

An Integrative Approach for Understanding and Treating Anxiety Disorders

Overview

This chapter reviews the concept of wounded self, which provides a common thread for binding the best extant theoretical constructs and the most effective treatment strategies for anxiety disorders into a comprehensive integrated model. The focus of this theoretical integration is the concept of self-wounds or early unresolved emotional injuries. This model offers an integrative perspective on the nature, development, aggravation and maintenance of anxiety disorders. According to this view, anxiety represents an unconscious fear of unbearable insult to the wounded self. This chapter describes SMAD and outlines the theoretical and empirical rationale for integrating CBT, mindfulness and hypnotherapy in the psychological management of anxiety disorders.

Introduction

Although anxiety disorders constitute the most common psychological disorders treated by mental health professionals and family physicians, a coherent etiological theory and a comprehensive integrated treatment for anxiety disorders are lacking. From his review of the literature, Wolfe (2005) found mainstream views of anxiety disorders to be flawed in respect to their conceptualization, etiological theories, treatment approaches, research hypotheses and research methodologies. He noticed that none of the current perspectives on anxiety disorders, including psychoanalytic,

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behavioural, cognitive-behavioural, experiential, and biomedical, provide a complete theory or a comprehensive treatment for anxiety disorders, albeit each viewpoint has made some important contribution to our understanding and treatment of the disorders. He also noted that none of the etiological theories upon which the current treatments are based on accentuated the role of interpersonal, family, cultural and ontological factors in the formation, onset and course of anxious symptoms. To rectify these shortcomings, Wolfe has developed an integrated perspective of anxiety disorders that accesses the best theoretical constructs, the most effective treatment strategies and specific evidence-based techniques from various existing etiological theories and treatment approaches. Before discussing the clinical implications of this integrated perspective of anxiety disorders, the main components of Wolfe's model are described and, where relevant, expanded on.

Self-Wounds Model of Anxiety Disorders

To differentiate from other models of anxiety disorders, the integrated perspective described in this book is referred to as the SMAD. The model consists of two interrelated theories: the integrative etiological theory of anxiety disorders and the integrative psychotherapy for anxiety disorders. Both theories represent a synthesis of major extant perspectives of anxiety disorders and their treatments (Wolfe, 2005, 2006). The focus of both the integrated etiological model and the unified treatment is the concept of self-wounds, which in the most general sense can be defined as the patients' chronic struggles with their subjective experiences. The components of SMAD are first discussed before describing the integrated psychotherapy based on the model.

Origin of self-wounds

Self-wounds result from interaction between damaging life experiences and cognitive and emotional strategies that are used to protect oneself from anticipatory catastrophes. Wolfe (2005, 2006) derived the notion of wounded self from his observation of patients with anxiety disorders. He noticed that in most of these patients, the anxious symptoms appeared to represent an implicit (unconscious) fear of unbearable catastrophe to their physical and psychological well-being (exposure of unbearable painful views of the self). Based on this observation, he

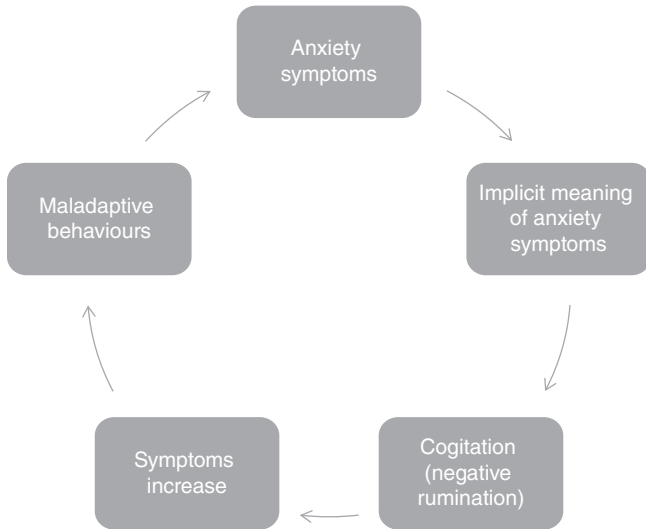


Figure 1.1 Schematic model of an anxiety disorder (adapted from Wolfe, 2005, p. 112).

hypothesized that the experience of severe anxiety in selected situations gives rise to conscious anticipations of impending calamity, which at an unconscious level, represents fear of exposing unbearable painful views of the self. In this sense, the etiological theory of anxiety disorders consists of two layers of information processing – the first layer comprises conscious awareness of anxiety symptoms resulting from anticipatory catastrophes and the second layer entails implicit or unconscious interpretations of what the anxiety symptoms mean to the patient (see Figure 1.1).

Anxious patients believe that exposure of their self-wounds, either to themselves or to others, will produce overwhelming affects, such as humiliation, rage, despair and loss of control, which they desperately want to avoid. These painful views of the self in turn create a feeling and experience that the patient will not be able to cope with the vicissitudes of life. This observation is supported by Kendall and Hollon (1989), who found patients with high levels of anxiety to have automatic thoughts about uncontrollability, threat or danger. Since the rigors and realities of everyday living are unavoidable, anxious individuals develop maladaptive coping strategies such as behavioural avoidance, rumination with cognitive distortions, preoccupation with symptoms and emotional constriction to protect themselves from facing objects and situations that

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are perceived to produce distressing affect. Unfortunately, these indirect manoeuvres often produce unintended interpersonal consequences (Alden & Taylor, 2004), which reinforce the patient's painful core beliefs about the self (Whisman & Beach, 2010). Moreover, these strategies keep the person away from facing his or her fears and self-wounds head-on, resulting in the perpetuation of the symptoms. Furthermore, in response to the initial anxiety, patients get into the habit of cogitating about being anxious and consequently become anxious for feeling anxious (Goldstein & Chambless, 1978).

Negative self-hypnosis in anxiety disorders

Alladin (1994, 2007, 2013a, 2014a) has depicted the similarities among the concepts of cognitive distortions, cogitation, rumination, worry and negative self-hypnosis (NSH). Although there are some subtle differences among these concepts, there are more similarities. For example, studies by Fresco, Frankel, Mennin, Turk and Heimberg (2002) and Segerstrom, Tsao, Alden and Craske (2000) found repetitive thought to be a common factor in measures of worry and rumination. Moreover, all the five constructs mentioned earlier are typically negative in valence, repetitive, perseverative, self-focused, overgeneralized, and they are all associated with cognitive inflexibility and difficulty in switching attention from negative stimuli. They also lead to performance deficits, difficulties in concentration and attention, poor problem solving, inadequate solution implementation and exacerbation of symptoms (Papageorgiou & Wells, 2004).

Cognitive distortions

Cognitive theorists have always asserted that preoccupation with cognitive distortions – related to threat, danger, loss of control and inability to cope – to be one of the key elements of cognitive theories of anxiety disorders (Beck, 1976, 2005). For example, Barlow (2002, p. 104) defined anxiety as ‘a future-oriented emotion, characterized by perceptions of uncontrollability and unpredictability over potentially aversive events and a rapid shift in attention to the focus of potentially dangerous events or one's own affective response to these events’. Similarly, Clark and Beck (2010, p. 5), in their recent volume on anxiety disorders, stated that anxiety is a complex cognitive, affective, physiological and behavioural response system (i.e., threat mode) that is activated when anticipated events or circumstances are deemed to be highly aversive because they are

perceived to be unpredictable, uncontrollable events that could potentially threaten the vital interests of an individual.

Cogitation

According to Wolfe, cogitation, or the preoccupation with symptoms, serves anxious patients one of the main defence strategies for protecting themselves from the ‘excruciatingly painful view of the self’ (p. 117). Rather than exploring the implicit meaning of their anxiety, anxious patients tend to detach from themselves and become absorbed in the imminent catastrophe they expect will occur. This form of catastrophizing is very characteristic of cognitive distortions described by CBT therapists (e.g., Beck, 1976, 2005), rational-emotive behaviour therapists (Ellis, 2005) and cognitive hypnotherapists (Alladin, 2014a).

Rumination

Rumination has also been equated with recurrent negative cognitive style of thinking (Martin & Tesser, 1989, 1996). Rumination can be defined as repetitive negative thinking (Hazlett-Stevens, Pruit, & Collins, 2009) associated with various psychopathologies, including anxiety, binge eating, binge drinking and self-harm (Nolen-Hoeksema et al., 2008; Papageorgiou & Siegle, 2003 for review). Nolen-Hoeksema (1991) has been instrumental in advancing our knowledge of ruminative thinking in depression. She proposed the response styles theory of depression to explain the insidious relationship between rumination and depression. According to her response styles theory, rumination is a mode of responding to distress that involves repetitively and passively focusing on symptoms of distress and on the possible causes and consequences of these symptoms. Rumination does not generate active problem-solving strategies for changing the circumstances surrounding the symptoms, instead it keeps patients fixated on the problems and their feelings. There is strong evidence that rumination exacerbates depression, enhances negative thinking, impairs problem solving, interferes with instrumental behaviour and erodes social support (Nolen-Hoeksema, 1991; Papageorgiou & Wells, 2004). The content of ruminative thought in depressed people is typically negative in valence, similar to the automatic thoughts, schema and negative cognitive styles that have been studied extensively by cognitive theorists (e.g., Beck, 1967, 2005). In addition to depression, there is evidence that rumination is associated with other psychopathologies, including anxiety, binge eating, binge drinking and self-harm (Nolen-Hoeksema et al., 2008).

Pathological worry

Given the high comorbidity between anxiety and depression, rumination is known to increase the risk for anxiety disorders as well as depression (Nolen-Hoeksema et al., 2008). Anxiety disorders, however, involve a different form of perseverative thought pattern from depression that is typically characterized by excessive or pathological worry (Borkovec, 1994; Papp, 2010). Based on empirical literature, Borkovec, Robinson, Pruzinsky and DePree (1983, p.10), define excessive worry as a chain of thoughts and images, negatively affect-laden and relatively uncontrollable. The worry process represents an attempt to engage in mental problem solving on an issue whose outcome is uncertain but contains the possibility of one or more negative outcomes. Consequently, worry relates closely to fear process.

The experimental study of worry began in the 1970s within the context of test anxiety, and by the early 1980s worry was delineated as a common cognitive process associated with states of anxiety (Hazlett-Stevens et al., 2009). This research found worry to be characterized by concerns about the future rather than the present and to be associated with feelings of anxiety, apprehension and general tension. Individuals with high levels of worry were also found to have more uncontrollable cognitive intrusions, poorer ability to focus attention on an experimental task and greater subjective anxiety than ‘non-worriers’. In a recent study (Mennin, Heimberg, Turk, & Fresco, 2005), individuals with GAD were noted to have greater tendency to avoid negative experience related to stress, anxiety and emotional responding. Excessive or unrealistic worry is therefore regarded as the central defining feature of GAD (American Psychiatric Association, 2013) and is present in most of the anxiety disorders (Barlow, 2002). Rumination and worry have been found to be significantly correlated with each other (Fresco et al., 2002; Muris, Roelofs, Meesters, & Boomsma, 2004; Segerstrom et al., 2000; Watkins, 2004; Watkins, Moulds, & Mackintosh, 2005), and they share many characteristics (McLaughlin, Sibrava, Behar, & Borkovec, 2006). For example, they are both self-focused, repetitive, perseverative and overgeneralized forms of thinking (Barlow, 2002; Borkovec, Alcaine, & Behar, 2004; Segerstrom et al., 2000; Watkins, Teasdale, & Williams, 2000). Moreover, both are associated with cognitive inflexibility and difficulty in switching attention from negative stimuli (Davis & Nolen-Hoeksema, 2000; Hazlett-Stevens & Borkovec, 2001). These cognitive styles lead to performance deficits, difficulties with concentration and attention, poor problem solving and inadequate solution implementation (Davey, 1994; Lyubomirsky & Nolen-Hoeksema, 1995;

Lyubomirsky et al., 1999; Ward et al., 2003; Watkins & Baracaia, 2002; Watkins et al., 2005). Consequently, both rumination and worry have been found to exacerbate symptoms of anxiety and depression (Abbott & Rapee, 2004; Barlow, 2002; Fresco et al., 2002; Harrington & Blankenship, 2002; Kocovski et al., 2005; Muris et al., 2005; Nolen-Hoeksema, 2000; Nolen-Hoeksema & Morrow, 1991; Schwartz & Koenig, 1996).

Worry, in anxiety disorders, tends to be future-oriented and centres on dangers that might occur but have not yet occurred. Barlow (2002) indicated that even when patients with anxiety disorders worry about something that has happened in the past – such as making a mistake in a social situation – they often worry about the implications of this event for the future (e.g., ‘Now everyone will think I am an idiot.’). Moreover, patients with GAD tend to have uncontrollable worry about minor topics more often than non-anxious individuals (Craske, Rapee, Jackel, & Barlow (1989). GAD is thus believed to be maintained by meta-cognitive beliefs about the functions and consequences of worry (Hazlett-Stevens, et al., 2009).

Negative self-hypnosis

There is convergent evidence that patients with anxiety disorders, compared to non-anxious patients, are highly susceptible to suggestions (e.g., to self- and hetero-hypnosis) and have greater capacity to dissociate (Bryant, Guthrie, & Moulds, 2001; Cardena, 2000; Heap & Aravind, 2002; Spiegel, Hunt, & Dondershine, 1988; Stutman, & Bliss, 1985). Clark and Beck (2010) and Taylor (2006) believe dissociative symptoms such as derealization, depersonalization and numbing may be automatic or deliberate cognitive strategies intended to avoid awareness of distressing recollection of the trauma or to suppress hyperarousal symptoms. Dissociative symptoms are also known to impede elaboration of the trauma memory and its integration with other autobiographical memories. Highly socially anxious patients have the tendency to ruminate more (Mellings & Alden, 2000). Abbott and Rapee (2004) found socially phobic patients to engage more in negative rumination. In addition to increasing the level of anxiety, negative ruminations reinforce cogitation or negative self-suggestions. The escalation of such a vicious cycle is readily observed in patients with panic attacks. Once a patient with PD begins to experience bodily sensations, he or she immediately begins to catastrophize about the sensations, and becomes convinced that he or she will lose control, faints, has a heart attack or lose control. Clark (1986, 1997), in his cognitive model of PD, also describes this phenomenon whereby patients with PD becomes stuck in cogitating about their bodily sensation. All these models emphasize that

catastrophic rumination adds fuel to anxiety, until it spirals into a panic attack. Likewise, DSM-V (American Psychiatric Association, 2013) describes a panic attack as an abrupt surge of intense fear or intense discomfort that reaches its peak within minutes. DSM-V, however, distinguishes between unexpected and expected panic attacks. Unexpected panic attacks are referred to attacks that occur in the absence of an obvious cue or trigger. In contrast, expected panic attacks are triggered by an obvious cue or trigger, such as elevated heart rate in a patient who has the fear of having a heart attack and dying. This would imply that patients with expected PD have a greater tendency to cogitate with the meanings of their physical symptoms than patients with unexpected panic attacks. Empirical investigation of this hypothesis is likely to provide further information about the nature of these two types of PD proposed by DSM-V.

Another commonality between the phenomenon of hypnosis and Wolfe's perspective on anxiety disorders relates to the experiential nature of anxiety. Wolfe (2005) has clearly asserted that his approach to understanding anxiety disorders represents an experiential model as the syndrome is characterized by 'fear of a future catastrophe that will produce unbearably painful feelings about the self' (Wolfe, p. 51). From this vantage point, anxiety represents a future-oriented emotion that thwarts an individual from focusing on his or her present emotional experience of the world (emotional constriction). This experience of self-endangerment (i.e., the subjective experience of anxiety or panic) emanates from underlying intrapsychic conflicts, negative self-beliefs and a holistic sense of shame about one's value or lovability. All of these forms of self-pathology produce painful self-awareness. In patients with anxiety disorders, this painful and immediate self-awareness is often experienced as dangerous. This sense of danger, coupled with negative cogitation, gradually evolves into a chronic sense of self-endangerment.

Unconscious processing in anxiety disorders

Although behavioural and cognitive theories provide useful explanations of what happens to patients with anxiety disorders once they have had their initial anxiety attack (e.g., panic attack), they do not explain the origin of the initial attack. Moreover, cognitive-behavioural models tend to downplay the significance of implicit meaning of anxiety attacks. Now we have abundant empirical evidence that a great deal of human behaviour arises from unconscious processes (for reviews, Wilson, 2002; Dijksterhuis & Aarts, 2010; Baumeister, Masicampo, Vohs, 2011; van Gaal, de Lange, & Cohen, 2012). Unconscious mental processes have been shown to facilitate

goal-directed behaviour (Bargh, Gollwitzer, Lee-Chai, Barndollar, Trotschel, 2001), memory consolidation (Tamminen, Payne, Stickgold, Wamsley, Gaskell, 2010), creativity and insight (Wagner, Gais, Haider, Verleger, & Born, 2004) and decision-making (Creswell, Bursley, & Satpute 2013; Dijksterhuis, Bos, Nordgren, & van Baaren, 2006; Dijksterhuis & Nordgren, 2006; Soon, Brass, Heinze, & Haynes, 2008; Strick, Dijksterhuis, Bos, Sjoerdsma, van Baaren, & Nordgren, 2011). Moreover, Creswell et al. (2013), from a study using blood oxygen level-dependent (BOLD) functional magnetic resonance imaging, found the dorsolateral prefrontal cortex and left intermediate visual cortex to be activated during unconscious thought processing. In the light of these findings, a number of cognitive-behavioural therapists have begun to recognize the existence of internal associative information processing. For example, Barlow (2000) and his colleagues (Bouton, Mineka, & Barlow, 2001) have highlighted the role of unconscious emotional conditioning and early conditioning in the etiology of PD. Similarly, Rapee (1991) has argued that conditioning is a subset of cognitive processes, involving implicit information processing. Moreover, cognitive theories undertake that human behaviour and experience are determined by internal processes that are stored in memory in an organized fashion (Mahoney, 1991). These tacit structures are believed to have a powerful influence on how human beings feel, behave and expect to react in certain situations. From this perspective, anxiety is considered to represent the internalization of certain schemas regarding the potential dangerousness of certain situations and the threat they pose, relative to the person's cognitive abilities. The fear schemas are presumed to exert a mostly tacit influence on a patient's perspective towards himself or herself, the world and the future (Beck & Emery, 1985, 2005). Furthermore, the cognitive perspective argues that the functional relationships that are established between certain stimuli and the person's anxiety responses are, in large measure, shaped by tacit psychic structures. Clark and Beck (2010) emphasize that fear schemas 'also represent information about the self in terms of vulnerability to threat as well as specific beliefs about the dangerousness of certain experiences or situations in the external or internal environments' (p. 45). They declare that there is robust experimental research (e.g., McLeod, 1999; Wells & Matthews, 1994; Williams, Watts, MacLeod, & Matthews, 1997) in support of unconscious cognitive and attentional processing of fear stimuli, and as such 'the cognitive perspective on anxiety is misrepresented when cognition is characterized only in terms of conscious appraisal' (p. 27). Foa and Kozak (1986) also emphasize that anxiety is based on either conscious or unconscious fear structures or schemas, which contain stimulus-response associations that

do not always reflect an accurate relationships in the world. The recognition of unconscious danger-related schemas in anxiety disorders have encouraged some cognitive-behavioural therapists (e.g., Foa & Kozak, 1986; Leahy, 2003; Young, 1990) to develop new techniques for activating underlying cognitive schemas, predicated on the assumption that therapeutic change is contingent on restructuring of underlying cognitive schemas. This book describes a number of strategies for accessing and restructuring tacit cognitions. The effectiveness of psychodynamic psychotherapy with anxiety disorders provide indirect evidence that restructuring of implicit fear-related schemas reduce anxiety (Alladin, 2014a; Leichsenring, 2005; Milrod et al., 2007; Shedler, 2010).

The implicit processes described earlier are not very different from Freud's (1926/1959) psychodynamic models, which contended that anxiety disorders are developed from unconscious wishes, feelings and fantasies, which are experienced as frightening or intolerable affect (Busch, Milrod, & Shear, 2010). Freud delineated two types of anxiety: traumatic anxiety and signal anxiety. Traumatic anxiety is thought to result when the ego – the psychic apparatus that organizes perception, defences, cognition, anxiety and mood regulation – is overwhelmed by danger. The danger heralds specific psychological meaning to the patient, triggering traumatic anxiety, which may be manifested as an anxiety attack or a panic attack as described in DSM-V (American Psychiatric Association, 2013). Signal anxiety, on the other hand, represents smaller doses of anxiety generated by intrapsychic mechanism, which attempts to alert the ego state about psychologically meaningful dangers. In other words, signal anxiety acts as a stimulus to mobilize defences to prevent the breakthrough of traumatic anxiety from which the ego is overwhelmed and unable to defend itself. Studies of patients with spider phobia clearly demonstrate that these individuals harbour unconscious cognitions related to threat and disgust (Teachman & Woody, 2003). Recently, magnetic resonance imaging (fMRI) study has demonstrated that conversion symptoms are mediated by suppression of adverse life-events (Aybek, Timothy, Zelaya, O'Daly, Craig, David, & Kanaan, 2014).

How does different anxiety disorders develop?

From wounded self perspective, each anxiety disorder consists of two factors: an emotional conflict and the suppression of the re-experiencing of the trauma. While the emotional conflict is believed to be generated from early traumatic events, the inhibition of the re-experiencing of the trauma is determined by the nature of the trauma and the cognitive-emotional

coping strategies used by the patient. Although perceived or imagined danger can be internal or external, different anxiety disorders are characterized by the diversity in the contents of threatening self-experience and the experiential processes used to stave off the danger. Although these strategies result in temporary reduction of anxiety, they reinforce the patient's underlying maladaptive self-beliefs. Psychological defences in this model thus serve as self-defeating efforts to protect one's image of the self (see Wolfe, 2005).

According to Wolfe (2005, 2006), external and internal cues that provoke anxiety are developed through one's perception of the relationships between certain life experiences and intense fear. In other words, certain life experiences are perceived as self-endangering. As mentioned before, the cues or events themselves do not provoke anxiety, it is the perceived relationship between certain life experiences and intense fear that creates the sense of self-endangerment. The cues or events often function as a kind of shorthand for unconscious painful memory. Wolfe (2006) provides the example of an agoraphobic woman whose fear of losing control (self-endangerment) is triggered by a feeling of light-headedness (internal cue), which reminds her of the intense fear she first experienced when she panicked at the sight of physically disabled people in a senior's home many years ago. In this case, the anxiety was not related directly to the internal cue (feeling dizzy), but it represented her unconscious fear of becoming physically disabled and confined to a senior's group home (intense fear).

Wolfe (2005) has described the sequential development of an anxiety disorder in the context of self-experiencing and its vicissitudes, which is summarized as follows:

1. The anxiety sequence usually originates from early traumatic experiences, which affects the individual's capacity for immediate self-experiencing. According to Wolfe, most anxiety-related traumas occur in interpersonal context and each trauma leaves the individual feeling helpless, trapped and incapable of warding off the subjective feeling of self-endangerment. Self-endangerment experiences range from a painful self-awareness to extreme trauma, and they seem to be associated with separation, rejection, loss, humiliation, disillusion or self-loss (dissipation of self-experience).
2. Any situation that resembles the trauma generates anxiety. The anxiety is perceived as a signal that something catastrophic is likely to occur.
3. Catastrophic interpretations deflect attention away from direct or immediate experience of the self or the world to reflexive experience of fear and vulnerability. Greenberg, Rice and Elliott (1993)

describe this process as a secondary emotional reaction to the primary experience of anxiety. Secondary emotional reaction shifts attention from immediate experiencing to thinking about one's immediate experience. This shifting of attention from experiencing to thinking increases catastrophizing of first-order anxiety and amplifies the intensity of the anxiety. Goldstein and Chambless (1978) describe this phenomenon as the fear-of-fear response (e.g., feeling anxious for feeling anxious, feeling angry for being fearful, etc.).

4. Another phase in the development of anxiety disorder is avoidance behaviour. Anxious patients often associate anxiety attacks with various contexts in which they have experienced anxiety, and, therefore, they tend to avoid these situations. Avoidance, unfortunately, increases the difficulty of re-entering the feared situation, thus maintaining the anxiety.

Lack of acceptance

In the context of mindfulness-based psychotherapy or third-wave cognitive behavioural therapy (CBT) (Baer & Huss, 2008), suppression of re-experiencing of the initial trauma observed in patients with anxiety disorders (Wolfe, 2005, 2006) can be equated with lack of acceptance. The concept of acceptance can be defined as receiving experience without judgement or preference but with curiosity and kindness (Germer, 2005). Acceptance is not merely tolerance, it is the active nonjudgemental embracing of an experience in the here and now, involving undefended exposure to thoughts, feelings and bodily sensations as they occur (Hayes, 2004). Acceptance is utilized in psychotherapy to reduce suffering by helping distressed individuals observe different aspects of a situation, or the relationship between the situation and the discomfort, or by creating a new stimulus that is less distracting or not distressing at all. This is well illustrated by the case of Ted, reported in a previous publications (Alladin, 2007, 2014), who transformed his suffering into creativity. Ted, a child psychologist, was involved in a road accident (hit by a drunken driver while he was biking) from which he sustained a complicated fracture in his left foot. Initially, he was very angry with the driver and constantly ruminated with the beliefs that he might not be able to ride his bike again or play soccer, which exacerbated his pain, anxiety and sense of hopelessness. But once he accepted the accident and the trauma (including surgery) he went through, he felt grateful that he was off work for 4 months, which he decided to devote to complete a paper he was planning to write for a few years. At times, Ted still had thoughts about the drunken driver and

the pain he was experiencing, but the pain or the accident was no longer the focal point for his energy and attention. This case provides an example of pure acceptance. His goal *per se* was not to change his distress but to utilize the time away from work to his advantage. Shifting Ted's attention to his writing might not have altered his experience of discomfort and displeasure, but he felt more content and productive, rather than being demoralized.

Acceptance can also be used in psychotherapy to increase decentring and there is empirical evidence that acceptance-based interventions reduce experiential avoidance and facilitate behaviour change (Levitt, Brown, Orsillo, & Barlow, 2004).

Summary

This chapter described in detail the SMAD. It discussed the theoretical and empirical rationales for integrating such concepts as cognitive distortions, rumination, hypnosis, mindfulness, biological vulnerability and unconscious information processing in the etiological understanding of anxiety disorders. The concept of the wounded self provides a common thread for binding these elements together into a comprehensive integrated model of anxiety disorders. This model offers an integrative perspective on the nature, development, aggravation and maintenance of anxiety disorders. Chapter 2 discusses the clinical implication of this model and describes comprehensive treatment strategies based on the model.