindfulness for the treatment of anxiety disorders: Empirical and applied perspectives

John Lawrence Clarke
James Madison University

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Hypnosis and Mindfulness for the Treatment of Anxiety Disorders: Empirical and
Applied Perspectives

John L. Clarke

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Dedication

This project is dedicated to my parents, Joe and Vickie Clarke, for their unwavering support and guidance throughout each stage of my life. Thank you for believing in me unconditionally and teaching me how to care for others.

Acknowledgments

I am appreciative to Craig Abrahamson for describing hypnosis with the passion that sparked my original interest years ago. Thank you to Kent Massie for helping me foster this interest and find my voice. My deepest gratitude is to the counseling faculty members who have had a lasting impact on my identity as both a counselor and a person. Lennie, Renee, Ed, Debbie, Eric, and Jack: thank you. Finally, I am indebted to my clients who continue to inspire me through their bravery and positive transformation.

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Abstract

The abundance of diagnosable anxiety disorders that are present in our culture today provides a convenient rationale for further investigating the types of treatments, especially non-pharmaceutical, that clinicians have to offer. Hypnosis and mindfulness are two noninvasive techniques that share some important structural and practical similarities. With the recent increase of interest in mindfulness in psychotherapy it is important to acknowledge what these traits are and how these methods complement one another in both theory and practice. It can be concluded as a result of the following literature reviews that both hypnosis and mindfulness as separate techniques have received some empirical validation, yet there are limitations in research design and an inadequate volume (especially in the mindfulness literature) of reliable clinical studies as opposed to case studies. Despite these limitations, there is reason to believe these methods could be even more powerful if used in conjunction. A rationale and suggested model for integrating hypnosis and mindfulness for treating anxiety disorders is included.

Chapter One: Introduction

Over the past few decades, there has been an explosion of mindfulness research and consequently more clinical attention gained for this modality (Williams, Hallquist, Barnes, Cole, & Lynn, 2010). Specifically, mindfulness has been evaluated as a therapeutic intervention for anxiety disorders. In a recent meta-analytic review of articles pertaining to mindfulness-based therapy (MBT) for anxiety, Hofmann (2010) concluded that MBT reduces symptoms of anxiety across a relatively wide range of severity.

Although perhaps not as widely supported, hypnosis for the treatment of anxiety also has a range of applications to be utilized by practitioners (Evans & Coman, 2003). According to Michael Yapko (2011), hypnosis and mindfulness (specifically guided mindfulness meditations) are similar in that they both utilize attention and the power of suggestion through openness to accepting new ideas. Although hypnosis does not share the same language as mindfulness (e.g., the concept of “acceptance”), its underlying principles are nearly identical (Yapko, 2011). These treatment modalities can be easily integrated to enhance one another in a complementary fashion, and in fact, empirical findings indicate that combining hypnosis and mindfulness may result in greater therapeutic outcomes, as compared to either modality used in isolation (Williams et al., 2010; Holroyd, 2003).

As a result of the aforementioned findings, there is a clear need for additional research and training in the synthesis and implementation of these treatment methods. Such a hybrid approach also has the potential to reduce public stigma and ignorance among counselors who are commonly unfamiliar with hypnotherapeutic techniques. It is my wish to shed light on not only the theoretical and structural similarities between mindfulness and hypnosis, but to provide a demonstration of how this integration can be

put into practice. In response to the illustrated clinical efficacy of hypnosis and the increasing attention toward mindfulness practices in therapy, it is useful for counselors to acknowledge this relationship and how these practices can positively affect the lives of their clients.

Anxiety Disorders

According to the National Institute of Mental Health (NIMH), anxiety disorders affect nearly 40 million American adults (about 18%) in a given year (Anxiety Disorders, n.d.). They last at least 6 months and can worsen if untreated (Anxiety Disorders, n.d.). The *DSM-IV-TR* (American Psychiatric Association, 2000) divided anxiety disorders into the following diagnostic categories: panic disorder, specific phobia, social phobia, obsessive-compulsive disorder (OCD), generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), acute stress disorder (ASD), and anxiety disorder not otherwise specified. The NIMH, in their guide to anxiety disorders, described the most common approaches to the treatment of anxiety disorders, namely cognitive-behavioral therapy (CBT) and medication. Further, the institute proposed that this combination is the best treatment approach for many people (Anxiety Disorders, n.d.). The benefits of these treatments also have some limitations, and hypnosis and mindfulness have the potential to surpass some of these (Huston, 2010). For example, medications often produce noxious side effects, yet hypnosis and mindfulness are unlikely to result in any. Further, these modalities can be relatively quick and inexpensive methods of treatment, while modalities such as CBT or supportive therapy can be time consuming and require more sessions than managed care allows, thus becoming a much more costly option (Huston, 2010; Miller, Fletcher, & Kabat-Zinn, 1995). Rather than ruminating on negative

cognitions and trying to reverse them, mindfulness training can help diminish preoccupation with negative self-appraisal and instead cultivate self-acceptance and self-reassurance (Koszycki, Benger, Shlik, & Bradwejn, 2007). Evidence for the long-lasting effects of mindfulness in particular is especially promising (Miller et al., 1995). Hypnosis, especially when involving imagery, can effectively reverse imagined fearful situations and instead foster feelings of control (Evans & Coman, 2003).

Purpose and Overview

Clearly, establishing hypnosis and mindfulness as effective methods for treating anxiety disorders can benefit both insurance companies and clients. With regard to the ongoing trends in psychotherapy, the purity of mindfulness is fading as it becomes increasingly popular, just as hypnosis was decades ago (Yapko, 2011). Therefore, the importance of acquiring hypnotic skills in addition to (or, in this case, in conjunction with) mindfulness skills should be well recognized if these methods are to endure the inevitable waning of enthusiasm for mindful techniques (Yapko, 2011).

The present study separately describes the two methods in order to give the reader a minimal familiarity with each. Next, the study examines the findings of randomized clinical trials (RCTs) and case studies in the investigation of hypnosis and mindfulness as both adjunctive and standalone treatments. This section serves as an updated summary of the current literature and as the basis for a rationale for integrating these methods. A suggested model for integrating these treatments for anxiety is included. This model could serve as a practical guide for clinicians and inform the research design of future trials using hypnosis and mindfulness in tandem. Ultimately, the aim of this report is to answer the following questions: How effective are hypnosis and mindfulness for treating

anxiety? How do these methods compare as treatment modalities? And finally, how can they be integrated for use in a clinical setting?

Chapter Two: Hypnosis

Hypnosis is a naturally occurring phenomenon that many of us experience on a daily basis to some degree when we mindlessly pass an interstate exit, become entirely unaware of the sounds around us while typing a text message, or inadvertently put the milk in the microwave. These are examples of a light trance state. Although many definitions of hypnosis exist, it was most concisely defined by Fromm and Nash (1992) as the induction of a trance state during which guided suggestions are given to the participant. The American Psychological Association (APA) provided a more in-depth and universal definition, acknowledging additional aspects of hypnosis such as the common experience of altered perception (e.g., time distortion), sensation, emotion, thought, or behavior (Green, Barabasz, Barrett, & Montgomery, 2005). Although many different methods of inductions exist, hypnotic procedures commonly involve suggestions for relaxation, calmness, and well-being that are accompanied by imagery experiences (Lynn & Kirsch, 2006). Although the clinical applications of hypnosis are vast, a sound empirical foundation for its effectiveness in treating specific psychological disorders is lacking in many areas.

What is Hypnosis?

Despite the various definitions of hypnosis that exist, clinicians and researchers of various theoretical orientations have agreed upon the following description, which has been officially espoused by Division 30 (Society of Psychological Hypnosis) of the APA. According to the APA, hypnosis is a procedure in which a practitioner suggests that a client experience changes in sensations, perceptions, thoughts or behavior as established by an induction procedure. Although people respond to hypnosis differently, many

experience a calming effect, more focused attention, and a pleasant state of altered consciousness. Contrary to the unfortunate stigma, hypnosis does not involve behavior or mind control. It is a benign therapeutic tool that is used to treat issues like pain, depression, habit disorders, and anxiety (Kirsch, 1994a).

Clearly, hypnosis is neither easily nor succinctly defined. However, for the purpose of this project, hypnosis will be defined as simply a state of focused attention that is usually, but not always, accompanied by relaxation, during which suggestions for positive change may be given (Daitch, 2011).

The Hypnotic Sequence

Hypnosis typically involves five sequential phases: hypnotic induction, deepening, therapeutic suggestion, post-hypnotic suggestions, and alerting. During the induction, the client is encouraged to get comfortable, ignore external stimuli, and focus on the therapist's voice. Although many types of inductions exist, they all aim to narrow and focus the client's attention and alert the unconscious mind to pay attention (Daitch, 2011; Zarren & Eimer, 2002). When choosing an induction, it is advisable to consider the individual needs, personality style and learning systems, and clinical needs of the client (Zarren & Eimer, 2002). Some common induction techniques include: progressive muscle relaxation, where attention is given to the release of tension from individual areas of the body; eye-fixation, where sustained attention is given to an object or point on the wall; and arm levitation, where the attention of the client is drawn to the arm and is often paired with an imaginary cue for trance induction (e.g., imagine a heavy stone is tied to your left hand) (see Appendix A for example induction transcripts). Induction techniques

are commonly paired with deep breathing techniques, which are relaxation provoking in themselves.

In the deepening phase, the client is led into a relaxed state in which “conscious, analytical thinking and processing are diminished [and the client becomes] more open to suggestion and to accessing memories, insights, and internal resources” (Daitch, 2011, p. 48). Deepening techniques often utilize peaceful visual imagery and suggestions to relax or envision yourself descending down a staircase (see Appendix B for an example deepening transcript). Deepening techniques often involve counting methods to further capture the client’s attention while also symbolizing the effect of going “deeper” (e.g., “as the numbers go down, you too can go down, deeper and deeper, sinking into a peaceful and pleasant state of relaxation”).

Therapeutic suggestion is a critical element of the hypnosis procedure. When the client is in a highly focused, relaxed state, he or she has an increased capacity to change, grow, and challenge unwanted patterns of behaving and thinking (Daitch, 2011). The hypnosis literature includes a large compilation of hypnotic suggestions that have been carefully organized by clinical issue into a highly useful resource for clinicians. The *Handbook of Hypnotic Suggestions and Metaphors*, commonly referred to as the “big red book,” is recommended for any practitioner of clinical hypnosis (Hammond, 1990). Although there are too many types of suggestion to describe for the purpose of this paper, some of the broad categories include suggestions that are direct (e.g., “you are letting go of this irrational fear”), indirect (e.g., a metaphor), and questions that may or may not involve two-way communication between the client and operator. There are also certain guidelines that may shape the language of the clinician when formulating and delivering

suggestions. Some of these guidelines may include positive phrasing (e.g., “you will feel more and more excited by the events of your life” rather than “you will feel less depression and apathy”); using present and future tenses; keeping suggestions precise, simple, and concise; and using an appropriate amount of repetition. Finally, it is of particular importance to remove unwanted suggestions (e.g., “your arms feel like warm, wet noodles”) before ending hypnosis (Zarren & Eimer, 2006).

Post-hypnotic suggestions are intended to increase the likelihood of something occurring in the future. For treating anxiety, a clinician might suggest that the client will effectively use the newly learned deep breathing technique whenever the client feels nervousness looming. Post-hypnotic suggestions may also be used to improve the client’s ability to enter easily into trance, serving as an anchor for instant relaxation. This could include a word or a sensory-motor cue (e.g., rubbing the forefinger and thumb of the left hand together) that is established during hypnosis (Daitch, 2011). These physical cues are relatively unobtrusive and easy to implement (Lynn & Kirsch, 2006).

The end of the hypnotic process, or the alerting phase, is marked by a gradual guidance out of the trance state. This is commonly achieved by a counting procedure, and it is important that this process is not abrupt (Daitch, 2011). Unlike the clinician’s tone of voice during the induction, the tone of voice should be increasingly energetic during this phase in order to return the client to a safe state of wakefulness. It is essential to ensure that the client is fully alert and coherent before he or she departs (Lynn & Kirsch, 2006).

Self-hypnosis refers to the independent hypnotic induction in the absence of an operator and can be an effective way to bring about desired results (Daitch, 2011). In fact, many clinicians believe that all hypnosis is self-hypnosis and that clients are indeed the

ones responsible for generating suggestion-relevant imagery, experiences, and behaviors (Daitch, 2011; Lynn & Kirsch, 2006). Self-hypnosis can be taught by the clinician and may involve common induction procedures (e.g., progressive muscle relaxation, pleasant imagery, counting) and ultimately self-suggestions (e.g., “I can negate anxiety with deep breathing”) similar to those received in therapy. By practicing self-hypnosis, the client can become the active agent in the therapeutic process while allowing the therapist to fill the role of facilitator and guide rather than a dictatorial figure (Lynn & Kirsch, 2006). This in itself can be an empowering part of a client’s therapy experience.

It is important to note that the above overview of hypnosis is not intended to serve as a training program, but rather an informative synopsis to help clinicians gain an understanding of the fundamentals of hypnosis. Those interested in practicing hypnosis in the clinical setting should seek proper education, certification, and supervision through one of the accrediting organizations, such as the *American Society of Clinical Hypnosis*.

Hypnosis and Anxiety

Panic Disorder. In a case study, Wild (1994) treated a 36-year-old woman suffering from spontaneous panic attacks with a two-week history of recurrence. The woman’s panic attacks frequently occurred in the middle of the night, jarring her out of deep sleep. The author further described some associated agoraphobic behavior and general anxiety in social situations. Similar complaints of spontaneous panic attacks were twice present at the ages of 20 and 33 and were successfully treated with medication, in combination with breathing and relaxation exercises. A similar approach was taken this time as the patient was prescribed a tricyclic antidepressant and instructed to once again utilize breathing exercises and reduce caffeine intake.

The hypnotic work began by inducing a deep state of relaxation in order to reduce general levels of physiological arousal, as well as phobic and anticipatory anxiety via the technique of reciprocal inhibition. This technique suggests that “anxiety and tension cannot co-exist with relaxation and peace of mind” (Wild, 1994; p. 113). Next, various anxiety-provoking situations were elicited in trance via imagery and then desensitized by replacement with a relaxation response. In order to address self-esteem needs, ego-strengthening techniques were also included. The actual inductions included common techniques, such as eye-fixation, muscle relaxation, heaviness and lightness of the hands and feet (including arm-levitation), deep breathing, and imagery of descending a staircase into a safe place (a mental scene in which the participant feels most at ease). Rapid induction and self-hypnosis techniques were also introduced.

The patient was initially assessed for hypnotizability using the Stanford Hypnotic Clinical Scale and scored a relatively high 4 out of 5. According to Wild, the patient was highly responsive to the hypnotic techniques that were used. After the first week of treatment with combined hypnosis and medication, the patient had no further severe spontaneous panic attacks. After about three weeks, her anticipatory agoraphobic and social phobic anxiety decreased substantially. She described an increase in self-confidence and ability to cope with life’s demands. The author concluded the patient had returned to her premorbid level of functioning. Wild’s work helped to set an early standard of measuring hypnotizability, a facet of hypnosis research that has since received increasing emphasis as an indicator of the validity of any hypnosis study. Although the researcher reported a decrease in panic attacks and anxiety symptoms, his study lacked any valid measure of anxiety and was also confounded by the inclusion of

medication. Ultimately, this single-participant design needed to be expanded into a randomized clinical trial (RCT) with greater accountability of extraneous variables.

Three years after Wild's (1994) study was published, Van Dyck and Spinhoven (1997) provided such a study. In their RCT, the researchers treated 64 outpatients suffering from panic disorder with agoraphobia using in vivo treatment, both with and without hypnosis. The researchers were also concerned with how patient preference affects treatment outcome. Although participants discontinued other forms of therapy for the duration of the trial, they were allowed to continue taking any pre-existing medications. No new medication, however, was provided during the study.

The researchers thoroughly assessed each participant by using a variety of self-report measures: the Fear Questionnaire (FQ) contains 15 questions about phobic avoidance and 5 pertaining to agoraphobia. The Self-rating Depression Scale (SDS) is a widely used measure for depressed mood. The Preference Scale (PS), a scale developed specifically for this study, allows for the patient to indicate the strength of personal preference for either treatment option (with or without hypnosis). The Creative Imagination Scale (CIS) is an assessment for imaginative capacity and in this case was used to measure hypnotizability. The observer ratings scales included the Fear and Avoidance Schedule (FAAS), which contains ratings for anxiety and avoidance in five common agoraphobic situations. The observer for this scale was blind to the treatment condition. Finally, the Stanford Hypnotic Clinical Scale (SHCS) is a 5-item scale intended to measure hypnotizability as it is relevant for clinical practice. The observer for this scale was unaware of the purpose and design of the study.

Although all participants were asked at the onset of the study to indicate their preference for treatment type, half were given their preferred treatment and the other half were not. The groups were equal in number of participants and were randomly assigned. All of the assessments were completed pre-, mid-, and post-treatment, and a therapist working from a treatment manual saw each participant individually. For each participant in the in vivo group, treatment consisted of four hours of therapist contact and 17.5 hours of exposure practice, such as walking through a busy street unaccompanied. Those in the hypnosis group had a similar structure, except ten hours of the 17.5 were devoted to self-hypnosis practice aided with audiotapes, in addition to 7.5 hours of in vivo.

The hypnotic participants were led through “Future Oriented Imagery,” in which they were guided through the process of developing realistic imagery scenes paired with successful encounters with the feared situation. After session three, once a participant had learned self-hypnosis, he or she practiced the strategy in preparation of the actual fearful encounter that would soon be faced. In spite of their predictions, the researchers concluded, based on statistical analyses of the measurements, that there was no significant difference in effect between the in vivo only and the combined therapy groups. Further, and despite popular belief among clinicians, preference for treatment failed to demonstrate any significant main effect or interaction effect in an analysis of variance. According to the researchers, possible factors to consider regarding the unsupportive results include the influence of the different therapists and the likely possibility that participants experienced the combined therapy as less demanding than hypnosis alone.

This study utilized a much stronger experimental design, as compared to Wild's (1994) single-subject design. The incorporation of multiple measurements, including hypnotizability and beyond, was a major improvement in itself. The sample size, randomization of groups, utilization of audiotapes, and the control for medications were all efforts toward a stronger research design. However, RCTs with a control group (e.g., CBT only) resulting in significant reduction of anxiety were still needed at this time to better support the effectiveness of hypnosis.

Despite the need for more RCTs, in 2002 yet another single-subject study was published in which Singh and Banerjee treated a man in his early forties suffering from panic attacks. The man attended one-hour sessions twice a week initially, then once per week during the final four sessions. The researchers introduced hypnosis into the treatment with relaxation (deep breathing and muscle relaxation), guided imagery (a safe place exercise), and an imagery suggestion (releasing a red balloon attached to a piece of paper containing a word that represents the problem). Singh and Banerjee also provided an elaborate explanation to the client of the A-B-C-D-E ((A) situation, (B) cognition, (C) emotional response, (D) physiological response, and (E) behavioral response) model within the Rational Emotive Therapy (RET) framework. These aspects of a panic attack, in this case, were incorporated into the treatment both in trance and in pre- and post-induction dialogue in order to highlight the client's irrational thoughts and self-defeating tendencies. After six sessions, the client only experienced one panic attack. Soon after, the panic attacks subsided completely and therapy was ended after 16 sessions. The client displayed better self-confidence, greater sense of control, and elimination of both physiological and psychological symptoms of panic disorder. Further, despite isolated

symptoms, the client reported a continued absence of panic attacks three years after this initial treatment.

There are clear limitations to this case study in particular. The researchers failed to measure for hypnotizability or any other assessment of anxiety and did not attempt to standardize their treatment by use of audiotapes or transcripts. Further, they utilized a model of hypnosis that is much less common than the popular reciprocal inhibition model and failed to mention any use of medication or other forms of treatment.

In 2005, another case study was published. Iglesias and Iglesias treated a 72-year-old widow with a history of social and public speaking phobias and a current diagnosis of panic disorder. The researchers began treatment by asking her to identify the different levels of her panic attacks in terms of physiological reaction, behaviors, and inner dialogue. In the second phase of treatment, the clinicians performed an eye-fixation induction, followed by a direct suggestion that the client would become instantly aware of impending panic attacks at the onset or earliest level. Next, the client was trained in awake-alert hypnosis, as opposed to the more traditional relaxation hypnosis. In this case, the client was gradually conditioned to open her eyes while remaining in a hypnotic state. This allowed the client to remain mobile in the therapy room and conversational with the hypnosis operator. In the fourth phase of treatment, the researchers utilized the “Waterford script” for mitigating panic attacks in which the client is referred to indirectly, in the third-person (e.g., “They are individuals that understand duress and know how to overcome it; this is why they belong to the ranks of the successful.”) (p. 253). This script was chosen because of the client’s difficulties surrounding her narcissistic tendencies that arose in social situations. After four weeks of half-hour visits

three times a week, the frequency of her panic attacks remained unchanged. The intensity of the episodes, however, was remarkably reduced, and the client was now able to extinguish the attacks during early onset by applying hypnotic techniques. The only quantitative assessment provided from this case study was a subjective rating of panic attacks on the “intensity thermometer” (p. 254). The strengths of this study include the use of a standardized transcript for the hypnotic suggestion in addition to the rationale for using this script in particular. Once again, however, this study is limited by its weak research design and failure to use any formal assessments of hypnotizability and anxiety. The researchers also used a model of hypnosis that is much less common, as compared to the reciprocal inhibition model.

Clearly, the hypnosis literature for treating panic disorder is in need of fewer case studies and more RCTs in order to prove its effectiveness. Although successful treatment as illustrated by a single-subject design is a positive contribution to the literature, the generalizability of its results is relatively low. In other words, it cannot necessarily be assumed that this treatment modality is suggested for the general population (and is at least as effective as other treatments, such as CBT) until an adequate number of RCTs have been established.

Generalized Anxiety Disorder. A separate set of studies has been published regarding the effectiveness of hypnosis for the treatment of GAD. In 1999, Nishith, Barabasz, Barabasz, and Warner completed a complexly-designed RCT in which they compared the effects of brief hypnosis and alprazolam (Xanax) among college students. There were low and high hypnotizables, as determined by the Harvard Group Scale of Hypnotic Susceptibility: A (HGSHS: A) (Shor & Orne, 1962)) and additional participants

in the alprazolam group. Subjects in the hypnosis group who scored above 8 or below 5 on the HGSHS: A were then individually assessed using the more stringent Stanford Hypnotic Susceptibility Scale: Form C (Weitzenhoffer & Hilgard, 1962) in order to determine subgroup placement. Age, gender, and handedness were also accounted for in the group assignment process.

Each participant was given 1 mg of alprazolam and instructed to focus for five minutes, with eyes closed, on the feelings brought about by the drug while EEG measures were taken. The researchers then administered the tension-anxiety subscale of the Profile of Mood States (POMS) (Eichman & Umstead, 1971) and waited four days for the medication to be completely processed. Upon return, the hypnosis participants were exposed to hypnosis alone and hypnosis with a suggestion to use their hypnotic state to recreate the feelings brought about by the alprazolam. The EEG and POMS measures were repeated. Subjects in the hypnotic suggestion condition had significantly lower scores on the POMS tension-anxiety subscale as compared to the alprazolam condition for both the low and high hypnotizables. The high hypnotizables had significantly lower scores on the POMS subscale as compared to the low hypnotizables across both the alprazolam and the hypnotic suggestion conditions. Finally, the hypnotic suggestion condition had significantly lower scores on the POMS subscale as compared to the hypnosis only condition. The high hypnotizables had significantly lower scores on the POMS subscale as compared to the low hypnotizables across both the hypnosis only and the hypnotic suggestion conditions. Although not significant between groups, EEG data showed frontal and occipital sites were specifically involved in both the alprazolam and the hypnotic suggestion conditions.

The greater implications of the results of this experiment are clear: subjects were able to recreate the relaxing feelings brought about by the alprazolam by using hypnosis. Further, hypnosis with a specific *suggestion* brought about greater reduction of reported anxiety, and those who were highly hypnotizable responded more favorably than those who were less hypnotizable. Not only was this experiment methodically sound, it was also successful in demonstrating the clinical efficacy of hypnosis. Although it was more intricate and thus more costly than the common single-subject studies, this study resulted in the contribution of some very exciting findings to the literature.

It is important to note that, excluding Nishith et al.'s (1999) bold experiment, this subsequent set of articles shares many similarities with the panic disorder research: too many case studies, not enough RCTs, and weak or inconsistent empirical design. In this particular case study, yet another confounding variable is highlighted: multiple diagnoses. In 2001, for example, Ellsmore treated a 55-year-old man suffering from generalized anxiety *and* panic disorder. The man was also suffering from medical issues, weight loss, nausea, sleep disturbances, and headaches. According to Ellsmore, the patient also suffered from bouts of agoraphobia and claustrophobia and upon assessment scored in the severe range for anxiety and depression, although the specific assessment is unspecified. The patient described previous experience with hypnosis as very beneficial. His capacities for dissociation, absorption, and anxiety-proneness indicated high hypnotizability. During the time of treatment, he was taking antidepressants, Valium, and sleeping medications.

Hypnosis was used in combination with many other forms of psychotherapy, including psychoeducation, rational emotive therapy, and goal-setting. The author used

hypnosis in a contemporary fashion, utilizing common inductions, deepenings, imagery, and suggestions. Music was also incorporated into the work. During the first seven months of therapy, progress was inconsistent and at times regressive. Progress became steady during the following seven months and the patient had regained his lost weight and was sleeping better. He had been using self-hypnosis every morning. He had also regained his sense of humor and was no longer irritable, and upon re-administration of the assessment he scored in the minimal ranges for both anxiety and depression. His ability to concentrate had increased, his breathing rate had slowed to a normal pace, and he felt optimistic about the future. In addition to the vast clinical complications of this patient in particular, the researcher further confounded his results by utilizing multiple approaches to treatment. Although this is by no means contraindicated in the clinical setting, it only weakens one's case in the experimental setting. On top of the influence of multiple medications, these results are further weakened by a seemingly predictable exclusion of reputable psychometrics.

In the following two case studies, a major methodological improvement is the inclusion of hypnotizability measurement. Baker (2001) described the case of a 16-year-old girl suffering from anxiety and low self-esteem. At the beginning of the hypnotic work, the author administered the Stanford Hypnotic Clinical Scale for Children using eye-fixation and observed successful completion of hand lowering, arm rigidity, visual and auditory hallucination, and dream and post-hypnotic response items, indicating high hypnotizability. During sessions two through five, the client was led through imagery exercises surrounding the social aspects of her anxiety and was also provided with a post-hypnotic cue for instant relaxation (pressing her index finger to her thumb). As a result of

these sessions, the client reported being able to spend time in public places that were once frightening, and that using her physical cue provided some relief from anxiety. During session six, a safe place exercise was used in order to improve self-esteem, including a box where she could lock up her memories of abuse. The client reported that this was beneficial in helping her feel relaxed and free of worry. In session seven, a garden scene was used to further reinforce more positive self-esteem and this too led to positive self-reports. Although in this case hypnosis was helpful in anxiety reduction and self-esteem improvement, it was unhelpful in reducing her fears of bad things happening and in alleviating her checking tendencies that were associated with her Obsessive Compulsive Disorder. It may also be of importance to note the popularity of the “safe place” imagery technique, as utilized in multiple studies of this review. In consideration of a proposed research design, this may be particularly relevant.

In a similar study, German (2004) treated a 20-year-old male college student for anxiety and depression. The Stanford Hypnotic Clinical Scale (SHCS) was used to determine hypnotizability and resulted in a score of 4 out of 5, indicating excellent hypnotic sensitivity. The Depression, Anxiety and Stress Scales (DASS), a self-reported measure, indicated extremely severe degrees of distress. The client also described an inability to experience positive feelings, a lack of having anything to look forward to, and anhedonia. Over the course of therapy, hypnosis was used to help reframe his perfectionism, strengthen his ego, teach relaxation techniques, and incorporate music as an anti-anxiety strategy. After approximately three months of therapy, the DASS was administered once again and revealed alleviated levels of depression, anxiety, and stress that were now in a normal range. The client reported an increased ability to concentrate,

better psychological flexibility, and healthier sleeping patterns. One limitation here is that a description of the hypnotic techniques (i.e., inductions, suggestions, etc.) was lacking. However, this simple case study is an improvement upon those previously discussed because it utilized hypnotizability and anxiety measurements that both illustrated clinical success.

In 2010, Huston performed a much needed clinical trial investigating the effectiveness of hypnosis for the treatment of GAD. Participants included 60 clients being treated at a private practice, half of which received hypnosis and the other half cognitive-behavioral therapy (CBT). Those in the hypnosis group had already chosen to use hypnosis in their treatment. All clients met the DSM-IV criteria for generalized anxiety disorder and scored at least a 22 on the Beck Anxiety Inventory (BAI). Treatment for the hypnosis group included a standard induction and suggestions for the alleviation of anxiety. Each participant in the hypnosis group received two hypnosis sessions lasting approximately one hour each that were performed from a standardized script to ensure consistency. CBT participants received an average of four sessions of treatment that included countering negative self-talk, reframing, and identifying and challenging cognitive distortions. Both groups were given the BAI before and after treatment.

Upon statistical analysis, Huston (2010) discovered no significant pretest differences between groups on the BAI. A dependent *t* test revealed a significant drop in BAI scores from pre- to post-treatment in the hypnosis group, and this same analysis with the CBT group also revealed a significant decrease in BAI scores. Further analysis revealed no significant difference in the impact of treatment on BAI score differences (i.e., pre-test and post-test scores). This supports the hypothesis that there will be

reduction in anxiety levels as a result of hypnosis, and although hypnosis was not proven to be *more* effective than CBT, it was proven to be equally as effective. The implications of these important findings are clear, and it is of particular importance to note that hypnosis was used not only as a standalone treatment rather than an adjunct, but also with multiple participants as opposed to only one. Finally, although it is not experimentally validated, it may be inferred that hypnosis produces faster results than CBT since those in the hypnosis group received fewer sessions. Similar to the research on panic disorder, these studies represent a foundational yet inconsistent set of findings regarding hypnosis for the treatment of GAD. With fewer case studies and more RCTs, this particular area of the literature would be greatly strengthened.

Phobias. It should be noted at this point that while researchers have ventured into the many different types of anxiety disorders, it is fundamentally a similar mechanism of anxiety that drives each one. Further, the same goals of replacing nervousness with relaxation and working toward self-sufficiency are common. The literature was provided with an important addition in 1997 when Schoenberger, Kirsch, Gearan, Montgomery, and Pastyrnak conducted an investigation of hypnosis in combination with CBT for the treatment of public speaking anxiety. Participants included 20 men and 42 women and were restricted to persons scoring 19 or above on a modified version of the Personal Report of Confidence as a Speaker (PRCS; Paul, 1966). The therapists included three advanced doctoral students in clinical psychology who were trained in both CBT and hypnosis. The researchers measured anxiety, hypnotizability, and more using an arsenal of additional assessment instruments (nine in total).

Participants were randomly assigned to one of three groups (CBT, Cognitive Behavioral Hypnotic Treatment (CBHT), or no treatment) and both treatment groups received five 2-hour sessions of CBT adapted from Heimberg's (1991) CBT treatment for generalized social phobia, which has also been used effectively for public speaking phobia (Heimberg, Becker, Goldfinger, & Vermilyea, 1985). This treatment includes cognitive restructuring and exposure to feared situations, in addition to progressive relaxation training that was added by the researchers. In the CBHT group, the relaxation training was replaced by the relaxation-based hypnotic induction described by Kirsch et al. (1993) and the primary difference between the groups was the inclusion of suggestions to enter hypnotic trance. Both before treatment and then beginning in the third treatment session, participants were asked to give a speech in a simulated public speaking situation, and then pre- and post-treatment assessments were administered accordingly.

Schoenberger et al. concluded that both treatments (non-hypnotic and hypnotic CBT) effectively reduced public speaking anxiety relative to no treatment. Further, the addition of hypnosis enhanced the effects of treatment, and an analysis of effect sizes confirmed this finding. It is important to note that the only differences between the treatment groups were the use of the term "hypnosis" and the use of some general suggestions for improvement. This suggests valuable implications about the power of expectancy in therapy outcome and also the potency of hypnotic suggestion, a variable in research that is uncommonly evaluated. The utilization of multiple groups (including a control) and a standardized script adds to the legitimacy of this study in particular, supporting the usefulness of hypnosis for treating a specific phobia.

In 2002, a case study was published in which Byron treated a 15-year-old boy with a social communication disorder and an inability to enter a classroom due to anxiety. During the first hypnosis session, the clinician utilized safe place imagery followed by progressive relaxation and suggestions for ego strengthening and confidence building. A post-hypnotic suggestion was also given to enable the client to access the feelings of calmness associated with his safe place by rubbing his thumb and finger together. During the second session, Byron used age progression to help the client fast-forward to a time in which he had achieved all of his goals. The third session also utilized age progression in combination with instructions for self-hypnosis.

Pre- and post-treatment assessment included the Beck Anxiety Inventory (BAI), which showed a reduction in nine of the 21 features of anxiety and an overall decrease in total score from 25 to 16. Six months after the last hypnosis session, the client's anxiety had steadily decreased (it was measured again during each session) to a score of 11. His attendance at school improved dramatically and he reported steady, continuous improvement of his home life. Although it was not measured, the author noticed obvious improvements in the client's self-esteem. Lastly, although hypnosis cannot be the only attributable cause of this improvement, it was the only new factor that was intended to improve the client's life during this six months period.

Although Byron's failure to measure hypnotizability is a weakness of this case study, the utilization of the BAI should be considered a strength. Further, in the absence of a standardized script, "safe place" imagery was once again utilized and thus suggestive of its usefulness and adaptability. Both the BAI and "safe place" imagery should therefore be seriously considered as part of a proposed experimental design. The

recurring theme of ego strength or self-esteem is also indicative of one possible mechanism that underlies anxiety and should be considered in terms of both hypnotic and non-hypnotic work. It may be hypothesized that negative self-esteem actively contributes to the inability of those with an anxiety disorder to self-soothe or reassure, which is an especially vital skill for those suffering from panic attacks. To bring about one's own relief is often an important part of attaining self-sufficiency.

Gow (2006) provided two similar case studies in which he successfully implemented hypnosis for anxiety reduction with dental procedures. In one study, he treated a 31-year-old woman with dental problems and in need of emergency extraction. Before treatment the patient scored 16/20 on the Corah Dental Anxiety Score and 23/30 on the Modified Corah Dental Anxiety Score, indicating a high level of anxiety. She scored 38 on the Creative Imagination Scale (CIS) and a score of three on the Spiegel Eye Roll, indicating high hypnotizability. The patient also reported high levels of pain. She described having a serious dental phobia that may be due to a very negative experience in an emergency situation with an unfamiliar dentist who was unkind and hasty in her treatment. Further, she described a traumatic experience when giving birth, which she then attributed to her intense fear of needles. After pharmacological interventions were made in order to alleviate her pain, the patient indicated an interest in hypnosis. Over the course of the following weeks, the patient went through a standardized systematic desensitization process to address her needle phobia, and then received a basic hypnotic induction. When an emergency extraction was suddenly needed, the patient was induced by an eye fixation and reverse counting induction, followed by imagery of descending a staircase for deepening and finally reaching a

“special place.” Ego strengthening suggestions were given, in addition to a posthypnotic suggestion for elimination of irrational fears regarding dental treatment. Next, a glove anesthesia technique (specific suggestions are given to eliminate physical sensations) was used to reduce dental sensitivity and the procedure was carried out. Despite some discomfort and anxiety, the patient endured the procedure and described it as being unbelievably easy. The patient’s post-treatment Corah Score dropped to 7/20, and the Modified Corah score dropped to 11/30, indicating significant anxiety reduction and consistent with someone who has little or no fear of dental treatment.

A common theme among the hypnosis literature is the inconsistency of empirical methods. Researchers frequently neglected to measure hypnotizability, compare treatment effects to that of an already validated model, and control for various confounding variables. Researchers should focus less on case studies and more on RCTs in order to further establish hypnosis as an effective treatment for anxiety. It is impressive, however, that the hypnosis literature spans a wide range of the different anxiety disorders as studied separately. In conclusion, multiple studies support the use of hypnosis for anxiety, yet further clinical trials are greatly needed at this time.

Chapter Three: Mindfulness

What is Mindfulness?

Mindfulness, much like hypnosis, is not so easily defined, although individuals from vastly disparate backgrounds have repeatedly attempted to do so. In *The Heart of Buddhist Meditation*, the Buddhist scholar and monk Nyanaponika Thera described mindfulness as “the master key for *knowing* the mind, the perfect tool for *shaping* the mind, and the lofty manifestation of the achieved *freedom* of the mind” (as cited in Kabat-Zinn, 2005, p. 108). In the English language, mindfulness is equivalent to the Pali words *sati* and *sampajaña*, which as a whole can be translated as awareness, circumspection, discernment, and retention (Shapiro & Carlson, 2009). Theravadin scholar and monk Bhikku Bodhi defined mindfulness as simply remembering to pay attention to what is occurring in one’s immediate experience with care and sensitivity (Wallace & Bodhi, 2006). According to Shapiro and Carlson (2009), mindfulness is a process *and* an outcome, and involves both mindful awareness and mindful practice.

Mindful awareness begins with bare awareness, such as the attention that can be given to one’s breathing in this very moment. Just as we can notice our breath traveling in and out, we can notice the state and the flow of the mind at any given time. In other words, we can be mindful of the mind, and certainly we can also be mindful of our emotions. Mindful awareness is fundamentally a way of being and a way of relating to all experience in an open and receptive way, regardless of the nature of the circumstance. It involves letting go of wanting things to be different and accepting what is here and now. According to mindfulness, and in accord with Buddhist psychology, suffering arises when we do the former while failing to do the latter. Mindfulness is about freedom from

reactivity, reflexive patterns, and ultimately, suffering. According to Buddhist teachings, although it is most typically unacknowledged, this way of being is inherent in everyone. Mindful practice, on the other hand, is a way to achieve mindful awareness. It is the intentional pursuit of mindful skills through a practice that is simple yet richly complex (Shapiro & Carlson, 2009). In order to communicate both the simplicity and complexity of mindful practice, Shapiro and Carlson developed a model of mindfulness composed of three core elements: intention, attention, and attitude.

Buddhist teachings consider intention to be a key component of mindfulness and vital to understanding the mindful process. At the beginning of this process it may be wise to simply ask oneself, “What is the intention of my practice right now?” (Shapiro & Carlson, 2009) In D. H. Shapiro’s (1992) study, he found that as meditators continued to practice, their intentions shifted from self-regulation to self-exploration, and finally to self-liberation and selfless service. This illustrates both the dynamic and powerful nature of intention in mindful practice. An added benefit of attending to one’s intention is the opportunity for better understanding of and insight into one’s values. Finally, intentions should be held lightly and not viewed as goals (Shapiro & Carlson, 2009).

Paying attention involves observing one’s experience in the moment both internally and externally. This process involves suspending interpretations of experience and rather attending to the experience itself. This deep, conscious attention provides a stark contrast to the way our minds tend to operate on a very surface level and often with scattered attention to many things at once. Although we can indeed pay attention to more than one thing at a time and be aware of these things on different levels of the mind (i.e., unconscious), mindful attention is both narrow and specific. Further, mindful attention is

both discerning and nonreactive. It is this attention that allows one to fully connect with the present moment and with oneself (Shapiro & Carlson, 2009).

Beyond the process of attending, mindfulness involves *how* one attends. In other words, one's attitude must be mindfully established and followed. In Asian languages, heart and mind are the same word. Therefore, it is perhaps more accurate to think of *heartfulness* as opposed to mindfulness (Shapiro & Carlson, 2009). Mindful attitudes may include nonjudging, nonstriving, nonattachment, patience, curiosity, openness (beginner's mind), gentleness, and loving-kindness. These attitudes are indeed interconnected and perhaps most salient when made explicit. Attitudes do not influence the experience itself but rather insert a lens through which the qualities of one's attention manifest (Shapiro & Carlson, 2009).

Mindfulness practice itself can be divided into two categories: formal and informal. Formal practice, as one might expect, involves intentional practices such as sitting meditation, body scan meditation, and walking meditation. Formal practice can entail routines that last years or just one day at an intensive retreat. Informal practice, on the other hand, involves participating in life experiences with a mindful attitude that is open, accepting, and discerning. Examples include mindful eating, mindful driving, or mindful listening. Mindfulness may hold relevance in the therapy setting in a number of different ways. For the purposes of this project, particular attention will be given to experimental uses of mindfulness-based techniques for the treatment of anxiety.

Mindfulness and Anxiety

In 1992, Jon Kabat-Zinn, a pioneer in bringing mindfulness to the United States, and his colleagues tested the effectiveness of his meditation-based stress reduction

program for the treatment of anxiety disorders. This program, referred to as *meditation-based*, eventually became the widely popular mindfulness-based stress reduction (MBSR) program. In this study, Kabat-Zinn et al. recruited 22 subjects who met the *DSM-III-R* criteria for generalized anxiety disorder or panic disorder with or without agoraphobia and controlled for other mental disorders. Half of the participants were taking medication for their anxiety at the time, and the other half were not. The participants met twice weekly for eight weeks, in addition to a 7.5-hour intensive and mostly silent meditation retreat during the sixth week. From pre- to post-treatment, the participants displayed significant reductions in anxiety and also depression as measured by the *Beck Anxiety Inventory (BAI)*, the *Beck Depression Inventory (BDI)*, the *Hamilton Rating Scale for Anxiety* and the *Hamilton Rating Scale for Depression*. Measures for agoraphobic behavior (the *Mobility Inventory for Agoraphobia* scale and the *Fear Survey Schedule (FSS)*) showed similar decreasing trends. All of these scores were maintained when assessed after three months for follow-up evaluation. Most participants (91%) also reported adherence to the stress reduction practice at this time, which is suggestive of the sustainability of this program in particular. Clearly, this intervention proved highly effective in the treatment of two different kinds of anxiety disorders, with few methodological limitations. Those limitations may include a lack of a control or comparison group and subsequent randomization. Despite these limitations, this study proved to be an early establishment of MBSR's potential.

Three years after Kabat-Zinn's (1992) study, Miller, Fletcher, and Kabat-Zinn (1995) followed up with 18 of the 22 original participants from the experiment. Repeated measures ANOVA clearly showed that the improvements in anxiety and depression

persisted at the time of follow-up, as demonstrated by both the Hamilton and Beck anxiety and depression measures. The same results were found with regard to the *FSS* and one of the agoraphobia scales. Finally, a majority of subjects demonstrated ongoing compliance with their stress reduction practice. Ultimately, these results reinforce the 3-month follow-up results from the previous study while adding a new dimension of effectiveness over time. The implications are that an intensive but time-limited mindfulness group can have long-term beneficial effects for individuals with anxiety disorders.

In 2007, Lee and his colleagues evaluated the effectiveness of an MBSR program as an adjunct to pharmacotherapy in patients with anxiety. The participants completed a program similar to Kabat-Zinn's (1992) study and utilized similar assessments. Lee et al. randomly assigned participants to either the MBSR group or an anxiety disorder education program. The researchers observed significant declines in the *Hamilton Anxiety Rating Scale*, the *State-Trait Anxiety Inventory (STAI)*, and the *Symptom Checklist-90—Revised (SCL-90-R)* among MBSR participants as compared to those in the education group. Although limited by the presence of medication and a more competitive comparison group (e.g., CBT) or control group, these results are consistent with Kabat-Zinn's (1992) findings and further support the use of this type of mindfulness program for anxiety in particular.

Evans et al. (2008) treated 11 participants who met the *DSM-IV* criteria for GAD using Jon Kabat-Zinn's mindfulness-based stress reduction program. Participants met with the facilitators over the course of eight weeks for two hours each week and were introduced to techniques such as the body scan meditation, sitting meditation, and gentle,

hatha yoga. The added cognitive therapy component of the program included activities such as observing the association between worried thoughts, mood and behavior. Participants were also given cognitive therapy homework assignments and guided meditation CDs that they were instructed to listen to at least 30 minutes per day. The participants completed a battery of self-report measures before and after treatment. Impressively, the participants exhibited statistically significant reductions in all measurements including the *BAI*, the *Penn State Worry Questionnaire (PSWQ)*, the *Profile of Mood States (POMS)*, and the *Beck Depression Inventory-II (BDI-II)*. From baseline to post-treatment, scores on the *Mindfulness Attention Awareness Scale (MAAS)* rose, indicating a day-to-day increase in mindful states, although this result was not statistically significant. One major limitation to this study is that it does not entail the characteristics of an RCT, namely the use of a control group and randomization of groups. The researchers also did not take into account the potential effects of medication, previous mindfulness training, or other therapies currently being received. They did control for comorbid mental disorders by eliminating those with dual or multiple diagnoses, and assessing for mindfulness abilities was a strength. Overall, these results indicate that MBSR is a feasible, appropriate, and most importantly an effective treatment modality for the reduction of generalized anxiety in an adult clinical population.

Much like that of hypnosis, the mindfulness literature generally supports its use for the treatment of anxiety disorders. At the same time, the number of mindfulness studies for anxiety is particularly limited when compared to hypnosis and covers less of a range of the different anxiety disorders. Therefore, more studies regarding mindfulness and anxiety are needed. There also appears to be some inconsistency with regard to

research design and measurement and therefore a more standardized approach would be beneficial. Although perhaps not fully established, mindfulness has indeed proven somewhat effective in the treatment of anxiety and should therefore be considered as a viable treatment alternative.

Although research separately supports the use of mindfulness and hypnosis, there is currently no research empirically evaluating the two used in conjunction. Williams and his colleagues (2010) supported this conclusion in their own analysis of the literature. The most obvious implication of this concurrent conclusion is that a need for such studies exists. In the event of such an experiment it should be carefully designed and executed in order to achieve the highest validity possible. Suggestions for a refined experimental design, based on the analysis of previous studies, can be found throughout the above literature reviews. As evidenced by these separate summaries, there is reason to believe that these modalities would be as efficacious or more when thoughtfully integrated. A limited number of clinician resources for how to achieve this integration currently exist, and in response the remainder of this project is dedicated to the theoretical and practical components of this combined approach.

Chapter Four: Integration and Practice

Comparisons and Connections

In 2009, Michael Harrer identified some possible contributions between mindfulness and hypnosis, many of which he referred to as “spectrums” that address the relative connections between two variables in comparison. This includes the spectrum from absorption, which is commonly induced in hypnosis, to open awareness, which is usually associated with mindfulness. Whereas in hypnosis the goal is often to eliminate awareness of one’s surroundings in order to increase absorption, mindfulness aims toward the opposite direction. This, however, is not always the case as it is common for hypnosis practitioners to give suggestions or use inductions that lead to heightened awareness of one’s environment (e.g., “as you sink further and further into the chair, notice the way it embraces you and supports each part of you”). At the same time, a practitioner may follow this type of suggestion with one that aims to have the client “let go” of the surroundings and “turn inward,” which is more characteristic of mindfulness.

Harrer suggested there is a polarity between hypnotic dissociation and mindful disidentification (2009). Whereas hypnosis may be used to induce dissociation, especially in cases of trauma, mindfulness is likely to be used to foster qualities of being an observer, participating but disidentified. This present-moment orientation allows the individual to detach and thus remain unbothered by noxious thoughts and feelings. Another interesting comparison is the spectrum from goal-orientation and change to exploration with acceptance and equanimity. Whereas hypnosis involves suggestions using change-based language for alleviation of symptoms, mindfulness promotes acceptance of the way things are through attitude reformation (e.g., loving-kindness).

However, it is not uncommon for hypnotic suggestions to include mention of increased acceptance of symptoms, especially regarding anxiety. Finally, there is a distinction to be made according to Harrer's spectrum of the "doing-mode" to the "non-doing and being-mode" (p. 238). Mindfulness suggests a new way of being that is centered on non-doing and letting go of the idea that the world should be a certain way. Although not as goal-oriented as hypnosis, mindfulness practice seems to entail some striving for an increased state of awareness, which is goal-oriented in itself.

Hypnosis and mindfulness are similar in that they both utilize the power of attention and suggestion. In mindfulness, suggestions are not as important but rather there is an emphasis on acceptance of the present moment rather than a direct attempt to alter one's experience (Williams et al., 2010). This acceptance, however, could be potentially taught and reinforced by hypnosis. Lynn, Das, Hallquist and Williams (2006) also identified a number of important similarities between hypnosis and mindfulness. For instance, both modalities underline promoting acceptance while minimizing experiential avoidance, which is a key component of anxiety disorders in particular. The hypnotic and meditational states share some similarities in appearance such as the eyes being closed and the experiencing of a trance-like state of narrowed attention or even dissociation. Both processes utilize attentional resources to establish a state that is conducive to positive therapeutic change. They both commonly induce relaxation, although neither technique is limited to this.

Hypnosis and mindfulness practitioners are often trained to observe their internal processes (i.e., thoughts and emotions) with a common attitude of nonjudgment and nonevaluation. Both modalities rely on and are enhanced by positive expectations of the

individual. Hypnosis and mindfulness are also very portable in such a way that allows for utilization in many situations outside the clinician's office. This is a significant advantage of these methods for anxiety in particular as anxiety often manifests in public and away from home. Ultimately, both of these processes rely on the subjective experiences of the individual, which can vary greatly in the context of either modality (Lynn et al., 2006).

Rationale for Integration

There are numerous ways to conceptualize the integration of mindfulness and hypnosis. One suggestion comes from Kirsch and Lynn's (1997, 1998) response set theory, which can serve as a foundation for integrating these two methods. Response sets are "conditioned patterns of associations that facilitate particular cognitions, behaviors, and self-representations" that can be activated by internal or external stimuli (Williams et al., p. 321). An example would be avoidance behavior triggered by the presence of large groups. Hypnosis and mindfulness can be used in tandem to replace maladaptive response sets with novel adaptive response sets. "Whereas mindfulness facilitates the recognition and dissolution of maladaptive response sets in general, hypnotic suggestions can target specific symptoms and maladaptive response sets and, through suggestion, replace them with more adaptive response sets, beliefs, and attitudes" (Williams et al., p. 321). Ultimately, the structural similarities and comparable research findings serve as a basic, logical rationale for integration from which to build upon.

Integrative Techniques

The following techniques are examples of how hypnosis and mindfulness can be used in tandem to achieve better therapeutic outcomes. In these exercises, hypnosis and mindfulness rely on and complement each other as cooperative treatment methods. Here,

mindfulness has often been woven into the induction and posthypnotic suggestion components of the hypnotic trance. This combination should only be used when directly indicated and when the client is both motivated and interested in these practices as a part of treatment. It is especially important to note that only licensed practitioners who have been trained and are competent in its practice should use hypnosis, even when combined with mindfulness. The same ethical considerations and contraindications apply.

Body Scan. The body scan is a technique common in both mindfulness and hypnosis. In hypnosis it is commonly used as an induction technique and might be referred to as progressive muscle relaxation (PMR). In mindfulness it may be used as a stand-alone technique to quickly raise bodily awareness in an attempt to locate and become mindfully aware of any tension. The body scan can be done sitting or lying down and can begin with the head or the toes:

As you continue resting comfortably, allowing yourself to sink more and more into the chair beneath you, you can shift your focus to the crown of your head. Notice any tension there and begin to envision a warm relaxation spreading downward through your face. Your job is to simply notice with acceptance and without judgment. Notice the sensations in your forehead. Notice the feelings in your cheeks and the muscles around your eyes. Just observe any tension that you're coming across. Simply observing. Shifting that focus down to the shoulders and slowly through the arms, just noticing whatever it is you're noticing. Focus on the feelings in your hands, perhaps they feel heavier or even lighter. Focus on the feelings in your chest and perhaps take a moment to admire the steady rhythm of your heart and the gentle rise and fall of the breath. Now

gently shift that focus through the abdomen and perhaps you can envision a warm light in the shape of a halo surrounding your body now. Imagine that halo slowly making its way down through your legs and eventually through the tips of your toes, just slowly scanning the body for tension. Take a moment to notice any differences in the way you feel.

If this exercise is being used as an induction it can flow nicely into a post-hypnotic induction to suggest scanning the body for tension whenever one notices the first sensation of unease, and as a result that tension will dissolve, along with any remaining anxiety (Williams et al., 2010).

Breath Awareness. When purposeful attention is given to the breath, a response set of nonjudgment toward internal experience can replace one of misinterpretation of bodily agitation that is commonly experienced during a panic attack in particular. The purpose of breath awareness is to simply observe with a mindful, accepting attitude, whatever the breath is doing in that moment. This is a common technique used in both mindfulness meditation and hypnotic induction, and can be utilized like this:

I wonder if you can just give some attention to your breath now. Giving some attention to that breath and not trying to change it. Just observing it with gentle curiosity and a mindful attitude of acceptance. You may notice your abdomen expanding with each inhalation and your chest falling with each exhalation. You may notice the rhythm of your breath, whether it is steady or sporadic, and practice a nonjudgmental awareness of how your body is breathing itself right now. Notice the point between inhalation and exhalation, the peak of the breath—that calm stillness as the lungs pause in their sequence. Perhaps you can pay some

attention to other qualities of the breath—its texture, its temperature, its subtle taste. As you continue to focus on the breath it is quite natural for the mind to wander. When this happens you can gently guide that focus back toward the breath with loving-kindness. The same applies for any emotions that come and go—you can simply notice them and allow them to float past. Just notice whatever happens and continue to focus on your breath.

A posthypnotic suggestion for this type of exercise might involve another suggestion for automatic activation of this new response set when confronted with a predictably bothersome situation (e.g., speaking in front of a group). To foster more general mindfulness, an additional suggestion may be for the client to learn a new habit of paying attention to the breath during routine activities such as brushing one's teeth or during a specific time of day. More broadly, a similar suggestion could be given for any situation that is problematic for that particular client (Williams et al., 2010).

Mindful Metacognitive Set. The development of a mindful metacognitive set involves being able to perceive thoughts as just that. When anxiety sufferers can appropriately differentiate between thoughts and truths, anxiety loses some of its potency. This skill combined with the body scan and breath awareness hold remarkable therapeutic potential. A guided experience for this type of learning might look something like this:

For a moment I want you to imagine sitting in front of a large television screen.

The TV is on, but the screen is black and empty. Now I want you to see if you can just sit back and give your thoughts permission to come and go. Imagine each one rolling across the screen like a scrolling marquee. These thoughts are just like any other thought. They occur within the self, but they are not the self. You realize

that you are not your thoughts, and they are not necessarily indicators of truth.

Thoughts can positively or negatively guide you, yet you have the ability to simply let them go. They are transient and fleeting.

Posthypnotic suggestions for metacognitive awareness may include suggesting the use of this skill in the presence of anxious thoughts (e.g., “I’m thinking about how scared I might feel in front of others, yet I am aware of having that thought. The thought is just a thought.”). Further, when thoughts seem directly paired with certain negative behaviors (e.g., violent outbursts), a posthypnotic suggestion may be given to raise awareness and empower the use of this skill (Williams et al., 2010).

Practicing Mindfulness. Williams and his colleagues (2010) suggested that hypnosis can be used to encourage both formal and informal mindfulness practice. Hypnotic interventions can enhance mindfulness practice in a number of different ways, such as directing the client toward “(a) watching the breath rather than thinking about or judging it, (b) returning to breath awareness as soon as attention becomes attached to thoughts, (c) not engaging in self-criticism when attention becomes absorbed in thinking, (d) realizing that the goal of meditation is not to attain a particular state of mind or experience, and (e) making a commitment to regularly practicing meditation” (pp. 325-326). Not only can suggestions such as these be used to empower a client with anti-anxiety exercises but also to foster a more mindful attitude of non-judgmental acceptance. Suggestions can also be given to directly support the motivation and inevitable success of the client as they pursue their practice.

Sensing. Shifting one’s attention is fundamental to both mindfulness and hypnosis. In mindfulness, a common exercise is to acknowledge one’s momentary

experience as perceived through each of the senses. A similar technique is sometimes used *within* a hypnotic induction and can be conveniently utilized in its entirety as a formal induction:

As you continue to rest comfortably with your eyes closed, you can practice calling upon each of your senses to bring you further into a state of calm relaxation. Notice your sense of touch in this moment. Notice how your body meets the chair beneath you; notice how the material feels against your skin. Notice the subtle sensation of your shirtsleeve embracing your right arm. Notice the temperature of the room and the way the air moves in this moment. Let these sensations continue to deepen your peaceful state while grounding you to this very moment. Notice any odors around you, perhaps familiar or completely novel to you. What do you hear? See if you can shift your attention to quiet noises around you—the gentle hum of the air conditioner, the steady ticking of the clock. Perhaps you can notice the tiny sounds of your own breath, letting those sounds relax you further and deeper, further and deeper. Now notice the taste in your mouth, just practicing a childlike curiosity toward the way your mouth tastes. Observing and letting go, accepting what is in each passing moment. That’s right. Now pay some attention to what you see beneath your heavy eyelids. Amidst the deep darkness, what else do you see? Just take this time to notice.

This integrative technique is flexible in its applications. Beyond its use as a standalone mindfulness exercise or an induction, a practitioner may choose to insert a post-hypnotic suggestion for an anxious client to call upon this grounding exercise whenever he or she feels uneasy. An abbreviated version of this suggestion may be to

simply notice five things that can be heard and allow this to quickly re-center ones attention.

Eye Fixation. The eye fixation is a commonly used technique for hypnotic induction. It typically involves the participant staring at a nearby focal point while the operator guides them into trance:

Begin by letting your eyes find a point in front of you that is comfortably within your gaze. Focus your attention on this point as you breathe more deeply now. More and more deeply, just breathing and staring, your eyes latched to the spot you chose. And as you continue to breathe you may notice something a little peculiar. You may notice that as you continue to hold your gaze, the areas around that point begin to blur ever so slightly. Perhaps all of the things outside this point are blurred now, and with each breath this effect will slowly grow. More and more attentive to this point, you can give all of your attention to it now. Just breathing and staring, that's right. And very naturally your eyelids may be getting heavy now, heavier and heavier from the staring, and very soon you may find they are much too heavy to hold open. When this happens, you can allow your eyes to gently close as you sink further in this state of peaceful relaxation.

A posthypnotic suggestion may be particularly appropriate when this type of induction is utilized because it provides a very tangible exercise for a client with anxiety. The suggestion may be for the client, whenever he or she feels anxious, to simply focus their visual attention on any given point near them and breathe deeply for instant relaxation and alleviation of tension. The operator may suggest, "Whenever you wish, you can do this successfully just as you have done today." This may be especially

appealing to clients who desire discreet ways of dealing with anxiety in public places (e.g., on a subway or in crowded restaurant). This exercise neatly blends a simple mindfulness exercise with a powerful hypnotic suggestion.

Clearly there are numerous opportunities to combine hypnosis and mindfulness into a more potent intervention than either would alone provide. This synthesis not only allows for a more expanded, holistic approach to therapy but also allows for creativity and artistry in the way these models are implemented together. It should ultimately be the highest priority of the practitioner to provide the best treatment possible for the client, and hypnosis and mindfulness have the potential to serve as an effective treatment for anxiety. The exercises and guidelines that have been provided are suggestions based on the current literature and this researcher's interpretation of the findings. The exercises are not intended to be a protocol for using mindfulness and hypnosis to treat anxiety disorders, but rather ideas to build upon within the clinician's own practice and skill set.

As a practitioner introducing mindfulness and hypnosis as treatment options it is important to be prepared to adequately describe what they entail. It may be necessary to first describe hypnosis in the most basic terms possible and dispel any myths that are present. For example, hypnosis may be described succinctly as a state of deep relaxation and focus during which suggestions for positive change are more likely to be accepted. To dispel the common myth of hypnosis being "mind control," the clinician can clarify that hypnosis is a benign technique, especially when used to manage anxiety symptoms, and under no circumstances does the clinician have "control" over a person in trance. Rather, the client must respond willingly and has the ability to ignore unwanted suggestions. The clinician might briefly describe mindfulness as an intentional state of

internal focus and raised awareness that often shares the same feelings that are brought upon by hypnosis. It is mainly the inclusion of suggestion that makes hypnosis unique in this situation. Finally, the clinician should be sure to invite and answer any questions or uncertainties that the client still has, and always be sure the client has elected for these particular methods of treatment on his or her own accord.

Conclusion

With mindfulness and hypnosis growing steadily as clinical interests and with the recent influx of mindfulness popularity, this is an exciting time for research in these areas. Based on the current literature review, both methods have empirical backing yet it remains inconclusive as to whether or not they are fully validated. With proper research methodology and ample replication of findings, it is likely that hypnosis and mindfulness for the treatment of anxiety disorders will gain more empirical momentum in the near future. With regard to hypnosis, it is likely that a significant amount of stigma is yet to be overcome which may continue to impede its growth.

Although many researchers continue to work toward validating one of these methods above the other, I do not perceive them as discrete, but as relatives that should be working toward a unique partnership. Considering the separate evidence for each of these methods, it is reasonable to believe they may indeed be much more potent when practiced in unison. Here I have provided a framework for what this integration might entail. Ultimately, a randomized clinical trial comparing the effectiveness of mindfulness and hypnosis versus an established modality such as CBT is necessary to achieve greater clinical reputation. For me it has been an exciting adventure to explore the vast

possibilities of these methods, and I hope that you may discover some of the wonderment that lies deep within hypnosis and mindfulness.

Appendix A

Basic hypnotic induction example transcripts:

Progressive Muscle Relaxation

Please make yourself comfortable. Close your eyes and let yourself relax. Take a few slow deep breaths, and notice that as you exhale, you can feel yourself becoming more relaxed. Notice that when you breathe in, your shoulders rise, and that when you exhale...fully and completely...your shoulders fall. Maybe you hardly notice the easy, gentle, natural way your shoulders move up and down...with your breaths...and you know, you don't even have to think about it a lot...but as you continue to relax in this easy natural way...with each breath...each time you exhale, let it happen...let your shoulders and your entire upper body relax even more...that's it...more and more...more and more relaxed...more and more relaxed. Perhaps you notice that as you exhale, you can enjoy a sense of becoming more and more relaxed... more and more relaxed...as you experience yourself resting more and more easy...more and more easy...calm...relaxed...peaceful...serene.

And as you go deeper and deeper into a state of comfortable relaxation, you probably are beginning to have a sense of what the experience of hypnosis is like. You probably already have a sense that you are the one relaxing...you are the one creating the changes in your state of mind...your state of being...even though I am the one giving you suggestions. Even as I give you suggestions that help you enter your hypnosis, you are the one who decides whether you want to experience those suggestions. If you don't like a suggestion that I make, you can choose to ignore it and to not have that experience. But if you want to experience a suggestion, you may find it easier to experience than you ever

thought possible. So the choice is always yours, and it's safe to enter hypnosis now, as you allow yourself to relax.

Feel yourself becoming more and more relaxed. But no matter how relaxed you become, you will hear my voice, and you will be able to respond to my suggestions. At any time, you can adjust your body to make yourself completely comfortable. And of course, if you need to speak to me, you will be able to do so easily, while you remain so very relaxed...very relaxed and at ease. Right now, you might want to relax even more, and as you relax, you may feel a slight tingly feeling in your fingers...or in your toes...and if you do, you will know that it is a feeling of relaxation that some people have as they begin to experience hypnosis. Let your body relax. Just let the tension drain from your body, letting go of all your cares and concerns, and just relaxing...more and more...feeling more and more at peace...more calm...more and more deeply relaxed, as you enter into a pleasant, comfortable state of hypnosis...becoming so deeply involved in hypnosis that you can have all of the experiences you want to have...deep enough to experience whatever you want to experience...but only the experiences you want...just your own experiences.

And you can focus your attention on your toes...your right toe...and your left toe. Feel any tension that may be there, and just let it drain from your right toe...and from your left toe...letting all the tension drain out and letting your toes relax...more and more...more and more relaxed. And let the relaxation spread from your toes into your feet, and let your feet relax. Let all the tension drain from your feet, and let them become more and more relaxed. And now pay attention to your ankles and to your calves. I

wonder if there is any tension in your ankles or your calves, in your right leg or in your left leg. And if there is, you can let it go right now. Just let your legs relax...more and more relaxed...more and more completely relaxed. And the relaxation can spread into your thighs...your thighs can relax more and more...just letting go. And you can let your pelvis relax. Just let it go loose and limp...loose and limp...relaxing more and more. Relax your stomach. Let your stomach become completely relaxed. Notice how it feels, and if you feel any tension at all, just let it drain from you...loose and limp...completely relaxed. And let the relaxation spread upward into your chest. Let all the nerves and muscles in your chest relax, completely relaxed...loose and limp...all the tension draining away. And now let your back relax, and your shoulders. Let yourself feel the relaxation in your back and your shoulders...more and more relaxed...loose and limp...completely relaxed. Let the relaxation spread through your arms, down into your hands and your fingers. Focus on the feelings in your arms and hands. Notice any tension that may still be there, and let it drain out through your fingers. Focus on your right upper arm...right lower arm...your right hand...and fingers...relaxing completely...more and more relaxed...completely relaxed. And now your left arm...relaxing completely, the tension draining out...completely relaxed...completely relaxed. Now relax the muscles of your neck...just let go and relax...loose and limp...completely relaxed. And relax your jaw muscles. Just let them go limp. All the nerves and muscles in your jaw relaxing completely. And relax all the rest of the muscles in your face...your mouth...nose...eyes...eyebrows...eyelids...forehead...all the muscles going loose and limp...loose and limp...completely relaxed...at peace...calm and relaxed...completely at

ease. And now take a minute or two to just thoroughly enjoy your experience of hypnosis. (Lynn & Kirsch, 2006, pp. 54-56)

Arm levitation

I'd like you to experience how thinking of an action can lead to a most interesting hypnotic response. All you have to do is think and imagine along with what I am suggesting and do your very best to have the experiences I suggest to you ... to go with what I suggest and lift your arm in response to the suggestion I will give you for it to be light...to float up...gently up...and let your body experience a comfortable sense of relaxation in the process. Now I know that if my arm had a helium balloon attached to it, it would feel so very light, just like it wanted to lift up off the resting surface. That would be very interesting to see. And wouldn't it feel good to imagine that it was a very lovely day, with a gentle wind blowing, and that there was a bright-colored helium balloon attached to your wrist? To the wrist of one of your hands? Perhaps when I mentioned a beautiful day, you could begin to picture it...the clouds that take shape in the sky...the sun's comforting warmth on your skin...the green grass...the sounds of life...the lovely scents as you take a deep, relaxing breath. That's right. A deep, relaxing breath. And if you look down at that hand of yours, and that wrist...in your mind's eye...perhaps you can see that balloon tied to your wrist with that oh...so...long...piece of string. I'm not sure exactly what color the balloon is. It's your balloon. But I'm wondering whether you would be willing to share the color of the balloon with me. If you are, please tell me the color. [If yes, proceed as follows.] Ah, that's so nice...a [red] balloon. Can you feel the balloon that is ever so light, beginning to tug at your wrist...can you feel how it is beginning to lift your wrist up off the resting surface, as the wind blows it...watch the

balloon...is it dancing in the sky? Feel this balloon lift that hand up...up...beginning to lift more and more...off the resting surface...feel how light your hand is becoming...how it just wants to lift up...lift...lift up...let it happen...go with it...if you need to, help the hand follow the balloon in the sky...let it lift up toward the balloon...almost like you want to shake hands with the balloon...funny, huh?...let it go up and up and up...lighter...lifting higher and higher...very good. (Lynn & Kirsch, 2006, pp. 60-61)

Appendix B

Hypnotic deepening example transcripts:

The staircase

Now imagine yourself on a magnificent staircase with 10 steps to the bottom. When you reach the bottom I think you will find it of great interest to discover just how relaxed, safe, and secure you will feel. And as you probably have guessed, in a few moments, I will ask you to walk down the staircase...and with each count, feel free to move one step down the staircase. Take a nice deep, full, and filling relaxing breath. Good, now take another, and see how calming that can feel. But as calming as simple slow breathing can be, why not discover how with each step down the staircase, your body will relax more and more, more and more. Of course, at this point neither you nor I know just how relaxed you will be, how deep you will go, but even that doesn't matter...all that matters is that you are comfortable and at ease...comfortable and at ease. OK, I am going to start counting, guiding you down the staircase, deeper and deeper into a most comfortable state of mind, a most comfortable state of being, calm and at ease, relaxed and secure. In fact, the truth is...you don't have to do much of anything, really...just listen to my voice. Let my voice go with you. One...one step down the staircase. Let your feet relax as you move down the staircase, feel the calmness spreading. There's lots of time. Two...let your legs relax. Do you feel more relaxed than when you are asleep or would you rather not think at all? Deeper and deeper calm and feeling quite secure. Three...three steps down the staircase...can you feel your thighs relax? Can you feel yourself letting go just a little bit more with each breath, can you feel waves of gentle relaxation, or are you not thinking at all, just feeling open and receptive?

Do you feel more heavy and warm or an easy floating feeling? Four...can you let the area around your pelvis relax? There is lots of time. Do you feel as relaxed as you feel when you are very tired before you know that you will fall asleep or as relaxed as you feel after you wake up from a deep, sound sleep? Five...five steps down the staircase. Halfway down. Can you feel a sense of calm in your stomach area? Do you want to experience a deeper level of hypnosis, of openness to ideas, receptiveness to images, feeling sure and in control, aware of possibilities for yourself? Or are you so comfortable with your level of hypnosis now that you want to just maintain that feeling in an easy, effortless way? You know you don't have to do anything, unless you want to, like adjust your position to get even more comfortable. Six...down the staircase. Six steps down the staircase...Can you feel the calm, easy feeling spreading to your chest? Can you feel that some parts of your body are catching up with other body parts that are even more relaxed? Seven...down the staircase. Can you feel your arms relax? Nothing to disturb, nothing to bother you. Can you feel time slowing down? Do you think you are ready to go even deeper? Would you like to be even more calm and secure within yourself? And yet it really doesn't matter just how deeply relaxed and at ease you feel, just that you feel comfortable. Eight...eight steps down the staircase. Almost near the bottom...soon you will arrive at that place where you feel so comfortable and secure, so much at ease. Can you feel a still, quiet point between inspiration and exhalation of your breath? Can you feel quiet and still inside? I really don't know and it really doesn't matter, because soon you will arrive at your special place, where you are so deeply centered within yourself. Nine...nine steps down the staircase. Are you aware of just how relaxed your face and eyes feel or are you in a dreamy state of mind, perhaps not thinking at all? Ten...ten steps

down the staircase. You have arrived! Feeling so good...so relaxed...so comfortable and at ease. (Lynn & Kirsch, 2006, pp. 58-59)

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