Hypnosis and Treating Depression

Applications in Clinical Practice

Edited by Michael D. Yapko

Clinical Hypnotherapy / Psychotherapy

Michael Yapko’s seminal 1992 book, *Hypnosis and the Treatment of Depressions*, was the first book ever written on the subject of applying hypnosis in the treatment of depressed individuals. Since its publication, Yapko’s work has not only withstood the test of colleagues previously dismissive of the merits of hypnosis as a tool of treatment, but has thrived in the face of it.

*Hypnosis and Treating Depression* diversifies the range of topics to consider and increases the number of knowledgeable contributors on the subject of treating depression with hypnosis. The book features chapter contributions by highly experienced and well-known experts on using hypnosis to treat specific forms of depression, with assessment and intervention strategies as well as sample transcripts of the use of hypnosis in therapy sessions. It discusses both broad and targeted applications of hypnosis in treatment, the treatment of depression with hypnosis in special populations, as well as special considerations regarding hypnotic treatment. As a practical guidebook for clinicians looking to add to their treatment protocols, *Hypnosis and Treating Depression: Applications in Clinical Practice* provides an updated and comprehensive volume on therapeutic uses of hypnosis in the treatment of depression.
Hypnosis and Treating Depression
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Edited by Michael D. Yapko
With lots of love to my folks, Madeline and Jerry Harris, in this, their 50th year of an amazing marriage. Your loving ways teach and inspire people in more ways than you could ever know.
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Foreword

Hypnosis was the first Western conception of a psychotherapy—the first time a talking interaction between doctor and patient was conceived of as having therapeutic potential. It has gone on a bumpy ride since then—oft ignored or redefined as something else. Hypnosis is a state of highly focused attention, with a reduction in peripheral awareness (controlled dissociation) and a heightened responsiveness to social cues. It is a valuable ability that people possess to varying degrees and that becomes a stable trait throughout adult life. It is a normal state that those with sufficient hypnotic ability can enter in a matter of seconds and exit just as rapidly. It allows us to concentrate intently, becoming absorbed in a book, in a play, or while engaged in physical performance. It allows some to reduce or eliminate the pain of childbirth or medical procedures, manage chronic pain, control non-epileptic seizures, improve psychosomatic symptoms, stop smoking, and ameliorate acute and posttraumatic stress disorder (PTSD) symptoms.

So why has so little been written (until now) on hypnosis in the treatment of depression? Depression impairs concentration, and some (but not all) depressed people have difficulty mobilizing and utilizing their fundamental hypnotic capacity. There was reason to worry that a desperately depressed person contemplating suicide would view a failure of treatment employing hypnosis as a pretext for a suicide attempt. Although that concern remains, it falls well within the realm of good clinical management of depression. Any treatment can raise hopes, and careful surveillance regarding suicidal ideation and intent is always a crucial component of treatment. With the growing recognition of the cognitive fellow travelers of depressed mood—the inappropriate guilt and feelings of hopelessness, helplessness, and worthlessness—came increasing recognition that the cognitions and mood reinforced one another. Thus the “cycle” of depression could be treated not just by elevating mood, for example, with antidepressant medications, but also by interrupting the cycle of self-denigration that perpetuates the mood. Hence, we now have cognitive behavioral therapies for depression, which have been shown to be effective. Similarly, depression affects relationships. A depressed person can make someone else feel hopeless and even angry—you want to shake the depressed person and say, “It’s not that bad—get on with it” (a technique that never works). So therapies designed to ameliorate the social consequences of depression, such as interpersonal psychotherapy based on the work of Harry Stack Sullivan, were developed and shown to be effective.
If altering cognition and interpersonal relatedness can affect depression, why not amplify these and other approaches with the intense concentration, ability to set aside aspects of cognition, and strong interpersonal relatedness that come with hypnosis? Michael Yapko and colleagues, leaders in the field of hypnosis and psychotherapy, have assembled a thoughtful and diverse range of techniques. Dr. Yapko has been a pioneer in this area, addressing the combination of hypnosis with psychotherapeutic treatment for depression in an innovative and effective way. The use of hypnosis for people with depression and comorbid disorders such as pain and PTSD is addressed, and a variety of useful hypnotic metaphors and images are described. As in any innovative and diverse book, there are elements here with which I personally do not agree, primarily Irv Kirsch’s dismissal of the efficacy of antidepressant medications. Although there is a placebo component to antidepressant response, Kirsch’s own review of the literature shows that there is a specific pharmacological response as well—we disagree about its magnitude. I think it is a fundamental mistake, from the points of view of both accuracy and strategy, for this field to attempt to trivialize other effective treatments. We need every drop of efficacy we can find, and most studies show that combined pharmacotherapy and psychotherapy work better than either measure alone. I always use both with my depressed patients.

The treatment of depression is getting less depressing all the time. Effective new treatments are being developed, described, and tested. This book contributes substantially to the array of skills that clinicians can bring to bear in treating depression, and it is long overdue. Enjoy it.

David Spiegel, M.D.
Willson Professor in the School of Medicine
Associate Chair of Psychiatry & Behavioral Sciences
Medical Director, Center for Integrative Medicine
Stanford University School of Medicine
About the Editor

Michael D. Yapko, Ph.D., is a clinical psychologist and marriage and family therapist residing in Fallbrook, California. He is internationally recognized for his work in depression and outcome-focused psychotherapy, and routinely teaches to professional audiences all over the world. To date, he has been invited to present his ideas and methods to colleagues in 27 countries across 6 continents, and all over the United States.

Dr. Yapko is the author of numerous books, book chapters, and articles on the subjects of hypnosis, depression, and the use of strategic psychotherapies. These include Trancework (3rd edition), Treating Depression with Hypnosis, Breaking the Patterns of Depression, Hand-Me-Down Blues: How to Stop Depression from Spreading in Families, and Hypnosis and the Treatment of Depressions.

Dr. Yapko is a member of the American Psychological Association, a clinical member of the American Association for Marriage and Family Therapy, a past fellow of the Royal Society of Medicine’s Division of Hypnosis and Psychosomatic Medicine (in England), a member of the International Society of Hypnosis, and a fellow of the American Society of Clinical Hypnosis. He is a recipient of the Milton H. Erickson Award of Scientific Excellence for Writing in Hypnosis, the Arthur Shapiro Award for the “best book of the year on hypnosis” from the Society for Clinical and Experimental Hypnosis (for Treating Depression with Hypnosis), and the 2003 Pierre Janet Award for Clinical Excellence from the International Society of Hypnosis, a lifetime achievement award honoring his many contributions to the field.

On the personal side, Dr. Yapko is happily married to his wife, Diane, a pediatric speech–language pathologist, author, and clinical trainer. Together, they enjoy traveling and hiking in the Great Outdoors in their spare time.
Contributors

Assen Alladin, Ph.D., R. Psych., is a clinical psychologist at Foothills Medical Centre and adjunct assistant professor in the Department of Psychology and Psychiatry, University of Calgary, Alberta, Canada. He is the president of the Canadian Society of Clinical Hypnosis—Alberta Division. He is a member of the Canadian Psychological Association, the American Society of Clinical Hypnosis, and the International Society of Hypnosis. Dr. Alladin was trained as a psychiatric nurse and a social worker before coming into psychology and clinical psychology. He received his B.Sc. in psychology from the University of London, M.Sc. in psychopathology from the University of Leicester, diploma in clinical psychology from the British Psychological Society, and Ph.D. on migraine headaches from the Faculty of Medicine, University of Manchester. Dr. Alladin has been teaching and practicing clinical hypnosis for 25 years. He is interested in the empirical validation of hypnotherapy and in integrating hypnosis with cognitive behavior therapy. He has published several papers on cognitive hypnotherapy for depression, and he has conducted workshops on this area nationally and internationally. He was associate fellow of the British Psychological Society and fellow of the Royal Society of Medicine.

Norma Barretta, Ph.D., is in private practice in the Los Angeles area specializing in hypnotic work with medically referred patients. She is a graduate of the University of Pennsylvania, was a Ford Foundation scholar at Glassboro State University, and holds a master’s degree from Rutgers University and a Ph.D. from the University of Southern California. She has been using clinical hypnosis in her work for more than 27 years as a therapist as well as in her teaching. Dr. Barretta is an approved consultant and fellow of the American Society of Clinical Hypnosis, for whom she regularly teaches and now serves as moderator of the Board of Governors. She is a diplomate of the International Academy of Behavioral Medicine, Counseling and Psychotherapy, and a member of the American Psychological Association, the Southern California Society of Clinical Hypnosis, and the Association for Humanistic Psychotherapy. Dr. Barretta is listed in Who’s Who among Women in the World. She has presented seminars in hypnosis and neurolinguistics worldwide, and is currently on the faculty at IKOS in Bari, Italy, and the Erickson Institute in Madrid, Spain.
Philip F. Barretta, M.A., M.F.T., is a marriage and family therapist who is “mostly retired” from private practice but continues to teach Ericksonian hypnosis and neurolinguistics with his wife, Norma. He is a graduate of Rutgers University in humanities and holds a master’s degree from California State University, Long Beach. He is an approved consultant of the American Society of Clinical Hypnosis (ASCH), for whom he frequently serves as faculty. He was honored by ASCH in 1989 by receiving the status of a “special member” of the Society. He is an honorary member of the Southern California Society of Clinical Hypnosis, and a life member of the Association for Humanistic Psychotherapy, Phi Delta Phi, and Phi Delta Kappa. He is a diplomate of the International Academy of Health Care Professionals and is listed in Who’s Who in the West. Mr. Barretta has presented seminars in hypnosis and neurolinguistics worldwide. He is currently on the faculty of IKOS in Bari, Italy, and the Erickson Institute in Madrid, Spain.

George W. Burns, B.A. (Hons.), is a West Australian clinical psychologist whose innovative work as a practitioner, teacher, and writer is recognized nationally and internationally. He has written numerous articles and has contributed chapters to books such as Contemporary International Hypnosis (1995), Changing Directives (2001), and The Science of Well-being (2005). His own books include Hypnosis in Australasia (1984), the much-acclaimed Nature-Guided Therapy (Brunner/Mazel, 1998) and the best-selling 101 Healing Stories: Using Metaphors in Therapy (J. Wiley, 2001). Standing Without Shoes: Creating Happiness, Relieving Depression, Enhancing Life (Prentice-Hall, 2003) is co-written with Dr. Helen Street and was honored with a foreword by His Holiness, the Dalai Lama of Tibet. His most recent book, 101 Healing Stories for Kids and Teens, has won praise from leading experts in the field. His books have been translated into six languages.

Mr. Burns is adjunct senior lecturer in the School of Psychology at Edith Cowan University as well as director of both the Milton H. Erickson Institute and the Hypnotherapy Centre of Western Australia. He has taught throughout Australia and New Zealand as well as in Europe, Asia, and America. He has a long-held interest in and knowledge of therapeutic stories and, as a keen traveler, has sat with storytellers and shamans from islands of the Pacific to mountains of the Himalayas. In recent years he has combined his passions for exotic travel and psychotherapy into workshops/study tours, leading colleagues into places such as the Himalayan kingdom of Bhutan and the High Arctic.

Steven M. Fraioli, L.M.S.W., a licensed master social worker, is a clinician at an inpatient psychiatric unit of a general hospital in Binghamton, New York. He specializes in cognitive therapy techniques for the treatment of depression and anxiety. Toward the assessment and treatment of patients and their discharge planning, he uses an ecological perspective whereby each individual is viewed in the context of his or her specific social environment.
Irving Kirsch, Ph.D., professor at the University of Plymouth in England, is an author or editor of 8 books, 38 book chapters, and more than 160 scientific journal articles on placebo effects, antidepressant medication, hypnosis, and suggestion. His work has been extensively covered in the media, with feature articles in The New York Times, Newsweek, Science, Lancet, Scientific American, Smithsonian, Science News, the Washington Post, and many other newspapers and magazines around the world. He has appeared on television documentaries and news programs broadcast on ABC, HBO, NPR, the Discovery Channel, and the BBC.

Daniel P. Kohen, M.D., is professor in the Departments of Pediatrics and Family Medicine and Community Health at the University of Minnesota. He is director of the Pediatric Department’s Fellowship Program in Developmental/Behavioral Pediatrics. He is board certified by the American Board of Pediatrics and the American Board of Medical Hypnosis, and is a fellow of the American Academy of Pediatrics, the American Society of Clinical Hypnosis (ASCH), and the Society for Clinical and Experimental Hypnosis (SCEH).

Dr. Kohen is past president of the Minnesota Society of Clinical Hypnosis (MSCH) and has been its director of education and training for 18 years. He is a diplomate, examiner, and past president of the American Board of Medical Hypnosis. For over 25 years, he has taught pediatric hypnotherapy workshops through the Society for Developmental and Behavioral Pediatrics (annually since 1987), for SCEH, for Milton Erickson Gesellschaft (Berlin), for several European Child Hypnosis Congresses (Heidelberg), in Australia, and for the International Society of Hypnosis in Toronto, The Hague, Jerusalem, Melbourne, and Singapore.

Dr. Kohen is recipient of the ASCH Award for Excellence in Teaching (1992); the American Journal of Clinical Hypnosis (AJCH) Milton H. Erickson Award of Scientific Excellence for Writing in Hypnosis (1993); the Thomas Wall, DMD award (ASCH); the Shirley Schneck Award for contributions to medical hypnosis (SCEH; 1998); and the AJCH Josephine Hilgard award for best pediatric paper (1998, 1999).

With Dr. Karen Olness, Dr. Kohen is coauthor of the major text in pediatric hypnosis, Hypnosis and Hypnotherapy with Children. He is the author of over 50 publications in a variety of pediatric, hypnosis, and other scientific journals and books.

Stephen R. Lankton, MSW, DAHB, is a psychotherapist practicing in Phoenix, Arizona, and teaches as faculty associate at Arizona State University, Department of Behavioral Science and Sociology. He is editor of the American Journal of Clinical Hypnosis and the executive director of the Phoenix Institute of Ericksonian Therapy. He is a recipient of the Lifetime Achievement Award for Outstanding Contribution to the Field of Psychotherapy. He is a fellow and approved supervisor in family therapy of the American Association for Marriage and Family Therapy, a fellow and approved consultant in clinical hypnosis of the American
Society of Clinical Hypnosis, and a diplomate in clinical hypnosis and past president of the American Hypnosis Board for Clinical Social Work. He is an Arizona licensed clinical social worker.

He has been a keynote speaker, invited faculty, and workshop or seminar leader for hundreds of conferences sponsored by virtually every major national and state professional organization, as well as by dozens of universities and internationally recognized postgraduate training centers.

Mr. Lankton studied directly with Dr. Milton Erickson for five years. He is internationally well known for his clinical work and teaching of Ericksonian approaches to psychotherapy, brief therapy, couples therapy, and hypnosis, and has taught in 20 countries. He has authored or coauthored six best-selling professional books, including *Assembling Ericksonian Therapy*, *Tales of Enchantment*, *The Answer Within*, *Enchantment and Intervention*, and *Practical Magic*, and has edited and co-edited 11 other books. He was founding editor of the *Ericksonian Monographs* and has published numerous clinical papers and chapters. His work has been translated into six languages.

As a corporate consultant, his clients include such large U.S. organizations as the IRS, New York State Human Services, New York State Tax and Finance, and Empire Blue Cross/Blue Shiel.

Steven Jay Lynn, Ph.D., is professor of psychology at the State University of New York at Binghamton, and a diplomate (ABPP) in clinical and forensic psychology. A former president of the American Psychological Association (APA) Hypnosis Division, Dr. Lynn is the author or editor of 14 books and more than 200 articles on hypnosis, abnormal psychology, psychotherapy, dissociation, anomalous experiences, and memory. He is a recent recipient of the APA Hypnosis Division’s Award for Distinguished Contributions to Scientific Hypnosis, and the Chancellor’s Award, State University of New York, for Excellence in Scholarship, Creativity, and Professional Activities. Dr. Lynn serves on 11 editorial boards, including that of the *Journal of Abnormal Psychology*, and he is a North American editor of *Contemporary Hypnosis*. His Laboratory of Consciousness and Cognition is funded by the National Institute of Mental Health.

Abigail Matthews is currently a clinical psychology Ph.D. candidate at the State University of New York at Binghamton. She completed undergraduate coursework at the State University of New York at Buffalo and California State University, Los Angeles, and earned a bachelor’s degree in art history (2000). Her primary research interests include eating disorders, with a specific emphasis on self- and interpersonal perceptions in bulimic women.

David I. Mellinger, L.C.S.W., is a licensed clinical social worker and coordinator of the Anxiety Disorders Treatment Service, Valleys Service Area, at the Kaiser Permanente Department of Behavioral Health Care, Los Angeles, California.
He is also in private practice in Woodland Hills and Westlake Village, California. He is the author (with Steven Jay Lynn) of *The Monster in the Cave: How to Face Your Fear and Anxiety and Live Your Life*, and he has contributed publications and lectured internationally on the treatment of anxiety disorders, phobias, panic, and anger problems. Mr. Mellinger is a board-certified diplomate of the American Board of Examiners in clinical social work and a charter professional member of the Anxiety Disorders Association of America.

**Katherine Murray, M.D.**, is the Robert O. Fisch Fellow in Developmental/Behavioral Pediatrics at the University of Minnesota. She completed her medical school training in Philadelphia at MCP/Hahnemann School of Medicine and moved to the University of Minnesota for her residency training. After her chief residency year, she began work as a fellow in developmental/behavioral pediatrics. She has participated in clinical hypnosis training through the Minnesota Society of Clinical Hypnosis since residency and discovered it was present in her practice all along. She is actively involved in caring for children with emotional and behavioral problems, and is interested in improving early recognition and treatment of these problems, lest they grow along with the children. Dr. Murray lives with her family in Saint Paul, Minnesota.

**Maggie Phillips, Ph.D.**, is a licensed psychologist in full-time private practice in Oakland, California. She is director of the California Institute of Clinical Hypnosis. She is an adjunct faculty member at the University of California at Santa Cruz extension and at Alliant International University/California School of Professional Psychology. She has co-chaired the basic, intermediate, and advanced workshop programs for American Society of Clinical Hypnosis (ASCH) annual meetings.

Dr. Phillips has led invited workshops internationally on hypnosis and psychotherapy in Europe and Asia specializing in the treatment of stress disorders in trauma-related and behavioral medicine contexts, and has served on the faculties for numerous national and international hypnosis and psychotherapy conferences. She has authored numerous papers and articles on trauma and dissociation, ego-state therapy, hypnosis, and mind–body healing.

Dr. Phillips is the author of *Finding the Energy to Heal: How EMDR, Hypnosis, TFT, & Body Focused Therapy Can Help Restore Mindbody Health* (Norton, 2000); and coauthor of *Healing the Divided Self: Ericksonian and Clinical Hypnosis in the Treatment of Post-Traumatic and Dissociative Conditions* (W. W. Norton, 1995). She is a fellow of the International Society for the Study of Dissociation (ISSD) and a fellow of ASCH. She is co-recipient of the Cornelia Wilbur Award from the ISSD and of the Crasilneck Award for excellence in writing from ASCH. She also was awarded the ASCH President’s Award in 2002 and has served as the book editor and as an associate editor for the *American Journal of Clinical Hypnosis*. 
Judith W. Rhue, Ph.D., is a professor of psychosocial medicine in the Department of Family Medicine at the Ohio University College of Osteopathic Medicine, and a licensed psychologist in independent practice. Dr. Rhue is a fellow of the American Psychological Association and the Society of Clinical and Experimental Hypnosis, and has assumed leadership roles in professional organizations including the American Psychological Association and the Society of Clinical and Experimental Hypnosis. She is the editor of the Handbook of Clinical Hypnosis (with Steven Jay Lynn and Irving Kirsch); the Casebook of Clinical Hypnosis (with Lynn and Kirsch); Dissociation: Clinical and Research Perspectives (with Lynn); and Theories of Hypnosis (with Lynn). Dr. Rhue is on the editorial board of the International Journal of Clinical and Experimental Hypnosis, and she has presented many workshops and invited lectures on hypnosis, imagination, and fantasy at national and international meetings. Her work in the areas of hypnosis and fantasy proneness has received extensive coverage in the media.

Moshe S. Torem, M.D., is a graduate of the Hebrew University School of Medicine. After completing his training in psychiatry, Dr. Torem spent 2 additional years of fellowship training in the field of psychosomatic medicine under the mentorship of Dr. George Engel at the University of Rochester School of Medicine. Dr. Torem has published numerous articles and book chapters in the fields of psychiatry, mind–body medicine, and hypnosis. He is the coauthor of the book Coping with Uncertainty (2002) and two other medical books. Dr. Torem served as president of the International Society for the Study of Dissociation (ISSD) and as president of the North East Ohio Psychiatric Association. He also served as chairman for the Department of Psychiatry and Behavioral Sciences at Akron General Medical Center (1983–1999). In addition, Dr. Torem served as professor and chair for the Department of Psychiatry at North East Ohio Universities College of Medicine (1989–1998). Presently, Dr. Torem serves as professor of psychiatry at North East Ohio Universities College of Medicine and medical director at the Center for Mind–Body Medicine in Akron, Ohio. He has been a member of the American Society of Clinical Hypnosis (ASCH) for 25 years, and he has served in a variety of leadership positions on the Executive Council of this society. Dr. Torem is a fellow of ASCH, the Society of Clinical and Experimental Hypnosis, the International Society of Hypnosis, and ISSD, and is a distinguished fellow of the American Psychiatric Association. Dr. Torem is certified by the American Board of Psychiatry and Neurology in the field of psychiatry and has served as an examiner for this board.

Diane Yapko, M.A., is a licensed speech–language pathologist in private clinical practice in Del Mar, California. She specializes in working with the pediatric population addressing cognitive, linguistic, social, emotional, and behavioral issues. She has worked extensively with children who have been diagnosed with autistic spectrum disorders, attention deficit disorders, auditory processing
disorders, and behavioral, social, speech, language, and learning disorders. In addition to evaluating and providing direct treatment to clients, Ms. Yapko consults with families and schools to provide recommendations for how to best help a child in his or her home and school environments.

Ms. Yapko is the author of *Understanding Autism Spectrum Disorders: Frequently Asked Questions* (Jessica Kingsley, 2003). She wrote the “Clinical Update: Key Aspects of Asperger’s Syndrome” for the *American Association for Marriage and Family Therapy* magazine (November–December 2004). She is an international speaker who has addressed audiences in Australia, Canada, Germany, Singapore, and the United States. She is well known for her individualized, thorough, and innovative approaches to treatment and for the ability to share those strategies enthusiastically with participants of her workshops.

Prior to going into private practice, Ms. Yapko worked at the Communicative Disorders Center at the University of California, San Diego Medical Center. She also worked at National University in San Diego, teaching both graduate and undergraduate education students how to integrate special needs children into the mainstream.

Ms. Yapko is happily married to her husband of 29 years, Michael Yapko (yes, the editor of this book). In their spare time, they enjoy hiking and being outdoors.

**Jordan I. Zarren, MSW, DAHB, DCSW**, has been a licensed clinical social worker in private practice in West Palm Beach, Florida, for over 20 years. He has a master’s degree in social work (MSW) from Tulane University and has an additional 30 hours of graduate work in psychology at Boston University Graduate School.

Mr. Zarren is a past president of the American Society of Clinical Hypnosis (ASCH), the first master’s-level member to be elected to this position. He is an ASCH-certified consultant and fellow, and regularly serves on their annual meeting and regional workshop faculty. He is an associate editor of the *American Journal of Clinical Hypnosis*.

He is a life fellow of the Society for Clinical and Experimental Hypnosis and an advisory editor of the *International Journal of Clinical and Experimental Hypnosis*. His other professional memberships include the Florida Society of Clinical Hypnosis, the American Hypnosis Board for Clinical Social Work, the International Society of Hypnosis, and the National Association of Social Workers.

Mr. Zarren has written a number of articles for professional journals and the public media on clinical hypnosis, and is the coauthor (along with Bruce Eimer) of *Brief Cognitive Hypnosis: Facilitating the Change of Dysfunctional Behavior.*
Acknowledgments

Still, and always, foremost is my acknowledgment with deepest love of my remarkable wife, Diane. She makes each day an adventure and a privilege, and no words can convey how vital a positive and loving force she is in all I do.

My heartfelt gratitude to each of my esteemed colleagues who were so generous with their time and expertise in agreeing to provide chapters for this volume. Each one was a pleasure to work with on this project. Thank you one and all.

My thanks to George Zimmar, Dana Bliss, and the many others at Routledge who have supported this and so many of my other projects over the years. George paves the way for implementing new ideas and creating new possibilities, which I appreciate very much. Special thanks to Mimi Williams, my project editor, for her invaluable help.

I’d like to also lovingly acknowledge my family for their continuing support for my seemingly endless enthusiasm for my work. They have been wonderfully encouraging every step of the way.

Finally, I’d like to acknowledge my best and lifelong friends, Wendy, Richard, and Megan, whom I love dearly, for forever being the oasis in the desert.
A Poetic Beginning

Clinical writing, the kind that fills the pages of this volume with professional jargon and insightful analysis, can only partially illuminate the complexity of depression. There is, however, another kind of written language, a use of words that conveys a type of depth, emotion and clarity that clinical jargon usually cannot equal. It is the language of the poet, a language that is rich with imagery and holds the power to move the spirit.

It is my privilege to know a young woman who has impressed me with her use of words. Her writing is dramatic, rich with imagery and stark with harsh realities. Her name is Megan Leigh Horowitz, and when I asked her to write a poem for this volume, a poem that would capture both the despair of depression and the joy of recovery, she honored me by writing the poem below. I hope it moves you as much as it did me.

M.D.Y.

Beneath the Shadows

It is cold and dark beneath the shadows
where I lay,
helpless and alone
a deep forgotten place,
where the chilling wind breathes the bitterness of despair
as the remembrance of unfulfilled hopes and dreams is swept away

I reach out,
searching blindly through the blackness
enclosed in a tunnel,
wishing for an end,
a way to stop my suffering
My mind is numb
sorrow pours through my veins,
a barbed arrow piercing my soul
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The hollow throb of life’s heartbeat
grows fainter in the darkness
as I slowly lose sight of myself
Words of hope echo through my mind,
yet their promises are lost
in the heavy fog of depression

I have forgotten happiness, wonder, laughter
Somehow, I have forgotten life

My hands slip against the cold wall of the tunnel
I am falling,
trying desperately to hold on
My heart is pounding
Shallow breaths course through my lungs,
as I gasp for one last chance to escape myself

The world is spinning around me,
throwing me into a whirlwind of emotion,
until suddenly the shadow fades
Finally, I can see light
Through a faint crack in the darkness,
a soft glow appears
I reach out,
my heart aching for the sun,
my soul drawing me nearer,
until I have reached the light
Sunlight floods my body,
as the dark walls which imprisoned me
crack and crumble to the ground
from the power of knowing that I am free
To live life in each new moment

My soul is lifted
as joyful memories long forgotten
shower me like falling leaves
Hope floods my heart and mind,
and suddenly,
I remember life

I remember wonder, and I remember laughter
I remember that the future holds unknown memories
yet to savor
How could I have forgotten
that which lets me live and love?
Or the happiness that fills my heart
and the hope that gives me strength?
From beneath the shadows, I remember life
I remember simple joys, invisible in the fog of blind despair
I remember the past, like a river of long forgotten time
and I remember dreams of the future
waiting to set me free

Megan Leigh Horowitz
Encinitas, California
November 2005
Introduction

For nearly three decades, I have been focused on two primary domains of professional interest: applying clinical hypnosis in brief psychotherapies and treating depression in individuals, couples, and families. At first glance, these seem to be two unrelated phenomena: The former is a means of multidimensional therapeutic intervention that represents the original “positive psychology” in its emphasis on expanding peoples’ resources, and the latter is a multidimensional disorder that embodies a painfully negative orientation toward key areas of life experience.

Upon deeper reflection, however, the overlaps between the separate yet related domains of hypnosis and depression become more evident. I’ll describe just a few of these:

1. Both depression and hypnosis come about and increase in intensity the more narrow your focus.
2. Both involve social processes and are greatly influenced by your relationships with others, whether the other person is a clinical authority describing the therapeutic merits of exposing you to an induction procedure, or is a parent or spouse viciously describing the flaws in your character.
3. Both are products of expectancy, whether the expectation is a positive one for getting the benevolent corrective message “into your unconscious” through hypnotic suggestions you will receive in a dissociated state, or a negative expectation that no amount of your effort will result in a success, thereby giving rise to the apathy so typical of depression.
4. Both involve what hypnosis pioneers Theodore Sarbin and, later, Ernest Hilgard described when they suggested that hypnosis is, in part, a “believed-in imagination,” that is, an experience based on the recognition that people can and do get deeply absorbed in highly subjective beliefs and perceptions that quite literally regulate the quality of their lives (Sarbin, 1950, 1954; Hilgard, personal communication, August 14, 1988). These beliefs and perceptions can be altered in therapeutic ways during the experience of hypnosis, illustrating the point well how idiosyncratic and malleable each person’s sense of reality can be, especially in response to “mere” suggestions.
The notion of an individual’s personal reality essentially being a believed-in imagination preceded the origin and development of cognitive therapy by decades, even centuries, and firmly established the relevance of hypnosis in treatment. Cognitive-behavioral therapy (CBT) is, at this time, probably the best researched method of therapeutic intervention. It is founded on the premise that people in general, and depressed people in particular, regularly make identifiable errors in information processing, thinking and genuinely believing in their mistaken notions of what truly—and depressingly—seems like reality to them (Beck, 1987, 1997; Beck, Rush, Shaw, & Emery, 1979). This process of becoming absorbed in one’s (depressing) imaginings is, indeed, an instructive parallel to what occurs in hypnosis, where a clinician performs an induction and attempts to absorb the individual in alternative ways of thinking about and experiencing him or herself. Through procedures employing hypnosis, the clinician creates a context where the individual can change the direction and quality of his or her focus. Perhaps the suggested focus is on engaging in some new life-enhancing behavior, perhaps on exciting and motivating glimpses of future possibilities, or possibly on rewriting some of the negative internal dialogue or somehow altering for the better any of literally scores of depressing focal points (e.g., cognitive styles, coping styles, and relational styles). What the clinician suggests during hypnosis may not be any more true in an objective sense than what the person previously believed—it may just feel much better and serve the person’s well-being better.

Depression as a believed-in imagination, that is, a consequence of getting deeply absorbed in ways of thinking, behaving, relating, or living that make life seem joyless and burdensome? Hypnosis as a means of absorbing the person in a more skillful, adaptive, beneficial, and even positive frame of mind? This is hardly an “on the fringe” perspective. On the contrary, for the treatment efficacy literature is wonderfully unambiguous in describing that when people learn the key skills for living life well, such as the skills for thinking critically, behaving effectively, and building positive relationships with others, they tend to recover from depression (Depression Guideline Panel, 1993; Yapko, 1997). Hypnosis as a means of teaching people, a vehicle for getting new possibilities for thinking, feeling, behaving, and relating integrated more quickly and deeply, is precisely why knowledgeable clinicians do hypnosis in the first place.

This volume is a dynamic and forceful witness to the wisdom of bringing hypnosis into the treatment context when addressing depression. This book contains current and well-informed contributions from highly experienced, well-known, and greatly respected clinicians who have been convinced for a very long time about the many ways hypnosis can enhance the treatment of depressed individuals. It was my hope in assembling this wonderful group of distinguished contributors that the case for making hypnosis a prominent component of any treatment plan would be so convincing as to be irresistible. Contained in every chapter are powerful examples of creative applications of suggestions and hypnosis in the treatment of depression, and all share at least one common denominator: They serve to empower the client. They empower the client to discover new resources,
and they empower the client to develop a flexibility in living that encourages shifting directions when a path is temporarily blocked. Contradicting the popular mythology of an imminent loss of control that makes uninformed people wary about hypnosis, this book draws your attention to the opposite truth: Hypnosis strengthens people, showing people a path of self-discovery and self-growth, and providing them a comfortable context for developing the best and most adaptive parts of themselves.

SOME RELEVANT HISTORY

It’s much easier to talk about the merits of hypnosis for treating depression now than it was in years past. In fact, when I wrote Hypnosis and the Treatment of Depressions in 1992 (published by Brunner/Mazel), it was the first book ever written on the use of hypnosis for treating depression. I detailed in the first few chapters why hypnosis had incorrectly and unfortunately been considered a contraindicated treatment for depression. I made the point that outdated views of both hypnosis (e.g., incorrectly defined only as a “heightened suggestibility” that would strip away peoples’ defenses or lead to symptom substitution) and depression (e.g., incorrectly said to be caused by “anger turned inward” or some hypothetical psychodynamic conflict) had caused many respected leaders in the field to dismiss its use as a serious therapeutic tool. I respectfully submitted that it was time to update our collective viewpoints with current information. To my great satisfaction, many people listened. The topic of using hypnosis in the treatment of depression has since worked its way into many clinical trainings and now is standard fare at many conferences. This volume that you’re holding in your hands could not have been assembled just a dozen years ago. Fortunately, it is here now.

As more practitioners have come to appreciate the social aspects of hypnosis, such as the power of a good therapeutic alliance and the catalyzing effects of positive expectancy, the field has been transformed. The ritualistic methods of hypnosis have all but disappeared, replaced by the more appropriate emphasis on treating people, not on diagnostic labels. As you will see throughout the array of chapters written by leading experts, there is another common denominator: The label depression is simply a convenient shorthand, a global term used to describe a range of specific symptoms and issues that are the real targets of hypnotic intervention. All of the experts are concerned, to one degree or another, with how people generate depression rather than in trying to explain why. All are deeply convinced that hypnosis is best aimed at the phenomenological processes that culminate in depression, and all choose to employ hypnosis as a way of joining and then redirecting peoples’ subjective realities.

None of the experts included here would say that hypnosis “cures” depression or, for that matter, that hypnosis cures anything. It’s not the hypnosis itself that offers therapeutic benefit—rather, it’s what happens during hypnosis. It’s the new
understandings, the new ideas, the new ways of responding, and the new internal associations that are formed during hypnosis that have therapeutic potential. This point is vitally important to appreciate from the outset, because when you fully grasp that hypnosis in and of itself cures nothing, it leads you to strive for a better understanding of the many variables that can come together in order to make an intervention succeed.

WHAT WE KNOW ABOUT APPLYING HYPNOSIS

As Jay Haley insightfully pointed out, there isn’t only one hypnosis. (See Haley’s “Frame of Reference” section in Yapko, 2003, pp. 529–531.) Rather, there are many different forms of hypnosis, and there are many different applications of hypnosis. Administering structured hypnotizability tests to delineate individual differences between people encourages one type of response in people, whereas using hypnosis to deliberately try to change people in specific ways that transform them from depressed and symptom riddled to happier and healthier encourages quite a different type of response.

Although there are some in the field who advocate the position that hypnosis is more about the client’s innate abilities than the clinician’s skills and, therefore, assessing a presumably fixed hypnotic capacity is deemed important, clinicians don’t seem to readily subscribe to this view. Clinicians tend to want to do whatever they can to generate a therapeutic effect, and coming to believe that their therapeutic skill or technique is a lesser consideration in the course of therapy seems inconsistent with that desire as well as with their clinical training and direct clinical experience. The fact that people differ in their hypnotic capacities is well established. What that means for effective clinical practice is still wide open for enlightened discussion.

What we have come to understand about hypnosis that has a high level of consensus among both researchers and clinicians in the field is that any therapeutic value hypnosis might have for a given individual will depend on multiple, interrelated factors. The factors affecting client responsiveness operate in three distinct but overlapping domains: (a) personal factors (such as the ability to focus, imaginative ability, the capacity for dissociation, and expectations), (b) interpersonal factors (such as trust for the clinician or a sense of being accepted), and (c) contextual factors (such as the noise level in the room, the quality of the chair the client sits in, and how the circumstances involving hypnosis are defined).

There are different styles for conducting therapy involving hypnosis. Some approaches are more technique oriented, such as when someone uses a prepared script or a specific structured approach to which the client is exposed and, hopefully, finds meaningful. Other approaches are more client centered, eliciting from the client his or her own resources and bringing them to the fore in more
natural and personalized ways. Both approaches have the potential to be helpful, depending on how the domains of responsiveness interrelate.

There are also different styles revolving around the types of suggestions a clinician employs. Some approaches are quite direct, essentially suggesting to the client in no uncertain terms what he or she “should” do or think. Others are much more indirect, employing communication devices such as metaphor and implication to encourage the client to actively engage in a proactive process of making the suggestions more personally relevant. People in the field have been divided over the question of whether direct or indirect suggestions are more potent. It should be a settled issue by now: No suggestion is worth anything until a client finds it meaningful and can apply it beneficially. It isn’t the structure of the suggestion that matters—it’s the way a specific client either does or doesn’t relate to it. Thus, the challenge for any clinician is to be skilled in all suggestion structures and styles, varying his or her approach according to the individual needs and responses of the client (Yapko, 2003).

The experience of hypnosis across clients will vary depending on multiple factors. Likewise, the experience of hypnosis will also vary within the same client at different times depending on a variety of factors, including his or her mood, motivation, and ability to focus, as well as other such variables (Lynn & Kirsch, 2006). Therefore, the process of induction, like the use of hypnosis in general, might best be approached as an inquiry, an effort to discover what the client might be capable of in general, and what he or she may be capable of today.

Each client has unique attributes, and there is not necessarily a crossover from one area to another: Just because someone shows good ability to generate age regression, for example, does not mean he or she will prove adept at generating an analgesia or a negative hallucination. This point is why the research on hypnosis has generally been unfavorable in attempts to correlate hypnotizability with therapeutic outcome. Simply put, how someone performs on hypnotizability test items has little or no bearing on his or her eventual responses to hypnosis conducted in the course of therapy. In the clinical world, it is hard to know in advance exactly how someone will respond to a particular approach or specific suggestion. Clinicians implement a strategy and strive to keep it flexible enough to modify according to the feedback obtained as sessions progress over time.

All of these points about applying hypnosis, and many more, are well elaborated and referenced in my comprehensive hypnosis textbook, Trancework: An Introduction to the Practice of Clinical Hypnosis (3rd edition; 2003; Brunner/Routledge).

WHAT WE KNOW ABOUT DEPRESSION

Depression is the most common mood disorder in the United States and, indeed, the world. It is a problem growing in scope and severity, and according to the World Health Organization as well as cross-national epidemiological surveys, the
XXXIV INTRODUCTION

rise in the rate of depression around the world is a leading cause of human suffering and disability (Klerman & Weissman, 1989; World Health Organization, 2001). The costs of depression on a variety of levels are huge: Marriages and families splinter, individuals suffer, societies suffer the consequences of the often destructive behaviors of people coping badly or not at all with their depression, businesses suffer the negative effects of employees too disabled to function properly, greater health care expenses for depressed patients lead to enormous economic costs, and societies experience the tragedy of suicides and lives lost to despair and apathy. Depression is a terribly disabling disorder, and despite significant advances in treatment, the problem continues to grow in scope rather than diminish. It is a sad fact that most of the people who need help don’t get it.

Depression is a multidimensional disorder. It has biological components based in genetics, neurochemistry, and physical health, and it has psychological components that involve many individual factors such as cognitive style, coping style, and qualities of personal behavior. And it has social components, factors that are mediated by the quality of one’s relationships, including such variables as the family and culture one is socialized into, and one’s range of social skills. The best, most accurate answer to the basic question “What causes depression?” is “Many things.”

Although there are many pathways into depression (these may involve gender differences in susceptibility, age and cultural differences, and many other differences as well), once someone is depressed the demographic differences become far less significant. Once you’re depressed, it feels lousy no matter what your age, race, religion, gender, or socioeconomic status. Thus, to a clinician trying to catalyze recovery, such factors are secondary. Empowering the person to better manage whatever his or her unique vulnerabilities might be is primary.

Depression is a highly comorbid condition, meaning that it is more often found to coexist with other conditions (medical and/or psychological) than it is found existing on its own. Some form of anxiety disorder is the most common comorbid condition, but other disorders are also common, such as substance abuse (especially alcoholism), eating disorders, personality disorders, and scores of medical conditions. The fact that depression is a highly comorbid condition is well represented in this volume, with chapters addressing depression and anxiety, pain, posttraumatic stress disorder, eating disorders, and Asperger’s syndrome.

Currently, the medical model of depression receives the greatest attention for a variety of reasons. The pharmaceutical industry in particular has spent many billions of dollars in advertising to the public as well as investing directly in individual psychiatrists, encouraging all to define depression as a disease caused by a neurochemical imbalance that requires medication to manage. There are currently nearly two dozen antidepressants available, and many more are currently in various stages of research and development. The lion’s share of research money goes to drug research, further elevating drugs to the status of being the source of hope for everyone who suffers depression. Considered a first-line treatment approach by many mental health professionals, antidepressants are
widely prescribed, thereby either de-emphasizing the value of psychotherapy or ignoring it altogether.

There is a growing backlash against the one-dimensional depiction of depression as a biologically based disease. There is already abundant and irrefutable evidence that many other factors, both personal and social, play profound roles in both the onset and course of depression (Pettit & Joiner, 2006). To ignore these factors and emphasize only biology is highly misleading. When clinicians so oversimplify depression, people are misguided into believing they don’t have to change themselves or their lives in any way, but need only change their biochemistry. When one underestimates the complexity of the problem, solutions will inevitably be incomplete, leading one to predict that the rate of depression will continue to rise. And so it does. It may sound extreme to some, but I stand by this statement: Depression is more a social problem than a medical one, and no purely biological cure will be found for it any more than biology alone will cure other social ills such as poverty or child abuse. There are things psychotherapy can do that no amount of medication can do, and some of these are the focus of the chapters in this book.

When there have been psychologically based treatments that match the success rate of medications and even surpass them in specific ways, that have lower rates of relapses, and that do more to make people feel better in the treatment process and can even be applied successfully in programs of prevention, there is more than sufficient reason to emphasize the value of psychotherapy in treatment. But not all psychotherapies are of equal merit. Some have clearly demonstrated a greater efficacy in the realm of depression, namely, those therapies that emphasize skill acquisition (such as coping skills or social skills) and require the client to actively engage in the treatment process in a goal-oriented way. Behavioral activation is the term commonly used to emphasize the importance of the client taking sensible, purposeful action to do something different in order to recover. This is not to say that antidepressant medications shouldn’t be a part of treatment, especially in those specific instances where there are clear benefits medication can provide over psychotherapy. Rather, medications should be used more carefully and with an associated recommendation for a well-considered psychotherapy.

The social side of depression is especially important yet is terribly under-considered in the field. We know, for example, that depression runs in families: The child of a depressed parent is anywhere from three to six times more likely to become depressed than the child of a non-depressed parent. Thus, a depressed parent is a large risk factor (Goodman & Gotlib, 2002). The genetics research makes it quite clear that faulty genes are not entirely responsible, especially because there is no “depression gene.” It has more to do with the patterns of thinking, coping, behaving, and relating that parents (and other significant role models in our society) model day in and day out than with one’s genetic makeup. When you have the largest demographic group of depression sufferers, namely, the 25- to 45-year-olds, raising children, it should surprise no one that they are raising the fastest growing group of depression sufferers. After all, parents can’t
teach their children what they don’t know. Furthermore, the more distressed one’s marriage is, the more likely one is to either already be or become depressed. The quality of one’s marriage is a very large risk factor, yet many clinicians never explore this vital part of a client’s world. These points provide excellent reasons for wanting to strengthen parents and marriages, something no antidepressant medication alone can accomplish (Yapko, 1999). To think of depression as only an individual’s disorder, as if he or she isn’t a product of powerful social forces that operate in families, organizations, and cultures, or to reduce it even further to a purely biochemical phenomenon, is so terribly reductionistic as to disempower the very people we purport to serve.

The significance of pointing out that there are many pathways into depression should be elaborated. By the time depression strikes, the risk factors have been in place for years. (See my book *Treating Depression with Hypnosis*, 2001, Brunner/ Routledge, for a fuller discussion of this point.) It is tempting to look for a single cause (such as your genes or your recent job loss), but these represent events. Depression is not generally an event-driven phenomenon; rather, it is a process-driven one. Its origins and course are evident in the process, the “how” of how the person thinks, copes, problem solves, relates, behaves, eats, moves, and does lots of other things that hold the potential to either insulate them against depression or land them in the middle of an episode (a theme addressed by several of the chapters in this volume). It will not escape your notice that virtually all the experts in this book target processes (such as information gathering or decision making) with their hypnotic interventions rather than just symptoms or hypothetical causes.

The prevention of depression is an especially important consideration (including the prevention of relapses, as discussed in the final chapter). The fact that programs have been established in a variety of contexts that have a proven ability to prevent depression is some of the strongest evidence we have for thinking of depression as a largely learned phenomenon (Seligman, 1995). To teach people the skills they will need to cope with the inevitable stresses of life (i.e., the hurts, rejections, disappointments, and losses we all face; the problems we must all solve; and the challenges we all must transcend), and then demonstrate that by learning such skills one’s vulnerability to depression is significantly reduced, represents an extraordinary opportunity. The still rising rates of depression make it clear, unfortunately, that we have not yet seized that opportunity, to the detriment of us all.

WHAT WE KNOW ABOUT TREATING DEPRESSION WITH HYPNOSIS

In describing the term *depression* as a global shorthand, a convenient label for a wide range of symptoms and patterns of experience, we know that effective treatment must first involve identifying the salient patterns that regulate the
experience of depression in a given individual. We also know that therapy, any therapy, will necessarily have to interrupt ongoing patterns of experience in some way and generate some new patterns of experience that prove beneficial to the client’s mood, outlook, and behavior. The task for the clinician is to absorb the client in new patterns, whether patterns of thought as in cognitive therapy, patterns of physiology as in somatic-based interventions, or whatever patterns are addressed in a style of intervention. Hypnosis is multidimensional in its ability to focus anywhere, and it serves to catalyze the merits of the intervention, whatever form it might take.

Hypnosis amplifies experience. The first principle that one learns in studying hypnosis is that what you focus on, you amplify. Thus, a clinician has to be deliberate about choosing focal points for interventions. Focusing on someone’s cognitions, for example, shouldn’t be a standard procedure even for a self-identified cognitive therapist; it should be a choice one makes because there is a powerful depressogenic pattern operating on that dimension. But, for someone else, the focus will need to be on his or her relationships, and for someone else on his or her negative expectations. What a clinician will focus on and amplify with hypnosis will differ according to the profile of each individual client. This is one of the great strengths of being knowledgeable about hypnosis: The ability to make good therapeutic choices based on client need outweighs loyalty to a particular theory of intervention. As you will see, each of the experts emphasizes different focal points in the chapters he or she has contributed, and each of them represents a choice point for when that particular issue or pattern is evident in a specific client. None of the approaches herein is presented as a “one-size-fits-all” formula.

Hypnosis in the treatment of depression is a relatively new application, as mentioned earlier. When experts in hypnosis taught for decades that hypnosis would strip away defenses and precipitate psychotic reactions in depressed people, or energize their suicidal ideation and transform it into suicidal behavior, there was no therapeutic rationale for employing hypnosis with depression sufferers. Treating people and not their labels, structuring the hypnosis sessions to build positive expectations for the future instead of amplifying negative ones, and finding and hypnotically expanding peoples’ resources are all ways in which clinical practice has changed and hypnosis has come to be immediately relevant to treating depression sufferers.

One of the prices for having ignored hypnosis as a treatment tool all these years, however, is that controlled research on ways hypnosis can be skillfully applied in the treatment of depression has not been done. This is an observation upon which nearly all the contributors commented. There are plenty of studies that show hypnosis enhances treatment results, helps people manage anxiety, helps them feel personally empowered, enhances their moods and outlooks, and helps in so many other important ways. But, historically, these have been framed as mere side effects of treating other client populations (such as pain patients), and so the benefits of hypnosis for depression can only be inferred from such data.
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But clinicians aren’t usually researchers, and psychotherapy is, at best, only partially about science. Clinicians can and certainly should be informed by science, but the reality is that therapy is largely about artistry. It’s about gut feelings, clinical judgment, thinking on your feet, and quickly turning corners when you start to hit walls with a client. These are not things that can be manualized, standardized, or scripted. Thus, applying hypnosis in novel ways and observing the effects are the clinician’s domain, and research can only go so far in informing it. Therefore, none of the experts included in this volume are or should be apologetic for sharing what they have found helpful in practice, even if there aren’t (yet) studies to support their insightful observations. Each reader will have to decide for him or herself how much merit to ascribe to the approaches of these experienced clinicians, and that’s true with or without supportive data. It really is all about clinical experience and skillful judgment in planning and executing an intervention, and using the feedback that follows to know whether it made a positive difference.

Hypnosis does many things that are immediately relevant to helping depressed individuals. Hypnosis (a) helps people focus, (b) facilitates the acquisition of new skills, (c) encourages people to define themselves as more resourceful than previously realized (enhancing their self-image as a result), (d) makes the transfer of information from one context to another easier and more efficient, (e) establishes helpful subjective associations more intensively, (f) provides learning to be more experiential and meaningful, and (g) defines people as active managers of their internal world. Hypnosis helps people sharpen key perceptual distinctions, allows them a safe distance from powerful feelings, and helps them proceed with new possibilities in a deliberate behavioral sequence, rehearse new responses, develop undeveloped personal resources, and detach from a sense of victimhood. No one gets past depression without achieving all of these things and more.

What does one say to a client to bring about such changes? How does one know when to target which specific pattern in a client’s depressive phenomenology? These are vitally important questions, and it is my privilege to be able to have so many experts I deeply respect help to answer them in the chapters they have contributed to this volume. As you read, I hope you will appreciate as I do the depth of their consideration, their creativity, the practical nature of their advice, their obvious compassion for their suffering clients, and their generous wish to make a positive contribution to a domain of literature so sorely in need of one.

THE ORGANIZATION OF THIS VOLUME

This volume is organized in a similar way to how one typically organizes hypnosis sessions: The flow of the session goes from general to specific. When you do hypnosis with someone, you first orient the person in a general way to the possibility of focusing and the possibility of experiencing (learning, discovering) something meaningful that has the potential to be helpful. Once the person has
accepted this therapeutic framework, the clinician can then introduce specific ideas or images to consider, engage with, and apply in the service of personal growth.

This book is divided into four sections that flow from general to specific. The first section is a general one, orienting you to what it is about depression that is debilitating and clinically challenging, and what it is about hypnosis that can be helpful. The concepts and methods described in the first four chapters are broadly applicable in a wide variety of cases.

The second section narrows the focus to more specific dynamics of effective treatment: These three chapters address the ubiquitous patterns of negative expectancy, anger, and rumination and insomnia in depressed individuals, and provide specific ways of addressing them.

The third section narrows the focus even further to the use of hypnosis in treating depression that either is comorbid with other conditions or exists in special populations. These include comorbid eating disorders, children and youth populations, comorbid posttraumatic stress disorder and pain patients, and children on the autistic spectrum.

The fourth and final section addresses two key issues in treatment: how to view antidepressant medications in light of evidence suggesting that a significant component of their effectiveness is the result of suggestion, and how to reduce the client’s vulnerability to relapses when depression is well known to be a chronic phenomenon (Pettit & Joiner, 2006). In a good clinical hypnosis session, the client is typically given a summary of the session’s key points as well as encouragement in the form of posthypnotic suggestions to think beyond the immediacy of the suggestions just given. The final chapter, in a similar way, can be viewed as an elaborate posthypnotic suggestion regarding applying the important points made throughout the rest of the book. But, just to make sure no one misses these along the way, I have added a section to the conclusion of each chapter called “Editor’s Summary” in which I draw your attention to the chapter’s key points and methods.

I hope you find the chapters contained herein both absorbing and empowering.

Michael D. Yapko, Ph.D.
Fallbrook, California
http://www.yapko.com

REFERENCES

INTRODUCTION


Section I

BROAD APPLICATIONS
OF HYPNOSIS IN
TREATMENT
Hypnosis in Treating Symptoms and Risk Factors of Major Depression

MICHAEL D. YAPKO

OVERVIEW

Depression is an urgent and widespread problem.¹ Currently, nearly 20 million Americans are known to be suffering with the disorder, and the rate of depression in the United States is on the rise in every age group (National Institute of Mental Health, 1999). Each afflicted individual directly affects others (e.g., family and friends), multiplying the number of people touched by depression to many tens of millions. Realistically, we are all affected by depression, even if only indirectly, by having to share in the hurtful consequences of the many antisocial behaviors (such as child abuse and drug abuse) that often have their origin in badly managed depression (Weissbourd, 1996).

The primary purposes of this chapter are twofold: first, to highlight some of what we already know about the nature of major depression (i.e., major depressive disorder) and what works in its treatment; and, second, to draw attention to how clinical hypnosis can further enhance aspects of the treatment process. This chapter considers hypnosis as part of a psychotherapy regimen for major depression only, and does not address either medication issues or other forms of depression (such as bipolar disorder, depressed phase), although concepts and techniques

¹This chapter was originally published in the American Journal of Clinical Hypnosis (October 2001, 44 (2) pp. 97–117) as two separate companion papers. It is modified and reprinted here with permission of the American Society of Clinical Hypnosis.
might apply to dysthymic disorder, an enduring depression, as well. When psychotherapy is clinically indicated, whether in combination with antidepressant medications or as a sole intervention, hypnosis may sometimes be deemed an appropriate means for facilitating the therapeutic goals. Given the reach of depression into our pockets, our personal relationships, our communities, and our very lives, addressing this complex disorder in a variety of timely and effective ways is an especially urgent challenge that we, as health care professionals, face.

SOME OF WHAT WE KNOW ABOUT MAJOR DEPRESSION

Depression has been and continues to be heavily researched. The amount of data generated by clinicians and researchers has been impressive by any standards and has led to some firm conclusions:

- Major depression has many contributing factors, not a single cause. The three primary domains of the contributing factors are biological, psychological, and social. Hence, the so-called biopsychosocial model predominates (Cronkite & Moos, 1995; Thase & Glick, 1995).
- Depression has many underlying risk factors and a variety of comorbid conditions likely to be associated with it (Stevens, Merikangas, & Merikangas, 1995). In fact, numerous medical conditions (e.g., cancer and heart disease) and psychological conditions (e.g., anxiety disorders and substance abuse disorders) are found to commonly coexist with depression, requiring sharp differential diagnosis and multifaceted treatment planning (American Psychiatric Association [APA], 1994).
- Depression can be successfully managed in the majority of sufferers with medication and/or psychotherapy (Schulberg, Katon, Simon, & Rush, 1998). Although no one antidepressant has been shown to be superior to another in rates of effectiveness, therapeutic efficacy studies show that some psychotherapies (specified below) outperform others in treating depression (Schulberg & Rush, 1994).
- Medication has some treatment advantages, such as a generally faster rate of symptom remission and greater effectiveness in treating the vegetative symptoms, for example sleep and appetite disturbances (DeBattista & Schatzberg, 1995). Medication also has some disadvantages, including uncertain dosing and effectiveness, potentially negative side effects, habituation and “poop-out” (i.e., the drug may eventually stop working), and higher initial rates of relapse (Altamura & Percudani, 1993; Dubovsky, 1997).
- Psychotherapy also has some treatment advantages and disadvantages. The therapies that enjoy the greatest empirical support are cognitive, behavioral, and interpersonal approaches (Depression Guideline Panel,
The advantages include therapy’s focus on skill building and the associated reduced relapse rate, the value of the therapeutic relationship, the greater degree of personal empowerment, and the potential to not just perform a “mop-up” of preexisting problems but to instead teach the skills of prevention (Seligman, 1990; Yapko, 1999). The disadvantages of psychotherapy include the greater reliance on the level of clinician competence (i.e., experience and judgment), the greater time lag between the initiation of treatment and the remission of symptoms compared with medications, the lesser effect in reducing vegetative symptoms, and the potential detrimental side effects of client exposure to a clinician’s particular theoretical or philosophical stance (Mondimore, 1993; Thase & Howland, 1995).

- The extraordinary ongoing success of the Human Genome Project has highlighted the complex relationship between genetics, environment, and specific disorders. Genetic vulnerabilities or predispositions exist, but they operate in association with environmental variables that may increase or decrease their likelihood of expression (Siever, 1997). In the specific case of (unipolar) major depression, the genetic contribution has been shown to be significant, with environmental factors (both social and psychological) appearing to also have significant influence in its onset (Kaelber, Moul, & Farmer, 1995). (In contrast, the genetic component of bipolar disorder has been shown to be a strong one; Dubovsky, 1997.) The relationship between neurochemicals and experience is bidirectional, meaning environmental triggers influence neurochemistry at least as much as neurochemistry influences experience (Azar, 1997; Dubovsky, 1997; Siever, 1997). There is evidence to suggest that psychotherapy may be a means for directly and/or indirectly affecting neurotransmitter levels in the brain, perhaps in some a parallel to the effects of medication (Schwartz, 1996).

Research has yielded many other insights about depression, of course, but the above statements reflect a high level of general consensus among depression experts.

SOME OF WHAT WE KNOW ABOUT TREATING DEPRESSION WITH PSYCHOTHERAPY

A number of important insights about major depression and suggestions for its treatment were articulated in the depression treatment guidelines developed by the U.S. Agency for Health Care Policy and Research (AHCPR), now the Agency for Healthcare Quality and Research (AHQR) (Depression Guideline Panel, 1993):
1. Three psychotherapies were shown to have the greatest amount of empirical support: cognitive, behavioral, and interpersonal. These are identified as the psychotherapies of choice, and any or all can be applied according to the client’s symptom profile (not the clinician’s preferred orientation).

2. Psychotherapy should be an active process in the way it is conducted, involving active exchanges between clinician and client that would typically involve providing psychoeducation, the development of skill-building strategies, the use of homework assignments, and the use of the therapy relationship as both a foundation and a vehicle for exploring relevant ideas and perspectives.

3. Therapy should focus on not only problem solving but also the teaching of problem-solving skills, especially as they relate to symptom resolution, the guidelines’ suggested focus of treatment.

4. Effective therapy need not have a historical focus. According to the treatment guidelines, the most effective therapies are goal-oriented, skill-building approaches. None of them focus on attaining extensive historical data to explain the origins of depression. Rather, they focus on developing solutions to problems and coping skills for managing symptoms (Schulberg & Rush, 1994).

Hypnosis is especially amenable to each of these psychotherapeutic applications, because it, too, is an active and directive means of intervention. The same indications and contraindications as articulated in the treatment guidelines (Depression Guideline Panel, 1993) prevail when applying hypnosis, particularly the recommendation that clinicians adapt their approach according to the patient’s symptom profile rather than a specific theoretical allegiance.

**TREATMENT GUIDELINES AND DEPRESSIVE RISK FACTORS**

In performing the extensive review of clinical and research literature in order to prepare the depression treatment guidelines, the Depression Guideline Panel formed the conclusion that trying to find a specific origin for an individual’s depression was unnecessary in promoting recovery. This sharply distinguishes what might be termed an *event-driven perspective* (the view that depression has its origin in specific historical events that must be identified and “worked through”) from what could be called a *process-driven perspective* (the view that depression has its roots in ongoing ways of erroneously or negatively interpreting or managing various life experiences). Recognizing that depression arises for many reasons of a process-driven nature accentuates the realization that by the time depression strikes most individuals, one or more risk factors
(such as perceptual style, cognitive style, and level of social and problem-solving skills) have already been well in place (Seligman, 1989).

As stated earlier, depression is the product of many contributing variables. Can hypnosis be used in ways that address risk factors and the process underlying the formation of some forms of depression? In this article, I offer clinical experience in using hypnosis in just such a manner.

**IS CLINICAL HYPNOSIS AN EMPIRICALLY SUPPORTED TREATMENT FOR DEPRESSION?**

There is a large body of clinical evidence and a growing body of empirical evidence that hypnosis can contribute significantly to positive treatment results in a variety of ways (i.e., directly and indirectly) related to depression. Specifically, a considerable literature already amassed attests to the value of hypnosis as a tool of empowerment, especially important in diminishing depression. In fact, clinical reports in professional books and scientific journals that describe symptom improvement in various disorders following the use of hypnosis routinely report a diminution of depression. These studies specifically mention depression reduction when describing positive results in treating pain, anxiety, and other physical and psychological symptoms (Crawford & Barabasz, 1993; Lynch, 1999; Montgomery, DuHamel, & Redd, 2000; Moore & Burrows, 1991; Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997; Yapko, 1993).

Therapeutic efficacy research involving hypnosis specifically for depression has, to this point, been essentially nonexistent. Practitioners of hypnosis are generally not researchers, and clinical researchers have generally focused on evaluating specific forms of therapy and not therapeutic adjuncts such as hypnosis. Further complicating matters is the history of hypnosis in relation to depression in particular. It was widely believed (and apparently still is, in some areas) that depression was a specific contraindication for the use of hypnosis (Crasilneck & Hall, 1985; Spiegel & Spiegel, 1978; Yapko, 1992). No controlled studies had been attempted to either validate or invalidate that conventional wisdom.

Another reason hypnosis has been excluded from efficacy research concerns the very nature of depression itself. Depression is a global construct that clinicians employ merely for the convenience of having a common clinically descriptive language. In fact, depression is composed of many specific patterns of cognition and behavior, and numerous multidimensional symptoms such as those listed in *DSM-IV* (APA, 1994). The value of the global term depression is reduced when considering its variations in individual appearances. In this article, I advocate the use of hypnosis to address specific patterns and risk factors, rather than attempting to resolve a client’s depression in a global sense.

Hypnosis has been evaluated for its therapeutic merits in a number of relevant arenas. Research shows that treatments that also employ hypnosis compared with the same treatments not employing hypnosis have a significantly more favorable
HYPNOSIS AND TREATING DEPRESSION

outcome (Kirsch, Montgomery, & Sapirstein, 1995; Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000; Schoenberger, 2000). However, it is admittedly an extrapolation of available data to suggest that hypnosis can enhance treatment results for depression in particular. Undoubtedly, this is a valid concern to those who want therapeutic efficacy data specific to the value of hypnosis in treating major depression. Until such research data become available, we can rely on the strong clinical evidence that indicates that when it is integrated with other established therapies, hypnosis can be helpful in addressing and resolving many of the most troublesome components (i.e., patterns and risk factors) of depression.

SOME OF WHAT WE KNOW ABOUT APPLYING HYPNOSIS IN PSYCHOTHERAPY

There is substantial evidence that psychotherapy for the treatment of depression can be highly effective (Antonuccio, Danton, & DeNelsky, 1995). Wherever psychotherapy may be well applied, so can the use of clinical hypnosis, because the two share the underlying mechanisms of communication and influence and are fundamentally inseparable (Spanos & Coe, 1992; Yapko, 1995, 2003).

Hypnosis encompasses a wide variety of concepts and methods that share a common denominator of appreciating that people often have more abilities than they may consciously realize. Hypnosis can help make those abilities better defined and readily accessible. By considering those psychotherapies that have already received empirical support for being efficacious for depression (i.e., cognitive, behavioral, and interpersonal therapies), we can better appreciate where hypnosis might help to further amplify their therapeutic components, such as their collective focus on process over content (i.e., considering how people think, behave, or relate rather than what they think or do) and their emphasis on active participation in treatment.

HYPNOSIS AND BUILDING REALISTIC EXPECTANCY

One of the strongest factors contributing to the viability of hypnosis as an intervention tool is termed expectancy (Coe, 1993; Kirsch, 2000). Expectancy refers to that quality of the client’s belief system that leads him or her to believe that the procedure implemented by the clinician will produce a therapeutic result. Positive expectancy for treatment involves multiple perceptions: The clinician is seen as credible and benevolent; the procedure seems to have a plausible, perhaps even compelling, rationale; and the therapy context itself seems to support its application. Thus, by the client’s being instructed in the value and the methods of hypnosis, whether directly or indirectly, an expectation is established that the associated procedures will have some potentially therapeutic benefit, increasing the likelihood of their actually doing so (Barber, 1991; Zeig, 1980).
Expectancy is an especially critical issue in the treatment of major depression. Cognitive theory in particular has viewed depression as existing on a 3-point foundation of negative expectations, negative interpretation of events, and negative self-evaluation (Beck, Rush, Shaw, & Emery, 1979). An individual’s negative expectancy for life experience is a cognitive pattern and risk factor that has been associated not only with difficulties in the realm of mood but also in poorer physical health, poorer social adjustment, and diminished productivity. Furthermore, negative expectancy has been associated to lowered treatment success rates (Seligman, 1989, 1990). At the extreme, negative expectancy in the form of a pervasive sense of hopelessness can be associated with suicidality (Beck et al., 1979; Beck, Brown, Berchick, Stewart, & Steer, 1990). Establishing positive expectancy in a variety of specific contexts may be a necessary ingredient in effective treatment (Yapko, 1988, 1992, 1993, 2001a, 2001b). Age progression in hypnosis as a vehicle for concretely establishing a positive and motivating view of the future may be helpful in this regard (Torem, 1988, 1992; Yapko, 1988, 1992, 2003).

Important as it may be, however, a focus on expectancy to the exclusion of other factors of potential therapeutic effectiveness can also be limiting. Someone can have positive expectations yet generate no meaningful therapeutic results for a variety of reasons. For every client who began therapy with high hopes that went unfulfilled, the point is clear that positive expectations are not enough. They must be realistic, and they must occur within a larger therapeutic framework that is able to convert the promise of expectancy into the reality of a goal accomplished. Expectancy matters, but even positive, well-defined expectations can become a source of problems rather than a source of solutions if they are unrealistic. Thus, a clinician must be able to educate the client in the process of distinguishing realistic from unrealistic expectations, whether positive or negative. Hypnosis can help in this therapeutic endeavor by encouraging a strategy for “reality testing” (Yapko, 2001b).

EXAMPLES OF DEPRESSIVE SYMPTOMS AND RISK FACTORS AS INTERVENTION TARGETS

The *DSM-IV* (APA, 1994) lists a depressed mood most of the day and a loss of interest in or lack of pleasure from things normally experienced as interesting or pleasurable as foundational symptoms of depression. Additionally, *DSM-IV* indicates that the depressed client may experience significant appetite disturbance and an associated weight change, a sleep disturbance, agitation, fatigue, feelings of worthlessness, excessive or inappropriate guilt, diminished concentration, and thoughts of death or suicide and even make suicide attempts.

A major cross-cultural study published in the *Journal of the American Medical Association* (Weissman et al., 1996) affirmed most of *DSM-IV*’s (APA, 1994) list of symptoms as among the most common symptoms of depression.
found across cultures. Most frequent of all symptoms were the symptoms of insomnia (but, interestingly, not hypersomnia) and feeling fatigued most of the time.

Targeting insomnia with hypnosis has special importance because insomnia is both a symptom and risk factor. (See my insomnia chapter in this volume [Chapter 7] for a more in-depth consideration of this topic.) For reasons currently unknown, there is a correlation between insomnia and later relapses. For someone suffering a depressive episode and experiencing a sleep disturbance, if the sleep disturbance remits when the depressive episode ends, the person is statistically at a lower risk for later relapses. If, however, the depression lifts and the person’s disturbed sleep does not return to normal, the person is at a higher statistical risk for later relapses (Kravitz & Newman, 1995). Thus, assessing the client’s sleep is important for clinicians to do. Actively intervening with hypnosis to enhance sleep (through suggestions for both relaxation and diminished rumination) might well have a profound impact on both the course of depression and the risk for later relapses. Research in this area is clearly needed.

The relationship between insomnia and fatigue, another frequent symptom of depression, seems obvious. When someone sleeps poorly, how can he or she feel an adequate level of energy? Furthermore, if someone has a global cognitive style that may lead him or her to see all problems as piled together in an insurmountable mountain of woes, how can he or she feel energized to want to move through them? Thus, addressing insomnia and simultaneously addressing any global thinking that may contribute to a sense of being overwhelmed and exhausted (just by thinking of all the problems to be faced) become vital aspects of treatment. How many people become depressed simply from unrelenting fatigue: an ongoing sense of never getting caught up, always having too much to do and not enough time to do it, routinely feeling sleep and fun deprived, and regularly living from frantic moment to frantic moment (Bell, 1997)? Thus, fatigue not only is a depressive symptom but also may reflect both a depressogenic patterning of perception and behavior that are likely risk factors for later depressive episodes as well.

Helping people learn to “slow down,” curtail their ruminations, establish stronger boundaries between their work and personal lives, and better separate problem-solving time from sleep time are all worthwhile goals to address in treatment. These are life skills that may be learned with clinicians serving as teachers or guides. Hypnosis can be an effective vehicle for teaching such skills, even if just used to teach basic relaxation skills, perhaps even outperforming sleep medications. As one prominent sleep and depression researcher wrote, “[U]sing deep muscle relaxation and other forms of progressive relaxation strategies may help individuals to fall asleep more quickly … controlled studies suggest effects as strong as, and with greater durability than, those observed with sedative hypnotics” (Thase, 2000, pp. 49–50). The quality of the symptoms a client presents can point the clinician in the direction he or
she might go if the client is to be sufficiently empowered to get some control back and reduce or eliminate symptoms, for as long as a client feels victimized by his or her symptoms, recovery from depression is extremely unlikely (Cohen, 1994).

The goals of therapy include not only reducing or eliminating symptoms, but also reducing or eliminating associated risk factors for further episodes. Depression is often described in the literature as a recurrent disease, and relapse statistics confirm an ever higher probability of later episodes the more episodes one has (Glass, 1999). Using the previous example of insomnia as a target, insomnia is the symptom. But, unless the individual’s ruminative coping style is altered, and unless the person’s global cognitive style is addressed by teaching better compartmentalization (boundary) skills (e.g., to separate problem-solving time from sleep time), the mere teaching of relaxation skills is unlikely to be of enough help to the person to overcome depression.

Patterns of client experience that underlie symptom structures might include (a) cognitive style (Is the person’s style of thought abstract or concrete? Global or linear? What is his or her attributional style?), (b) response style (Is the person more self- or other-directed? Open or guarded?), (c) attentional style (Is he or she more focused or diffuse? Focused on saliency or irrelevance?), and (d) perceptual style (Does the person tend to focus more on similarities or differences between experiences? Does he or she tend to magnify or diminish perceptions?) (Yapko, 1988, 1997).

By identifying these and other patterns of self-organization, the clinician is in a stronger position to aim interventions at more meaningful targets. Perhaps the best researched of such risk factor patterns is attributional style, the characteristic ways that a person explains life events to him or herself, or to others (Seligman, 1989, 1990). Attributional style encompasses such dimensions as personalization (“Are negative events due to me or others?”), permanence (“Are negative events permanent or transient?”), and pervasiveness (“Do negative events adversely affect all things in my life or just some things?”) (Sacco & Beck, 1995). Without intervention, one’s attributional style is an enduring way of organizing subjective perceptions. The typical depressive pattern of seeing negative events in life as personal, permanent, and pervasive (so-called internal, stable, and global attributions) represents a high level of risk for depressive episodes whenever life gets painful (Seligman, 1989). Thus, a risk factor level of intervention would strive to teach the person to make realistic attributions context by context, rather than maintaining a negative attributional style pattern that increases the risk for depression.

Risk factors for depression may be addressed singly or in combination. The therapeutic goal is to introduce variability and accuracy into the pattern according to situational cues. Thus, instead of interpreting events in a rigid, consistent manner (e.g., routinely taking things personally, even when they’re not personal), the person would learn to distinguish when it is and isn’t personal,
and how to respond to specific contexts flexibly and appropriately (Yapko, 2001b).

The heart of therapy may therefore lie in teaching clients (depressed or otherwise) to identify which subjective patterns for perceiving and responding to life demands will likely work well in a given context and then using one’s hypnotic and strategic interventions to deliberately help them incorporate those patterns. Such a proactive approach requires people to read situations accurately in order to better know what the situation requires (e.g., an impersonal response) and what specific resources one has to effectively meet those demands (e.g., an effective strategy for reminding oneself that the criticism isn’t personal, based on well-elaborated criteria).

This is precisely what people in general and depressed people in particular don’t do, however, to their own detriment. For example, people may want to self-disclose (e.g., “Let me tell you what I think of this job”) but then don’t read the context well in order to recognize this isn’t a safe place for self-disclosure (e.g., it’ll get back to the boss, and the person is likely to be punished).

Relating to the context means adapting to situations flexibly. Facilitating flexibility in clients while simultaneously encouraging them to be more observant (therefore less internally and more externally oriented) and critical in their thinking are primary goals of each of those therapies that enjoy the greatest amount of empirical support for their effectiveness in treating depression. Hypnosis can help magnify a key learning underlying adaptability that “every pattern is valuable somewhere, but no pattern is valuable everywhere.”

The clinical literature and published treatment guidelines for treating major depression indicate the importance of teaching specific skills to depressed clients, such as the ability to recognize and self-correct cognitive distortions (i.e., cognitive therapy), the ability to develop effective strategies for performing life tasks (i.e., behavioral therapy), and the ability to relate to others in positive and meaningful ways (i.e., interpersonal therapy). The efficacy data on the treatment of depression consistently affirm that when people are empowered, and when they learn the skills for living better, they are more likely to recover (Lewinsohn, Munos, Youngren, & Zeiss, 1986; Schulberg & Rush, 1994).

Hypnosis has been described in the clinical literature as a significant means for enhancing a sense of personal empowerment in a wide array of client populations. Through the development of personal resources that were previously unrecognized or undeveloped by the client, or through the facilitation of relaxation and a psychological readiness to learn new skills, the capacity for hypnosis to increase the sense of—and even the reality of—personal control that individuals can apply in their own behalf carries a strong potential to reduce the sense of victimization associated with depression, and even many of the symptoms of depression itself.

In the remainder of this chapter, one such intervention strategy for empowering depressed clients is presented. It aims to disrupt the process by which people can become caught up in their own depressogenic beliefs.
HYPNOTIC INTERVENTION FOR AMBIGUITY AS A DEPRESSIVE RISK FACTOR

Ernest Hilgard, paraphrasing Theodore Sarbin (1950), once described hypnosis as “believed-in imagination” (Ernest Hilgard, personal communication, 1988). That is an astute framing, capturing both the flesh and spirit of hypnosis. To go a step further, though, one could also say that anyone’s view of life is similarly a product of believed-in imagination. For one person to form from the ambiguous stimulus of life a belief that “life is wondrous and joyful” whereas another forms the belief that “life is a miserable burden to endure” represents two different believed-in imaginations that have specific and measurable consequences for each individual.

The body of literature describing the relationship between the quality of one’s beliefs and one’s mood is substantial: It is well established that the positive, optimistic person is less likely to suffer depression. Likewise, such a person will also benefit (a) physically by likely suffering less serious illness and higher rates of recovery; (b) in terms of productivity, having higher levels of focus, persistence, and frustration tolerance; and (c) in terms of greater sociability and likeability, enjoying the many health and mood benefits associated with having more close and positive relationships (Peterson, 2000; Seligman, 1989, 1990; Yapko, 1997, 1999, 2001b).

The overlap between depression as a problem and hypnosis as a means for addressing it centers on the believed-in imaginations of the depressed client. Beliefs that “life is unfair,” “I’m no good,” or “I’ll never be able to do that” are just a very few of the many self-limiting and even self-injurious beliefs that depressed individuals may form and come to hold as true. Thus, it is no coincidence that cognitive-behavioral therapies, which challenge depressed individuals to learn how to identify and self-correct their cognitive distortions and behave more effectively, have been shown to be highly effective approaches (Clarkin, Pilkonis, & Magrude, 1996; Greenberger & Padesky, 1995).

A variety of therapeutic efficacy studies have been published attesting to the added value of hypnosis to established treatments, especially cognitive-behavioral approaches (Lynn et al., 2000; Schoenberger, 2000). No formal studies have yet been done specific to the use of hypnosis with depressed populations. As discussed earlier, however, depression is a global term. In fact, depression is composed of many different components, including cognitive patterns (such as attributional style), behavioral patterns (such as avoidant coping styles), and relational patterns (such as hypercriticalness). Many of these components have been addressed successfully with hypnosis (Kirsch, 1996; Schoenberger et al., 1997). In fact, much of what is presented in this chapter could be characterized as cognitive-behavioral therapy performed within a hypnotic and strategic framework (Yapko, 1992, 1995, 2001b).
AMBIGUITY, MAKING MEANING, AND DEPRESSIVE RISK

Ambiguity may well be the most powerful and pervasive risk factor for depression of all known risk factors. Ambiguity in this context refers to the lack of clear meaning associated with one’s various life experiences. Events occur, we observe them occur, but what we most often don’t know is what, if anything, they mean. The great majority of events in life do not have a clear and inherent meaning, leaving each of us the task of having to establish for ourselves our own subjective interpretation of what the meaning or significance is of the event. Similarly, a particular person’s symptoms invite inferences from clinicians: for example, “I think you’re depressed because your thinking is distorted and you need to learn to identify and self-correct your cognitive distortions” or “I think your depression is caused by too low a concentration of serotonin in your brain.” Depression, like almost any problem, can be interpreted and treated from many viewpoints.

In response to any life event, however minor or major, the formation of an idiosyncratic meaning represents the heart of a belief system, whether self-reinforced (“I believe it no matter what others might think”) or culturally reinforced (“Any true American would believe this”). Beliefs are multidimensional, encompassing feelings, physiology, and behavior, as well as the obvious cognitive components, and all will need to be addressed in a comprehensive intervention.

To diagnose a depression is not the same as declaring that it has a specific meaning. Aaron Beck was right to have questioned decades ago whether instead of depression being the outgrowth of some deeper intrapsychic conflict, depression might itself be the problem and the symptoms of depression the most appropriate targets for treatment (Beck et al., 1979). This provided a foundation for a clever “divide and conquer” strategy that works quite well, as efficacy studies indicate. Now, decades later, we can recognize that each of the treatments that has been deemed “empirically supported” for treating depression is short term and focuses on the dual goals of skill building and symptom resolution (Depression Guideline Panel, 1993; Schulberg et al., 1998).

Cognitive therapy (CT) in particular has flourished as perhaps the best studied and most systematic form of psychotherapy (Dobson, 1989). Aaron Beck and Albert Ellis in particular spawned a revolution in the field of psychotherapy by shifting the focus away from what someone thinks (the content) to how someone thinks (the process). Whether assessing the specific cognitive distortions in the context of Beck’s cognitive therapy or the irrational thoughts in the context of Ellis’s rational emotive behavioral therapy (REBT), the underlying mechanism for the development of depression is in the inability to distinguish inferences from facts (Sacco & Beck, 1995; Ellis, 1997).

Why are there cognitive distortions or irrational thoughts to have to correct in CT or REBT? Why can’t people willingly and with self-awareness sidestep the vulnerability of their own beliefs? Consider as an example a so-called cognitive
distortion, “jumping to conclusions,” the error of reaching a conclusion despite the lack of supportive evidence. Why jump to conclusions, if not merely to have a conclusion? But the salient question is “Why the need for a conclusion?” What is it about ambiguity that is so uncomfortable and compelling in the force it generates to reach a conclusion, even at the risk of reaching an incorrect and potentially depressing one?

RECOGNIZING AND TOLERATING AMBIGUITY AS THERAPEUTIC GOALS IN HYPNOSIS

For as long as an individual is unable to tolerate uncertainty, he or she will be motivated to continue forming meanings about life experience with little or no insight into the interpretive process and, thus, suffer the mood consequences when they are negatively distorted yet accepted as “true.” Thus, one of the most basic goals in treating therapy clients in general, and depressed clients in particular, is to teach them how to recognize and tolerate ambiguity. It is a therapeutic goal that even precedes identifying specific cognitive distortions or irrational beliefs in the client. Before someone is taught to avoid jumping to conclusions (or personalizing, or thinking dichotomously, or forming any other cognitive distortion), that person would have to become more comfortable with no conclusions, that is, reduce the drive to have an answer. By addressing the issue of ambiguity in therapy and making it a primary target of a specific hypnotic intervention, the larger goals of therapy such as teaching skills in rational thinking are well facilitated (Seligman, 1990).

The primary therapeutic goals, therefore, are to (a) learn how to quickly recognize ambiguity in situations, (b) be on guard against one’s own tendency to interpret such events in some patterned and hurtful way that may not be objectively true, and (c) develop a tolerance for ambiguity that permits comfort with not knowing. Not knowing what’s “right” or what’s “true” in a given context can be either empowering or victimizing, depending on one’s perspective. Not knowing can be an empowering spur to finding out.

The positive value of cognitive therapy in particular has been well documented in the literature, and it is clearly a treatment of choice for depression (Depression Guideline Panel, 1993). Cognitive skills can be learned more easily with hypnosis as a vehicle of experiential learning, and they can be more easily learned when the basic human need to believe something, anything, can be reduced (Beck, 1976; Kirsch, 1993; Kirsch et al., 1995; Schoenberger, 1996; Yapko, 1992, 1997, 2001b). Furthermore, hypnosis can provide anxiety reduction, lowered agitation, and reduced ruminations. Hypnosis can thus be a means for demonstrating to the client that his or her symptoms are malleable, helping to build the positive expectancy that is crucial to recovery from depression (Beck, 1997; Seligman, 1990; Yapko, 1992).
STRUCTURING HYPNOSIS SESSIONS FOR RECOGNIZING AND TOLERATING AMBIGUITY

Table 1.1 outlines a generic, process-oriented structure (developed and used with depressed clients in my clinical practice) for a formal hypnosis session designed to encourage recognizing and tolerating ambiguity.

In calling the above strategy’s structure *generic*, not only will the content of the clinician’s verbalizations vary according to the unique attributes of each individual client, but the steps themselves may vary according to what needs more or less amplification in the client’s experience. One client might respond better to direct suggestions for greater comfort with uncertainty, whereas another client may better respond to metaphors about brilliant people who are adept at publicly stating, “I don’t know,” in response to questions supposedly in their area of expertise. As always, it is a matter of clinical judgment as to what a particular client is likely to best respond. The more feedback from the client a clinician uses in formulating an approach, the more likely the interaction can be tailored appropriately (Yapko, 1995, 2003).

**Describing the Strategy**

Every hypnosis session has an identifiable structure, just as every psychotherapy session has a structure. From first greeting the client to saying goodbye at session’s end, there is a sequence for how a session progresses. Sequences will vary, of course, with the goals and methods of specific sessions, but there are sequences nonetheless. It can be helpful to have structured sequences for conducting hypnosis sessions, a progression of ideas and suggestions that move the client in the direction of the session’s goals.

**Table 1.1 A Generic Structure for Hypnotically Facilitating, Recognizing, and Tolerating Ambiguity**

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<thead>
<tr>
<th>Orientation of client to hypnosis</th>
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<tr>
<td>Induction processing</td>
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<tr>
<td>Building a response set regarding uncertainty</td>
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<tr>
<td>Introduction of the process of inference</td>
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<tr>
<td>Suggestions and/or metaphors regarding inferences</td>
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<tr>
<td>Introduction of the value of “knowing”</td>
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<tr>
<td>Suggestions and/or metaphors regarding knowing</td>
</tr>
<tr>
<td>Introduction of the value of “not knowing”</td>
</tr>
<tr>
<td>Suggestions and/or metaphors regarding not knowing</td>
</tr>
<tr>
<td>Reframing not knowing as desirable in some contexts</td>
</tr>
<tr>
<td>Suggestions for identifying when not knowing is desirable</td>
</tr>
<tr>
<td>Posthypnotic suggestions for integration</td>
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<tr>
<td>Closure</td>
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<td>Disengagement</td>
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The first step is to orient the client to hypnosis. Any time formal (overt) hypnosis is to be employed, there needs to be a statement (or two or three) that encourages the client to prepare him or herself for the hypnotic process to begin. A common tactic is to simply ask, “Have you experienced hypnosis previously?” or to suggest that he or she “find a comfortable position in which to sit” as a means for getting the client “on the track” of thinking about and preparing for hypnosis.

The induction process is whatever means a clinician uses to absorb and direct the client’s attention. Inductions can be structured (e.g., countdowns) or conversational (“Can you recall how good it feels to close your eyes and get absorbed in relaxing images?”). The chief function of an induction is to facilitate some degree of dissociation in the client, so the actual method employed is a secondary consideration. The primary consideration is the client’s ability to relate well to it and get absorbed in it, whatever it is.

The building of a response set is the means for establishing a momentum in client responsiveness. To expect the client, following an induction, to instantly be able to relate to and absorb new ideas isn’t usually realistic. Most clients need time to progressively develop their hypnotic responsiveness over the course of a session, and the goal of this step is to deliberately assist in that process. An example of the most commonly used response set is the so-called yes set, a means for building agreement and receptivity in the client to further suggestions. The client may be offered a series of truisms (i.e., suggestions so obviously true there is no legitimate basis for rejecting them) that he or she naturally will agree with, establishing a momentum in the direction of more easily agreeing with whatever else the clinician might say. In the context of this strategy where the goal is to increase awareness and acceptance of uncertainty, a response set might include such suggestions as the following:

There are many different things I could say intending to help you relax … and I don’t know which of them would be the most valuable in helping you get deeply comfortable … and you don’t know exactly what I’m going to talk about that will be helpful to you … and you don’t know quite yet how you’ll come to think differently about yourself … and you don’t really know at just what moment you’ll find yourself so wonderfully comfortable with the possibilities you’ll discover here….

In each suggestion, uncertainty is amplified but also associated to positive possibilities.

Hopefully, receptivity is now well established and the clinician can introduce the process of inference to the client. Direct and/or indirect suggestions can be employed in the service of getting across the concept that ambiguity invites inferences. Suggestions to illustrate the process (in personal and/or impersonal terms according to client responsiveness) are used to teach the client that forming inferences is normal (thereby depathologizing the client) but self-monitoring will be necessary because they are not always accurate. For example, one might say,
I’m sure you’ve had the experience of calling someone … getting his or her answering machine … and leaving a message … and when the person doesn’t call back in a time frame you think reasonable … you might wonder what it means … whether the person is busy … whether the answering machine worked properly … whether the person is avoiding you for some reason … or any of many possible reasons … and how do you know what the real reason is? … But it’s human nature to speculate about what things that happen mean … and the real skill is knowing when you’re speculating … and when you have evidence to affirm your interpretation … after all … you don’t want to react to something on the basis of an incorrect interpretation … .

Introducing the value of knowing is a validation of the human need to believe, the human need to understand. Another step in depathologizing the client, the goal at this stage is to affirm to the client that scientific and social progress originate in the desire to know, but the distinction between truly knowing versus merely imagining can begin to emerge. So, following the above example of no return phone call, one could say,

And all the speculations about why the person didn’t call back … are normal … and reflect our desire to make sense out of things that don’t seem to make much sense … and whether you want to understand something like why someone doesn’t call back, or something much more complex like how the universe works…. It’s one of human beings’ greatest strengths … that we strive to understand … and make sense of the things that go on around us….

In the next step, the value of not knowing is introduced. The goal at this stage is to depathologize not knowing. Suggestions are offered to highlight that there are questions in life that no amount of analysis will ever answer, and that not having an answer not only is acceptable, but also may at times be the best possible outcome. The client, hopefully, begins to absorb the notion that not knowing is often preferable to “knowing” something that is merely made up. In line with the phone call example, one could continue by saying,

And the fact that you can generate so many different explanations for why someone doesn’t call back … gives you an opportunity to realize you don’t know why he or she didn’t call back. … You can make lots of guesses … but you really don’t know for sure. … And when you don’t know how to explain something … it’s perfectly all right to say you don’t know … after all, no one really expects you to know why someone else doesn’t return a phone call. … It’s a gift of honesty and clear thinking when someone says, “I don’t know,” instead of making up an answer that might well be wrong. … There are so many times in life you’d rather be given no answer than a wrong one…. .

In the next step involving reframing, the client is taught a strategy, an internal mechanism of sorts, that he or she can use to discriminate what is known from
what is inferred. Such a strategy might be something as simple as the following direct suggestion:

Before you reach a conclusion, *any* conclusion … ask yourself, “How do I know?” and if your answer is “I just feel it’s so” or “I just think so” … then know you are forming a conclusion with no apparent objective data. … That doesn’t mean you are wrong, necessarily, but it increases the chances considerably. … So, you can remind yourself to go to the next step and ask yourself, “Are there any objective data to support this?” and maybe there will be or maybe there won’t be, but you’ll notice the quality of your ideas and conclusions getting better and better over time… .

The function of the posthypnotic suggestion is to associate new learnings to desired contexts. Posthypnotic suggestions are a routine part of hypnotic intervention, for without them, new learnings would be unlikely to generalize to the relevant contexts of the client’s life. So, a clinician might offer a posthypnotic suggestion such as the following:

And each time throughout the day you encounter a situation where the meaning isn’t clear to you, or can even anticipate such an event before it happens, you can recognize there are many different ways to interpret the event … and you can instantly remind yourself you don’t know what it means just yet … but can entertain a variety of interpretations … and can ask yourself directly how you will know which one—if any—it is … and it will lead you to look deeper and you can do so comfortably … knowing you can look for evidence for your views if it exists … and comfortably knowing you can adopt any perspective that might feel good to you … when one interpretation is merely as plausible as another… .

A session’s closure can be suggested permissively, encouraging the client to “do whatever processing you need or want to do to bring this session to a comfortable close.” Disengagement can also be done permissively, encouraging the client to “reorient yourself at a gradual rate that is comfortable for you, and when you’re ready to fully reorient you can do so and allow your eyes to open.”

**SUMMARY**

As the rates of depression continue to rise, and more research attests to the therapeutic value of skill-building approaches in the treatment process, clinicians will need to have more varied and effective means for teaching such skills. Hypnosis has been shown to be an effective vehicle for catalyzing therapeutic interventions. In the treatment of depression in particular, hypnosis holds great potential as a means of helping suffering clients feel less victimized and more empowered to better manage their symptoms and to more easily learn the skills known to reduce depression and even prevent later episodes.
HYPNOSIS AND TREATING DEPRESSION

One of the primary skills one can teach depressed clients is how to recognize and tolerate ambiguity in order to reduce the probability of noncritically accepting one’s depressogenic thoughts and beliefs. A generic hypnosis strategy for achieving this treatment goal was presented with sample verbalizations.

Depression is the most common mood disorder that clinicians are asked to treat. The hopelessness and helplessness of depression are powerful forces that serve to maintain its grip on individual sufferers. There is much that mental health professionals can do to raise the general awareness level in both their clients and their colleagues that hopelessness and helplessness are more about perceptions than facts.

EDITOR’S SUMMARY

- Depression has many causes, and there are many risk factors that can lead to the onset of depressive episodes; treatment can be aimed at both symptoms and risk factors.
- Successful psychotherapeutic treatments generally teach specific life-enhancing skills and define the client’s role as an active one in the learning process.
- Hypnosis can enhance the acquisition of key skills that can serve to reduce depression’s severity, duration, and likelihood of recurrence.
- Positive expectancy for the benefits of treatment helps create a receptivity to new ideas and the possibilities for improvement.
- Specific identifiable patterns of self-organization, such as coping styles, attributional styles, and cognitive styles, are vital to address in formulating interventions; rigid reliance on such patterns can lead to depression when they are at odds with situational demands.
- A primary risk factor for depression is how people cope with uncertainty, or ambiguity; depressed individuals typically project self-limiting and distressing negativity into ambiguous situations.
- Hypnosis aimed at helping the individual to suspend making negative projections and recognize specific situations as ambiguous has both treatment and prevention value; a step-by-step strategy for encouraging, recognizing, and tolerating ambiguity is detailed in this chapter.

REFERENCES


HYPNOSIS AND TREATING DEPRESSION


HYPNOSIS AND TREATING DEPRESSION


INTRODUCTION

Research on depression derived from a cognitive therapy viewpoint has demonstrated a link between depressed mood and a biased recall toward negative information (Lyubomirsky, Caldwell, & Nolen-Hoeksema, 1998; Williams, Teasdale, Segal, & Soulsby, 2000). That is, adults who suffer from depression have been shown to exhibit selectively enhanced recall for negative information. Recent research has shown that this recall bias is mediated by the accessibility of a cognitive schema that contains negative self-references and was likely learned as a result of earlier adverse experiences. This informational recall bias seems to also apply to children. In one recent study, children who displayed a high degree of depression had enhanced recall for negative stories over positive stories when compared with children with less depression (Bishop, Dalgleish, & Yule, 2004). Clearly, this bias toward the negative is capable of exacerbating depression and is, therefore, an appropriate target for therapeutic intervention.

My initial goal with clients who present depression is to assess their degree of lethality and other impairments. I want my clients to help me understand their ongoing experiences in various social settings—especially the stressors, reinforcers, and punishments that they encounter in each of them. Individuals who are employed, for example, may report experiencing many more stressors in the workplace than they do at home. Similarly, it is not uncommon in my practice to find that individuals who are unemployed report far more punishments or stressors in their ongoing family life while imagining that far greater stressors exist in areas of life outside the family that have gone unexplored. For example,
they may feel that they do such a poor job of managing their lives while living in their family that they would likely be even worse off in the workplace. It is important for clinicians to discover the areas in which clients experience the greatest life stressors because these will most likely become targets for both the psychoeducational and experiential interventions that are to follow.

FOUR HYPNOTIC INTERVENTIONS

Retrieving Positive Experiences

**Rationale.** When our learning history teaches us to automatically recall and even savor positive experiences, we may be more likely to grow into adults who, without thinking, can collect, store, and more easily retrieve positive experiences from within. So, when we want or need to feel confident in a group, for example, we can access that quality of experience; when we need to have the experience of aggressiveness to succeed in a job interview, we can access that particular type of experience; or when there are stressors, we can look for relevant personal resources and then are more likely to seek out and feel support from within.

However, many of us do not have a personal learning history that taught the retrieval of positive experiential resources on a global level. Many people have not learned to use their conscious experiences to deliberately bolster themselves. Instead, their learning history taught them to doubt themselves, “tough it out” alone, rarely or never ask for support, push people away, have low expectations, avoid positive expectations, and so on. As a result, many people, or even most people, automatically anticipate a negative experience, and they anticipate, apprehend, and store memories that keep them on guard with the goal of avoiding more negative experiences. This is especially true of people who suffer depression, a disorder in which these negative patterns are commonly manifested (Beck, 1997; Burns, 1999; O’Connor, 2001).

One of the most fundamental teachings from Milton H. Erickson, M.D., was that a cure is having the required experiences (i.e., personal resources) in each context (Erickson, 1980; Erickson & Rossi, 1979, 1981). There are innumerable situations that call for innumerable resources; thus, it would be impossible to list them all. Although some logical agreement may exist about which experiences are relevant to particular situations, each individual will have a unique set of labels for the experiences he or she wishes to have in the course of daily living. It would not be best to ask, “What are the experiences a person who is depressed needs?” Rather, for each individual it seems better to ask, “What are the various experiences this person needs to have in the varied tasks in which he or she engages each day?”

There is a 100% certainty that every client who presents as depressed is at least partly unaware of how to retrieve desired experiences in the course of his or her daily life. Clients who are depressed spend a majority of their time having unpleasant experiences. Although they may state that they wish to feel good, they
do not know how to retrieve positive experiences, and in the absence of relevant strategies, they do not spend any time doing so. Thus, a significant portion of time in therapy is spent training clients to identify and retrieve experiences that they consider desirable. Homework assignments should be given that require clients to spend time retrieving positive experiences on a daily basis in order to reinforce the key learnings of therapy. Furthermore, clients need to learn to enjoy and even savor the positive experiences they retrieve.

During the first session with clients who are depressed, I endeavor to quickly move beyond assessment and begin the process of retrieving positive experiences, either with or without formal hypnosis. Clients will move at varying speeds with regard to this intervention. It is important for therapists to reinforce clients for whatever degree of progress they make.

Method. The basic intervention for retrieving positive experiences is quite simple, yet it eludes most depressed clients. After explaining the importance of retrieving and indulging in positive and desirable experiences as a counterbalance to their emphasis on the negative, I ask clients to begin the hypnosis session by becoming relaxed. If necessary, I lead them through an exercise in systematic relaxation. I then ask them to recall a time when they felt the experience of being safe or some other similarly positive experience. Some depressed clients will claim that they cannot recall any positive memories. They usually can recall a few, however, when they are given sufficient reminders of common enjoyable events. It is permissible to ask them to imagine what it would be like to feel a positive and desirable experience. Clients can use their imagination and pretend to have one, if necessary, although pretending is usually not necessary. If a client can only produce one such positive experience in the first few weeks of therapy, that single experience can (and should) be used repeatedly. Typically, clients begin to recall other positive experiences after participating in this protocol a few times.

I ask them to notice that they have sensory memories (e.g., pictures, sounds and smells) of this earlier experience. They are to try to enrich or revivify the sensory impressions until they begin to remember this earlier time in an experiential way (rather than as merely a spectator). As they remember experientially, they are to allow themselves the luxury of feeling the positive experience both viscerally and emotionally. The following is a sample transcript illustrating this approach:

Stephen: From what you’ve just said, you worry about things all day long, all night long, postpone sleep with your worrying, and possibly even have dreams that concern worrying. And furthermore, you’ve done this for at least the last 22 years.

Clark: Yeah, that’s the way it seems. I worry all the time. [Clark launches into describing some additional area of life wherein he worries.]
Stephen: Do you not know one thing that you never do?
Clark: You mean just feel happy or content or satisfied?
Stephen: Well, yes; I didn’t expect you to make it so clear. You have practiced and become very good at wondering what’s going to happen in the future and being worried about it. In fact, you’re an expert. But you have forgotten to take the time to relax yourself, allow your immune system to recharge, clear your mind, and just have a sense of happiness and satisfaction with something.
Clark: I don’t know how to do that. I never feel that way.
Stephen: I don’t want to seem oversimplified about this, but I think we should spend some time on that very issue. The question is “What does a person do, or how can you specifically have some of those feelings in your life?” And that’s the bottom line, isn’t it?
Clark: What are you getting at?
Stephen: Lean back on the couch, get comfortable, and close your eyes for a moment. I want you to relax for just a moment—maybe for a few minutes. Let your shoulders relax, relax your chest, then let your upper arms, and then your forearms, relax. [A progressive relaxation protocol continues until Clark’s entire body is relaxed.]
   Clark, your conscious mind does not need to do much of anything right now…. Let your unconscious take over … and don’t do anything more than recognize how interesting it is … that you can function without consciously doing anything…. The first thing that I want you to do is focus your attention … focus in a way that will disrupt your normal conscious association … so much so that you’ll have an opportunity to have a new experience…. An interesting way to do this is to concentrate your attention on the area between your eyebrows…. And in the next few moments, I will count backwards from 5 to 0 … and I want you to move your awareness deeper into your brain with each count…. That is, I’d like to have you imagine with each count that your awareness moves back about an inch into your brain…. So that by the time we reach zero … your awareness will be focused on your medulla…. It’s not really possible to know that you have succeeded in this … 5, and going just a little deeper…. Because this is a very unusual situation … 4 … if you concentrate your attention on your hand … you can alter the temperature in your hand…. If you concentrate your attention on your heart … you can change your heart rate … and getting just a little deeper … if you concentrate your attention on your breathing … you can change your breathing … 3, and getting a little deeper … and if you concentrate your attention on your bladder … you can increase or decrease your awareness of a pressure in an area…. But it is indescribable…. I just wanted you to experience how good you can feel … when you concentrate your attention in the middle of your brain … 2 …. a little deeper…. However, it’s very likely that we increase the functioning
of that area ... when we concentrate our attention there ... after all, we increase the functioning of all those other areas when we concentrate our attention on them....

One ... and still deeper.... And in just a moment you're going to be as deeply concentrated in that area of your mind as you have ever been ... and you can transform the words that I say so that they are relevant to you.... Zero.... Now take a moment ... to let the first incident you recall come to mind.... Let yourself skip to the first memory you come to wherein you had a feeling of joy or safety.... It might be a time when you were playing with a puppy that insisted upon licking your face.... Maybe it was a time when you were getting sloppy eating a watermelon ... maybe it was a time when you got an unexpected good grade on a college paper ... or maybe it was a time when you simply relaxed on a beach and soaked up the sunshine for an hour or two.... Just wait and let your conscious mind find out what your unconscious brings forward.... Now, with the slightest memory of such a time ... I want you to make all of the sensory memories more vivid.... Notice what you see.... How bright was it?... How in focus was it?... And who was there?... What was the rhythm of their speech?... What do you remember being said?... What do you remember saying?... What smells do you remember occurring at the time?... Remember all of the senses that you have present in the experience at the time.... And soon, use your imagination if necessary ... you can put yourself back into that situation so that you can remember the actual feelings you had.... You can begin to feel what it was like then.... And, you remember the experience on your face.... Let yourself smile, and even smile the way that you smiled then.... Have that experience again and luxuriate in that feeling.... Hold onto it—all of the feelings—and keep them for a few moments....

Now, before you stop this experience ... allow your awareness to move around through your body.... Become aware, even for a small period of time ... of what it feels like in your shoulders, your stomach, your chest, and your thighs.... Become aware of what it feels like to have a sense of joy in your chest and in your face, in your back and in your legs.... Let your awareness scan your entire body ... and recognize that for just now, you have intensified a memory of the time when you felt joy and safety.... And, you have let these experiences fill your body and your mind with a desirable experience you can have any time you want ....When I count backwards and ask you to come out of hypnosis ... you'll remember a bit of this experience.... Maybe you will remember a lot of this experience. But there will be a hollow effect, and you'll continue to experience a positive feeling for a few moments after the trance is over.... This is what I'd like you to do several times a day between now and our next session....
Twenty, 19, and 18, 17, 16, and so you begin to reorient yourself to the office little by little ... as I count backwards, 15, 14.... And as I do this, you recover those motor skills and attention skills, 13, that are necessary for you to carry out driving and conducting yourself in a safe way for the rest of the day, 12, 11, and throughout the evening.... And also, 10, 9, you will bring back with you from this concentration 8, 7, some of those positive experiences and desired resources that you thought about ... 6, 5, while I was speaking to you, 4, 3, and you were enjoying. Two, and just open your eyes and return to the room, 1.... How do you feel?

Clark: I feel strange. I ... I feel pretty good.

Stephen: What I’d like you to do, Clark, is sit down two or three times a day until I see you again next week and remember this experience. You can remember this same experience that you remembered now, or you can even change it or include a different one. But each time, indulge yourself in the experience that’s positive at the feeling level. And when you stop this practice, you will have 15 minutes up to maybe a couple of hours or even more of the halo effect. That is, there will be some time after you stop the experience that your positive feelings continue.

Now, this will be only a few drops in the bucket for you. It might not make you feel wonderful the very first time you do it. It might not make you feel wonderful the second or third time you do it. But each time you do it, you begin to accumulate more and more ability to recognize and tune into and hold onto positive experiences. And so, very soon this will begin to be recognizable as positive feelings during the day. As a result, the overall depression you face will have to diminish.

Clark: Well, I guess I understand it. So, I will give it a try. I’ll let you know next session what I accomplished.

Stephen: Terrific, Clark. That’s all I can ask. Let me know how it was for you, and we’ll take it from there.

The typically depressed clients will either terminate the memory prematurely or retrieve the memory in a cognitive manner but not feel the feelings. When this happens, it is important to explain to the clients exactly what is intended and to be patient as they attempt to reach the goal. It is necessary to take sufficient time at this stage so clients can really grasp the extreme importance of proactively using their memories to enhance their feeling states in a desirable way. This reduces their sense of helplessness, increases their internal locus of control, and is thus empowering to them. These activities then become expanded into homework assignments with a rationale that their life has been “relatively impoverished by the absence of these positive feelings and it is time to change that state of affairs.” Although the process of therapy will, realistically, vary, with each client focusing on different skills, each client can learn to better manage his or her mood, and it is important to take time during each session to reinforce this
particular learning about the merits of retrieving positive resources from within. As clients increase the amount of time spent retrieving and savoring desirable experiences, the impact of their depression diminishes.

**Confronting “Racket” Feelings**

**Rationale.** The concept of “racket” feelings was introduced by psychiatrist Eric Berne (1972). In presenting this term, he referred to the emotional “noise” that often accompanies communication. In psychoanalytic terminology, this phenomenon of substitution is referred to as a “neurotic affect” (Fenichel, 1945, p. 21; Freud, 1938, p. 448; Langs, 1973, p. 346). In more common terms, this is a person’s most commonly experienced emotion, even though it might not be the person’s most desired emotion. Thus, for the person who regularly feels abandoned, rejected, misunderstood, overworked, confused, or enraged, this racket can be viewed as the person’s emotional “comfort zone.”

The premise behind the acquisition of a racket feeling is that as children, people learn or decide upon an acceptable substitute feeling in their family of origin when a natural or more vulnerable feeling appears to be unacceptable. This substitute feeling and the cognitive schema that supports it may lead to a perception that outcomes are independent of one’s efforts. These form the basis for learned helplessness (Peterson, Maier, & Seligman, 1993) and will then recur throughout the person’s life. The cognitive schema that explains the feeling contains elements that comprise a self-fulfilling prophecy.

As an example, consider a man who frequently feels depressed and hopeless because, in his mind, nobody cares about or understands him. Such a man will not be assertive about making clear his contributions to the interactions in which he engages. In addition, he will likely demonstrate social behavior (e.g., irritability and impatience) that precipitates shunning, avoidance, or rejection by others. In the course of social interaction, he will naturally encounter some individuals who understand him and some who do not. He will also encounter people who shun and avoid him and some who will not. However, his negative conduct will most likely elicit a greater number of individuals who do avoid him and do not demonstrate understanding. In any event, he will selectively overvalue or focus on those who avoid him and do not understand him, and continue to conclude that he is misunderstood and that nobody cares, thereby reinforcing his self-limiting belief.

Often, depressed clients will not recognize their role in creating, continuing, and co-creating negative outcomes. In labeling this as active racket behavior, then, Berne also apparently intended a double meaning by emphasizing that individuals will selectively behave and, in essence, manipulate social reality in a self-injurious attempt to arrive at their common but undesirable feelings.

Clients who suffer from depression may have one or even two personal racket feelings. In some cases, the feeling of depression is itself a racket feeling. However, some depressed clients do not consider themselves to be depressed. Indeed,
some clients diagnosed with clinical depression do not label their emotional state as depressed. Instead, they may refer to their condition as feeling rejected, feeling that they “don’t care” about life, and feeling “what’s the use,” dejected, unimportant, and so on. These feelings are substitute, or racket, feelings that, during their lifetime, have habitually concealed other chronically unexpressed feelings (Berne, 1972).

In clinical practice, it may be desirable to help a client learn to accept and express his or her chronically ignored feelings. However, in brief therapy for depression this may not be a realistic or desirable goal as it will require using precious therapy time that might be better used in teaching clients to identify and make use of their positive resources. It is a desirable goal, however, to help a client come to realize that there are situations in which he or she will want or need to express his or her feelings, but it is not a necessary given. A case example would be useful to illustrate this point.

One of my former clients used to report that she was often rejected by others in social situations. She felt rejected by individuals at her workplace, and she avoided other social contexts outside work. After the educational treatment of racket feelings during her third therapy session in which she was taught to focus on and identify her most common feelings, especially when they didn’t reflect very well what was actually going on around her, the client returned for the next session with the following narrative: She and three other coworkers had decided to go to a local restaurant to have lunch together. It was possible for all of them to ride together in the same automobile; however, she needed to run another errand after lunch and chose to drive in a separate vehicle. When the lunch ended and the three coworkers drove off together in the same car, my client began to feel rejected. Unlike her response in previous similar episodes, however, she quickly realized that there really was no rejection taking place in the situation. Rather, she reminded herself that she had voluntarily driven in a separate automobile and had not been excluded by the others. She was very excited to report this event and the new, more objective awareness that she had developed. In effect, although she initially did not accept the concept of racket feelings, she was now convinced that she did in fact go out of her way to manufacture feelings of rejection when circumstances could have been interpreted differently. This same example illustrates the cognitive distortion of personalization, a reflexive perception to take something personally that is, in fact, not at all personal, and an alternate means for helping clients recognize and self-correct such a distortion (Burns, 1999).

**Method.** I attempt to introduce the concept of racket feelings into the therapy sessions with my depressed clients as soon as it is clear to them that I am truly trying to help them and the therapeutic alliance is established. It is important to wait until clients recognize that you are positively aligned with them before introducing this concept and the psychoeducational material about racket feelings.
This is because the entire matter can be viewed as personally threatening to the clients because it involves challenging them on an issue that is, in their minds, not their fault (usually referred to in the cognitive literature as an external attribution involving an external locus of control). In other words, it will have been the clients’ perception that it is the behavior of others that creates bad feelings in them and that they have done nothing to set up or co-manufacture the situations. So it is essential for therapists to be sensitive about the manner and timing in which they introduce this concept, and to ask their clients to monitor their behavior regarding racket feelings. Using hypnosis is especially valuable as a means of “softening” the message. The following is a sample transcript to illustrate this point:

Stephen: So, what do you customarily feel or tell yourself about situations like this?
Denise: No one cares. My parents didn’t care—my brothers and sisters never cared—my ex-husband never cared—no one cares.
Stephen: You mean that despite all the people you’ve ever known and encountered, there really is no one who has ever cared?
Denise: No one I’ve ever noticed.
Stephen: Denise, I think what’s happening here is that you selected a feeling of “no one cares” long ago, even as far back as childhood, and you still use this explanation even today to interpret the behaviors of other people.
Denise: What do you mean I “selected” that feeling? I don’t choose it—it is what really happens!
Stephen: Denise, I’d like you to lean back and relax for a few minutes. If you are willing to examine your feelings at a deeper level, let’s use this time to develop an experience of hypnosis as you have done in the past. [At this point, an induction is conducted for several minutes.] We were speaking about the difficulty some children face when they try to express their true feelings…. Let me explain it this way…. In real life, parents have a number of problems…. As a child, it may be impossible to see that parents care a great deal but have some other issues to which they have to respond…. I can’t say that this is true for your parents, of course…. But, it could be that a parent has a problem, not understood by the child … problems with health … difficulties with money … problems with their own emotional adjustment … and so on … which causes them to respond in a way … that is not very beneficial for the child at various times….

Of course, in hypnosis you can easily modify what I say so it fits for you as a person … or just discard comments that are less appropriate … and try to grasp the spirit of the points I’m making…. And given these sorts of issues you’re learning to deal with … while your parents may have cared very much … they simply didn’t respond in a way that
felt right... Does that make sense?... And doesn’t it seem extremely unlikely... that the very same feeling the child came to feel in childhood... would later result from many social interactions in your adult life?... That is, you find the very same feeling to be present now that surrounded the “you” in childhood?... Doesn’t that seem just a little odd or highly coincidental?... There is a concept that I learned long ago... from a social psychiatry text that I studied... that I’m sure you’ll find helpful, too.... The concept was that when children are unable to express their real feelings... they sometimes cover those feelings up with a safer feeling.... That feeling can be called a “racket” feeling... because it frequently surrounds your communication like background noise or a racket.... It is like a way of signaling to a parent... when the child speaks... and it sort of says... “I’m not happy about the situation here.”... So in your case, I suspect that you covered up your real feelings of hurt... with this feeling that you call “no one cares.”... Denise: [Weeping.] Stephen: Yes, you have some hurt and sadness.... And sometimes a child never ever tells anyone that she feels hurt and sad.... She thinks, “No, no one cares.”... Like many children do, you hide your hurt and sadness behind a feeling that no one cares.... And then, throughout your life, you have continued to avoid showing others when you were hurt or showing anyone that you are sad whenever these feelings arose... and instead, you’ve settled for a sort of protected feeling that no one cares.... I wouldn’t say that it’s bad... but it does prevent you from seeing the people who do care... because if we never show what we’re really feeling, then we’ll never find people who respond to our true feelings.... I wonder if that makes sense?... And I wonder what you’ll start to notice that feels good that you never noticed before.... When I count backwards from 20 to 1... I would like you to discover if it is time for you to come out of hypnosis and discuss your feelings with me. [A reorientation is completed.] How do you feel, and what are you thinking? Denise: [Drying her cheeks from the tears.] I never thought of it that way. So... I mean, well, what should I do? I can’t go around telling people that I’m hurt and sad, can I? Stephen: Well, maybe you can, at least in some situations where it makes sense to do so. Certainly, you can show it to some of them some of the time. But, I’m not certain that you’re hurt and sad all that often. What I’m suggesting is that you frequently take a position or react without really thinking about it. And, that is the position of this erroneous early childhood decision of yours that says people don’t care. How about monitoring how often you come to that conclusion during the next week? And as you do, take some written or mental notes about it so that you can report back in the next session. We’ll see if it is a perceptual habit...
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and whether you think that maybe you should replace this habit with something a little bit more useful for you. And when I say useful, I mean something that will contribute to building good feelings in yourself.

Denise: I’d be willing to do that—I just never thought of it that way before.

Stephen: Great; then I will look forward to receiving your full report on monitoring and confronting this so-called racket feeling next week.

As clients come to realize that they do have a choice about how they interpret experiences and arrive at emotional states, a further refinement can be made that brings with it a far greater opportunity for reward—chunking logic. This pattern is described in the next section.

**Chunking Logic**

*Rationale.* It is well established that the same stressors affect people differently. What constitutes a threat for one person is not perceived as a threat to another person. This is true for many reasons, of course, but one especially important reason is because as we interact with and experience the world, we give meaning to it (Goffman, 1969). **Chunking logic** is a term derived from information science that refers to the cognitive processes clients use to make meaning out of the world around them. As clients perceive sensory data about the world around them, they necessarily attach personal meaning and importance to what they experience. Some events and experiences are considered desirable or positive, and some are considered undesirable and carry varying degrees of negative associations. In addition, events and experiences are also assigned a certain level of importance such that some may be considered extremely important or “big,” whereas others are considered unimportant or “small.”

The process of making meaning is, in cognitive terms, attribution formation. The quality of one’s explanations for ambiguous life events serves as a strong risk factor for depression (see Seligman, 1990, and Yapko, Chapter 1, for a more detailed explanation of attribution formation and the effects on depression). For example, consider a client in an office lunchroom who is telling a humorous story to a table full of seven coworkers. If a man who is listening suddenly sighs heavily and frowns in the middle of the story, it may simply be that he was internally absorbed recalling the heavy workload he has for the afternoon. His sigh and frown may have absolutely nothing to do with the story being told. However, the client prone to depression will ignore the six listeners who are showing clear signs of enjoyment and “tune in” to the man who sighs and frowns, forming the erroneous and hurtful conclusion that his story is boring and that he is not well liked. This is accomplished by reducing or making a small positive “chunk” of experience from the six people enjoying his story and enlarging or making a large negative “chunk” of experience from the one person frowning (what would be referred to as a *global and internal attribution* in the cognitive therapy literature).
In the previous example, there are actually two important aspects of chunking logic that are predictable for depressed clients. The first aspect discussed was the size of the experience chunk: Usually positive experiences are undervalued and chunked small, and perceived negative experiences are overvalued and chunked large. But the second aspect of chunking logic is perhaps even more important. There is a choice in valuing an event as positive or negative in the first place. We know from the example that the sigh and frown had little, if anything, to do with either the storyteller or the story. And yet, the depression-prone individual will not make this discrimination, instead making a reflexive interpretation and then believing that interpretation.

People who selectively scan the environment for experiences that can possibly be viewed as negative will find many of them. To their own detriment, they will predictably interpret these “negative” events as very meaningful (chunks), and they will eventually become depressed as a result of viewing them this way. Chunking logic is about two aspects of making meaning: (a) the choice of interpreting an event as negative or positive, and (b) the choice of making the event stand out as very important and meaningful or making the event small and insignificant. Because the issue is clearly one of perception, the malleability of perception that is amplified in hypnosis becomes a compelling reason to employ hypnosis in helping depressed clients chunk logic more beneficially.

When speaking with clients about this matter, I often use a card trick I obtained from a local magic shop to illustrate my point. The trick consists of a special deck of cards constructed in the following manner: There are 26 regular cards of varying numbers and suits, and there are 26 identical king of clubs cards. The king of clubs cards are sorted alternately behind every normal card. But here is the important thing that makes the trick possible—each king of clubs has been manufactured to be just a tiny bit shorter than the regular cards. When you fan through the deck, the shorter king of clubs cards quickly fall face down on the normal-size card in front of it and is therefore hidden. The effect is that when fanning through the deck, the observer only sees the 26 normal cards. But, when I cut the deck, the top card will inevitably be a king of clubs. I can fan the deck for their inspection and then cut the deck and remove the king of clubs 10 to 12 times without error, and the clients, of course, are always surprised and curious. Then I reveal the construction of the deck to them, and most importantly, I ask them what this has to do with their depression.

The answer is relatively simple: when we sort through our memories or our perceptions, we are going to bump into the large chunks of experience, and those larger chunks will tend to obscure the small ones. Therefore, if the large chunks are all negative (due to the manner in which we have been collecting and labeling our experiences), we will more likely be depressed. This has been an effective way to drive home the point that clients need to discriminate and practice chunking logic so they can build a large number of positive experiences from which to draw strength and support. Faced with stressors, individuals who have large numbers of positive experiences from which to draw can cope better than
individuals with a majority of negative experiences in memory. Individuals who have collected primarily negative experiences will be more likely to experience depression. Thus, it becomes a goal of treatment to encourage clients to reconsider how they chunk information. Suggestions given either in or out of hypnosis, as in the following transcript, can help greatly in this endeavor:

Stephen: So, do you see any therapeutic point to that card trick?
Gene: Well, no, not really. But you really had me going there for a minute.
Stephen: When we sort through the deck, what card do we always bump into?
Gene: It always stops on the normal random cards … so?
Stephen: It doesn’t stop on random cards; it stops on the large cards!
Gene: Oh yeah, right.
Stephen: So, do you see the relationship here to the process of thinking?
Gene: Do you mean that when I think about things in my life, I’m always going to bump into the larger memories?
Stephen: Congratulations! You have absolutely hit upon the important point! When you sort through your memories, you always bump into those memories that you have valued more highly, or in some way made bigger in your perception. And if you’re making the negative experiences in your life bigger … well, you tell me, what will happen?
Gene: I will only be remembering unhappy memories. [Pause. Thoughtfully spoken:] And I guess that will leave me feeling unhappy most of the time.
Stephen: So, I guess I don’t have to tell you what the alternative is.
Gene: To remember positive happy experiences?
Stephen: No, that’s not quite it. Remember, you won’t bump into positive and happy experiences unless you have already noticed them, and enhanced the meaningfulness of them, what might be called chunking them big, and stored them as big chunks of positive experience.
Gene: So, how do I do that?
Stephen: That’s exactly the right question to ask. And the answer is, you have to deliberately notice events during the day which you can comment upon to yourself as positive. And furthermore, you can deliberately choose a label for those events which might even be a little bit exaggerated in the positive direction. For example, if you sit down to a business meeting and all of the people introduce themselves and say hello, you have an opportunity to label that as a positive event. You could say, “People are very friendly here.” But, in addition to that observation, you could exaggerate the label you use for it on purpose. You could say to yourself, “There’s a lot of love here,” and even let yourself notice your bodily state for a moment … even if it is only an enjoyable sense of silliness for making the exaggerated label. After all, that is somewhat pleasant, right? [Gene nods in agreement.] Now, I realize that that’s a big exaggeration, to call it love, but why not do it? Why not begin labeling
things in such a way that it creates for you a deck of cards in your
memory that allows you to bump into positive feelings and memories
rather than those which make you depressed? And, Gene, I mean that
you should begin this process immediately and do this sort of thing a
dozen times a day or more. What do you think? Are you willing to do it?
Gene: I guess so. I don’t see any harm to it.
Stephen: And another point of doing this, of course, is to learn to make
it your own. I want you to do it until you find a sense of value in it. It
is absolutely critical for you to begin practicing a new way of creating
your own experience. So, next week I’ll expect a full report, okay?
Gene: Okay. I guess you want me to say something like “this is a brilliant
opportunity”?
Stephen: [Chuckling.] There you go—you’re doing it perfectly already.
Good going!

Explaining this concept of chunking logic has become a valuable part
of psychoeducation in my clinical practice. I provide clients with many examples
of chunking experience in ways that are both positive and negative, as well as
large and small. I require that my clients begin to report on the manner in which
they apply the chunking logic in-between sessions. As they demonstrate increas-
ing skill in articulating this aspect of their thinking process, I require them to
begin purposefully selecting words that will attribute larger meaning to positive
experiences and smaller meaning to negative experiences. In subsequent weeks,
I usually extend this homework assignment further by requiring that they monitor
those experiences that they have initially selected to be negative chunks and
experiment with ways in which they can attribute a positive frame to the smaller
negative chunks. Clients learn directly and indirectly that their perceptions are
malleable, increasing their sense of ability to choose how they will consider the
events that take place in their lives.

On average, within 2 to 4 weeks, these homework assignments result in clients
having more positive experiences during the week. As they find themselves having
more positive experiences, they find it increasingly easy to achieve a positive
outcome with the other homework assignments that include retrieving experience
and avoiding racket feelings, described earlier.

**Self-Image Thinking**

*Rationale.* Identification and confrontation of internal dialogue are promising
ways to recognize maladaptive habits pertaining to chunking logic and repetitive
retrieval of racket feelings. However, it is generally inadvisable to simply educate
clients to monitor the self-statements and then attempt to stop them. Some studies
have shown that the suppression of thought can be a factor in the development
and continuance of a variety of psychological disorders (Borton, Markowitz, &
Dieterich, 2005). Some of those disorders include obsessive–compulsive disorder,
posttraumatic stress disorder, and depression. Individuals who suppress negative thoughts, compared with those who do not, were found to experience more anxiety and depression and lowered self-esteem. Individuals who had a greater degree of depression were more apt to experience these negative consequences of thought suppression. Clearly, then, it is essential to help clients develop a positive replacement for negative self-talk rather than simply helping them to stop their current thoughts.

To help systematically accomplish this goal, I published my conception of an experientially based protocol for behavioral and emotional self-management in 1980 and elaborated it in 1983 (Lankton & Lankton, 1980, 1983, pp. 312–344). I called this protocol “Self-Image Thinking” to imply that it should become a habit pattern and not just a single intervention. A similar intervention was empirically researched and upheld by Meichenbaum and reported by O’Neil (1978). It was shown that the protocol increased the likelihood of the client acting in accordance with his or her personal values, desired experience, and behavior, even in unexpected situations that somehow paralleled the rehearsed fantasies. In one area of measured performance, Meichenbaum’s results showed “that the cognitive modification treatment program was significantly more successful in reducing test anxiety, as assessed by several self-report and performance measures, than a conventional systematic desensitization treatment procedure of the same length” (O’Neil, p. 64).

The specific performance reported by O’Neil (1978) concerned test anxiety; however, he was conducting controlled research. What we are concerned with in using this paradigm is that any emotional resource can be applied to any fantasizing situation—provided that a carefully elaborated protocol is used. This was also shown to be true using my self-image thinking paradigm to enhance the behavioral performance of certain athletic stunts (Nugent, 1989a, 1989b). We can reasonably conclude that this protocol is effective for both emotional and behavioral experiences.

Over the last 25 years, I have used the self-image thinking protocol extensively with a wide range of clients. I have found that my clinical results correspond with others’ research results, as summarized by Albert Bandura, who stated that “thought-induced affective reactions may be successfully employed for purposes of controlling one’s own overt behavior” (1969, p. 40). Furthermore, clients who control their experience in such rehearsals are able to conduct themselves accordingly in future situations that had previously driven them to undesirable conduct. As Bandura went on to say, “[G]iven the conjunction of fictional [imagined] contingencies and a powerful internal reinforcing system, a person’s behavior is likely to remain under very poor environmental control even in the face of severe externally administered punishments and blatant disconfirming experiences” (p. 43).

Because the therapy initially depends upon identifying and retrieving desired personal experiences, teaching the self-image thinking protocol to clients in the therapy session flows smoothly from the previous psychoeducational and
experiential work of retrieving positive experiences. In order to introduce it into
the therapy sessions, a brief explanation of the steps in the protocol is provided
for clients. Following the explanation, clients are led through an experiential
exercise using each step for experiences and situations that have previously been
identified as relevant in the clients’ daily lives. For instance, when one of my
clients named Sam was having difficulty responding effectively to hurtful office
gossip that led to depression, the self-image thinking exercise was specifically
tailored to that exact situation, teaching him how to more skillfully manage that
difficulty. As a result, Sam quickly recognized the value of the protocol, its
application, and the importance of practicing it in his extramural activities away
from the office.

There are three main components of self-image thinking that will be described
and illustrated below: the central self-image, scenarios, and habit patterns.

**Central Self-Image.** The central self-image (CSI) is the most important step in
self-image thinking, as it is fundamental to the overall success of the protocol.
When it is complete, it consists of the person seeing in his or her “mind’s eye”
a replica of him or herself and another person, as well as physically experiencing
one or more desired emotional or affective resources. There are two goals accom-
plished with the CSI. First, visceral connections are associated to the images.
The CSI represents, symbolizes, and associates the person to the desired feelings
and behaviors by providing an avenue of association for him or her to experience
these feelings again. Second, the CSI depicts an interpersonal field. The presence
of the other person in the picture ensures that the CSI will not foster self-
absorption. This not only allows a person to imagine a valued goal and work
toward it, but also allows him or her to maintain his or her values as a guideline
throughout the time spent attaining the goal.

Following the induction of hypnosis, clients begin constructing the CSI by
first visualizing their face and body in their mind’s eye. The entire posture ought
to be visible at any given point in the process. To this picture, clients add several
qualities (e.g., confidence, joy, and poise) until the image depicts them looking
as they desire to eventually be. Adding these qualities usually requires proceeding
in stages. After the face and posture can be pictured, that image may be tempo-
rarily released so that they can conduct the following steps:

1. A mental or written list of desired experiences should be made explicit.
   Items on the list will consist of labels for experiences, such as confi-
dence, safety, patience, and courage. For instance, a person who has
been having difficulty dealing with malicious office gossip would prob-
ably want to make a list that includes feelings of acceptance, confidence,
joyment, or happiness. Each individual client will have a
unique list for any particular situation. The therapist’s job at this step
is to suggest logical experiences to include in a list and to help clients identify those additional experiences that would be most beneficial for them to include in the situation to be rehearsed. Pragmatically, a range of three to six experiences has proven to be most effective in the clinical setting.

2. Clients are to take each item on the list one at a time and perform the recall and reexperiencing described below. Clients should identify a time in the past during which they experienced the desired resource. Generally, clients will have some sensory memory of a time in which they experienced the desired resource. Clients need to realize that they are not searching for a time in which they had the desired resource in the context in which they now wish to have it. That is, if clients are attempting to find a sense of confidence to use in a public speaking situation, they should not hunt for a memory of a time in which they previously had confidence in a public speaking situation. Instead, they should simply search for a time in which they had confidence. This could be, for instance, a moment from childhood when they were building a model airplane or doing some such constructive activity successfully.

3. After clients find a memory, they are to allow it to become as vivid a sensory memory as possible until such enrichment allows them to partially or fully reexperience the feeling embodied as in the original situation. It is important for clients to actually allow themselves to viscerally feel this component of the memory. Some clients will do this to a greater degree than others in the beginning, but repeated practice will usually result in greater success with this step. Clients should make a mental note of small changes in their visceral experience or behavior so they can use and build upon those changes in the following step.

4. While noticing indicators of the desired feeling (such as small changes in posture, smile lines around the eyes, increased muscle tone in the cheeks, and slight upturned corners of the mouth), clients are to construct a visual image of themselves including these indicators. That is, they are to take the previously constructed visual image of themselves and alter it by adding the small indicators of physical change as symbols so that the image better reflects the desired feeling.

5. Clients are to repeat steps 2 through 4 until they have built a clear visual image of themselves with small indicators that reflect each of the desired feelings. In addition, clients should not have forgotten the feeling of the desired experiences that were previously retrieved. When clients have completed this step, two important accomplishments will be realized. They will be sitting in your office feeling the desired
resources that they listed previously, and they will have a visual conception of themselves with those same resources available.

6. The final step of building the CSI is to add a “supportive other” person to that visual picture. This could be an imaginary person, a religious figure, a child, a parent figure, a friend, or even the therapist. The importance of adding a social aspect to this image lies in the fact that clients are going to do a great deal of mental manipulation of this image during the following stages of self-image thinking.

The following is an abbreviated sample of how such a session might be structured and delivered during hypnosis:

[After hypnosis has been induced.] Now, Jayne, I want you to hold onto your relaxation and comfort and make an image of yourself just as you really look…. Make the image appear the same age and in every way make it look just like you…. Let me know when you have it by signaling with a nod of your head…. And, be prepared to change the way you appear…. [A pause for about a minute and a half occurs. Then, Jayne nods her head.] Now, turn your attention to the resources you selected before we began the hypnosis…. You listed four that you thought were necessary: feeling appreciated, feeling interesting, feeling people are accepting you—are’n’t criticizing you, and feeling like you can take risks…. Let’s begin with the feeling of being appreciated…. You mentioned that you felt that way when you returned a stranger’s dog when you were 8 years old…. Think back to that day…. You may recall the sounds of that day … a picture of the dog … or the man … or you may recall only the understanding of the incident…. Sooner or later, you will have a few sensory memories…. Everyone remembers in her own unique way…. Let my words be a stimulus for you to remember or recall in the manner that works for you…. As you gain a memory of the sounds or pictures of that day … use your imagination to enhance those that you have contacted…. Enhance them, enrich them, and make them more vivid…. Let your imagination take you back to that moment and that place…. Your conscious mind may not fully realize how much of the experience your unconscious can allow you to feel…. Switch your attention to your feelings…. Notice how you sense the temperature, the rhythm, the change in your body…. Have the feeling…. Let it form on your face from within … let it inform you…. [Pause, as Jayne slightly changes her posture and facial expressions.]

Jayne, return to that picture of yourself that you created a few minutes ago…. Bring that picture into the foreground and modify it slightly to represent the physical changes that you sense in your body now that you are feeling the experience of being appreciated…. Notice the small changes
in your shoulders, and make adjustments to that picture of yourself so that those same changes appear the picture... Also, there are some small changes around your mouth ... and your cheeks seem to have slightly more definition—make those changes to the picture of yourself as well....

[The same procedure is repeated for the additional resources that were discussed prior to hypnosis. After each of the four resources has been remembered and then reexperienced, small indicators of those experiences are added to the visual image that Jayne made.]

Jayne, I want you to add another person to this picture.... Think of someone who will support you and be on your side ... and really celebrate the fact that you have these resources.... It could be a religious figure, a parent, a friend, or anyone at all ... as long as you know that he or she would support you in having these resources.... Now, having accomplished that, I want you to change the background of this picture.... Keep the same image of yourself with all of these resources ... and even keep the person who supports you in the picture ... but I want you to change the background so that what you now see is Jayne in the boardroom at work.... I want you to watch Jayne as she interacts with coworkers who seem not to have listened to her opinion.... Watch how she holds herself ... watch how she conducts herself ... and listen to what she says while she continues to feel these four desired feeling resources.... And, while you continue to feel them in your body as you sit there ... nod your head when you see that she has accomplished the entire interaction and kept the desired feelings intact....

[Several minutes are allowed to pass so that she can accomplish this anticipated behavior in her imagination. After Jayne nods to signal her accomplishment, this particular scenario is complete.]

Note that while Jayne is imagining, anticipating, and elaborating the desired interaction, she is sitting in the room actually experiencing the resources that she believes to be necessary for her accomplishment. In the course of therapy up to this point, Jayne had mentioned a few other key situations that left her feeling demoralized. These times served to accelerate her depression and provided her with more incidents about which to ruminate. Each of these key situations needed to be rehearsed in a scenario using her CSI. After the CSI is initially created, it can serve as the foundation for each scenario and can be enhanced by additional desired resource experiences as they become identified. The following discussion of scenarios will define and explain the imagination, anticipation, and elaborating of scenarios that she was asked to perform after creating her central self-image.
Creating Scenarios. Scenarios are visual rehearsals in which the CSI will be animated and seem to interact in anticipated future situations. Scenarios are like short movies in which the main character is the client, having all of his or her desired experiences and resources in place, and maintaining them as he or she interacts with others. This next major step in the process of building self-image thinking involves having clients use their CSI as a guide for how to conduct their behavior in various desired situations. In a previous illustration, it was suggested that Sam had moments of depression that followed a response to office gossip. If he had created a CSI that included experiences of acceptance, confidence, and enjoyment, he would now modify the background of that CSI so that he saw himself in the office where the gossiping might occur. Sam’s job would be to maintain the image of himself with the desired resources in place while visually rehearsing interacting skillfully with others at the office. The rehearsal would entail hearing himself speak in such a way that would be consistent with the desired resources. In other words, Sam would visually think through how he would actually speak at the office while maintaining those desired resources. In addition, Sam would be thinking these thoughts while also feeling those desired resources. In effect, he would have created an integrated learning regarding having acceptance, confidence, and happiness in three major sensory representational systems. When a learning is created in three sensory representational systems, it is less prone to extinction, forgetting, or interference than when it is learned in only one or two (Bandura, 1969).

When a client’s anticipated situations are expected to be intensely threatening or difficult, it is recommended that a graduated hierarchy of difficulty be created establishing a range from easy to more difficult. This fantasized hierarchy will provide clients with opportunities for many successes and variations of rehearsed behavior before behaviorally attempting the previously feared scenario.

Habit Patterns. The habit pattern stage of the complete self-image thinking protocol consists of clients learning to use the slightest indicator of stress as a sign to engage in goal-directed scenarios using their CSI and associated desired resources. This habit pattern can begin to be created in the office in short steps while strengthening all other aspects of self-image thinking. This is done by first building the CSI and several scenarios, and then having clients purposefully recall a previously stressful moment. At the first physical signal of building stress, the client’s thinking is quickly directed to the CSI and previously established scenarios. Doing this for 6 to 10 different anxiety signals and scenarios is suggested in order to help generalize greater feelings of confidence.

For example, let us consider a depressed man who reported he felt most lonely, alienated, and depressed when he traveled alone on business trips. His CSI was built to look like him and to have resources of confidence, enthusiasm, and other desired experiences. As he anticipates the process unfolding, he constantly maintains these traits in his body as he watches a scene in which he is
doing a related task, such as buying a ticket at the airport during rush hour. He imagines interacting with other people, tasks, and machines at work, and when confidence and enthusiasm are associated with that imagined picture, he is better able to think of several possible options that he may have never tried previously to sustain these qualities under adversity.

Once he has built a scenario, it is possible to begin building a habit pattern. To build the habit pattern, the client is asked to remember a previous anxiety-creating event and to locate the stressor in that context. The client is asked to monitor his body and to be aware of the smallest possible signal that indicates his anxiety is building. As soon as the anxiety signal or signals begin, he is to immediately switch to the positive visualization of his previous scenario and to sustain it until his anxiety signal disappears. This process should be performed repeatedly so that these anxiety signals will become discrete stimuli to trigger this goal-directed thinking pattern. Even under novel stress, clients who have created a habit pattern will automatically begin to switch to visualized options of themselves handling situations with the qualities they desire, possess, and value.

CONCLUSION

This chapter has presented two psychoeducational and homework-oriented interventions, and two experiential interventions for the treatment of depression within the context of brief therapy. These strategies are confronting "racket" feelings, learning chunking logic, retrieving experiences, and learning self-image thinking. There are many other important factors to consider in the treatment of individuals who are depressed, as described throughout this volume. Actual treatment with each individual will vary according to that person’s needs and should consider a range of related factors such as a client’s employment, marital situation, child rearing, education, use of free time, exercise, dietary habits, sleeping habits, and interpersonal skills. However, what has been discussed in this chapter are core interventions that I recommend including in the therapy for clients with depression. With minor modifications to address individual differences, the therapy interventions discussed in this chapter offer a potentially valuable core contribution to the recovery of depressed individuals.

EDITOR’S SUMMARY

- Depressed mood increases the likelihood of greater recall for negative experiences.
- Mood can be enhanced by accessing positive resources and positive memories, not just by avoiding negative experiences.
- Mental health is most evident when people feel empowered to use appropriate skills and resources in specific contexts.
Effective treatment helps clients identify and retrieve experiences they consider desirable and savor the positive experiences they retrieve.

Hypnosis can be used to revivify past positive experiences and extend their representation into daily life.

Depressed individuals often focus on feelings that support behaviors that worsen depression. Hypnosis can be used to diversify the client’s focus and shift it to more constructive responses.

The process of attribution formation, or making meaning, can lead to an error common to depressed individuals, namely, overrepresenting the negative and underrepresenting the positive in awareness. Hypnosis can be used to beneficially alter the internal representations.

Negative self-talk is a common feature of depression. Going beyond “thought stopping” and actually replacing negative self-talk with positive self-talk can be a valuable hypnotic intervention.

Case example transcripts illustrating each of the four interventions described above are provided.

REFERENCES


Building Coping Skills with Metaphors

GEORGE W. BURNS

OVERVIEW

There are definable differences in the type and quality of coping skills used by people who cope well in managing life difficulties and those who cope poorly; between those who lead a satisfying, happy life on balance and those for whom feelings of misery and depression are common; between those who, in the words of Keyes (2002), “flourish” and those who “languish.” Over the last 2 or 3 decades, we have learned much about the cognitive styles, coping skills, and other such patterns associated with depression (Beck, Rush, Shaw, & Emery, 1979; Seligman, 1975). More recently, however, we having been discovering much more about the skills, styles, and processes that correlate with happiness (Burns, 2003; Burns & Street, 2003; Fredrickson, 2005; Lyubomirsky, 2001; Seligman, 2002).

Coping skills in particular represent an important focus of psychotherapeutic intervention if depression is to lead to greater happiness. Thus, in this chapter I shall first explore some of the key differences evident in life-diminishing and life-enhancing coping strategies. Then I will discuss how to assess a client for defining a positive outcome and how one might offer a hypnotically based intervention for building coping skills through metaphor. There are many questions I will pose throughout this chapter as a means of organizing the processes of assessment and intervention.

WHAT DO DEPRESSED PEOPLE GENERALLY DO IN ATTEMPTING TO COPE THAT IS NOT HELPFUL TO THEM?

There are many different styles of coping associated with depression (Elliot, Sheldon, & Church, 1997; Emmons & Kaiser, 1996; Lyubomirsky & Nolen-Hoeksm, 1995;
Avoidance

Depressed people tend to cope by being avoidant or, as is common in therapeutic language, being “in denial” (Yapko, 2001). Avoidance can be manifested in many ways, such as when a person “buries his head in the sand” rather than face up to pressing life issues that are perceived as threatening or anxiety provoking.

Summarizing the ineffectiveness of such problem avoidance, Yapko said,

> It may seem to provide some small temporary comfort to the person to turn a blind eye to percolating problems, but to do so poses additional hazards; most problems don’t just go away if one ignores them. On the contrary, they tend to get worse. (2001, p. 97)

Depressed people tend to focus more on avoidant rather than positively defined approach goals in life. A person with an approach goal is one who might say, “I want to find ways to be happier in life,” whereas the person with an avoidant goal might say, “I don’t want to feel so depressed.” An approach goal may be expressed in positive terms, such as “I want to spend more time with others,” in contrast to an avoidant goal statement such as “I want to avoid being lonely.” Another example of an approach goal may be “I want to find ways to enrich our relationship,” rather than an avoidant statement such as “I don’t want to fight so much” (Emmons, 1991, 1999, 2003; Street, 1999, 2000, 2001, 2002; Street et al., 2004). The pursuit of such avoidant goals is negatively associated with well-being and positively with depression (Elliot et al., 1997). Emmons (2003) has described avoidant goal setting as “a risk factor for psychological and physical distress” (p. 16).

Another style of avoidance can be evidenced in what Seligman (2002) called “avoidant loving styles.” He described avoidant adults as people who typically remember their mothers as cold, rejecting, and unavailable; whose attitudes toward other people are characterized by suspicion, mistrust, and a lack of confidence; who try to avoid intimacy and closeness; and who manage distress by suppressing their upset and anger. Such interpersonal styles are highly correlated with depression. Conversely, strong and positive intimate relationships with a partner, family, friends, and community are highly predictive of happiness (Diener & Seligman, 2002).

Rumination

A second characteristic coping style typically found in depressed individuals is called *rumination*, a cognitive pattern that features a constant mental rehashing of negative thoughts about bad past experiences, especially those incidents
associated with guilt (Nolen-Hoeksema, Grayson, & Larson, 1999; Street, 2000). Just as in learning our times tables in elementary school, for example, the more often we repeat them to ourselves, the more deeply entrenched they become. A healthier response seems to be one in which people are able to focus their minds away from themselves and their worries and take effective action, whereas a focus on the self and personal worries to the point of inaction is both less helpful and less emotionally healthy. Susan Nolen-Hoeksema, the principal researcher in a number of important studies regarding rumination and depression, referred to this latter pattern as a “ruminative response style.”

Rumination is associated with more depressive symptoms, longer depressive episodes, and more vulnerability to relapse (Lyubomirsky & Nolen-Hoeksema, 1995; Street, 2000). In one relevant study, people who displayed this ruminative style rated highest on depression scales following a natural disaster, such as an earthquake (Nolen-Hoeksema & Morrow, 1991). It is tempting to think that going over and over an unresolved issue will eventually provide us with a better understanding and, thus, help us to solve the problem. However, the reverse seems to be true (Lyubomirsky & Nolen-Hoeksema, 1995). Rumination can be counterproductive, actually reducing a person’s ability to effectively solve problems. Segal, Williams, and Teasdale (2002) stated this clearly when they said, “In fact, in this state of mind, repeatedly ‘thinking about’ negative aspects of the self, or of problematic situations, serves to perpetuate rather than resolve depression” (p. 36).

WHAT DO HAPPY PEOPLE GENERALLY DO IN COPING THAT IS HELPFUL TO THEM?

The correlations between avoidant and ruminative coping styles and depression are not perfect. There may be specific times when it is both appropriate and beneficial not to worry about a problem. This may simply be pragmatic rather than avoidant. Why worry over something if the worry is not going to enable one to fix it? Similarly, there may be times when it is helpful to think repetitively about a problem, particularly if that thinking may lead to insights regarding how to avoid or even prevent such problems from occurring again in the future. Thus, a key issue to address in therapy is how to distinguish when avoidance and rumination may be reasonable responses and when they may compound depression’s negative effects. People who cope well tend to successfully discriminate when to, and when not to, employ such strategies. Those who don’t cope well have greater difficulty employing a deliberate strategy of discrimination, that is, knowing the times to avoid and the times to engage, and knowing the times to think and the times to act.

Just as there are many different styles and skills that depressed people use to cope, albeit not necessarily effectively, so are there many different styles and skills that happy people employ to maintain their good feelings. Possessing a broad range of acquired (and acquirable) positive emotional strategies—not just
for coping with the challenging times but also for enjoying life as a whole—can both enhance well-being and protect against depression (Fredrickson, 2000; Lyubomirsky, 2001).

In the area of cognition, happy people tend to think more optimistically and more hopefully (Peterson & Chang, 2003; Seligman, 1990, 2002; Seligman, Parks, & Steen, 2005). They are generally more flexible, less global, and more discriminatory (i.e., relativistic) in their thinking (Yapko, 2001). They are better at problem solving, and more oriented toward the future than the past. In the later section detailing specific hypnotic interventions, these points are discussed further, and an illustrative case example of using a metaphor for building such cognitive coping skills is provided.

On a behavioral level, happier people tend to do things differently than unhappy people. In fact, a key behavioral difference is that they actively do rather than passively ruminate. They tend to engage in more physical exercise and more action oriented (Faulkner & Briddle, 2001; Mutrie & Faulkner, 2004). They are more skilled at setting appropriate goals and actively taking steps to achieve them (Emmons, 1991, 1999, 2003; Street, 1999, 2000, 2001, 2002; Street et al., 2004). They are more likely to seek social and intellectual stimulation (Burns, 1998, 2005b) and engage in social and community activities (Diener & Seligman, 2002; Seligman, 2002; Seligman et al., 2005). They are more positive in their relationships with others (Myers, 2004; Reis & Gable, 2003), more other-oriented (Piliavin, 2003), and more spiritual in terms of holding “a big picture” perspective or worldview that provides both positive motivation and emotional comfort (Diener & Clifton, 2002; Emmons, 1999; Emmons, Chueng, & Tehrani, 1998; Emmons & McCullough, 2003; Myers, 2000a, 2000b, 2004; Piedmont, 1999).

What is important for both the therapist and the client to know is that the effective strategies employed by happy people can be developed. Fredrickson (1998, 2000, 2005) described this as the “broaden and build” model, based on her substantive research indicating that it is possible to first broaden the range of positive emotions a person experiences, and then to build on this more extensive range for enhanced coping and enjoyment.

**IS HAPPINESS MERELY THE ABSENCE OF DEPRESSION?**

It is worth bearing in mind that happiness is more than just being free of symptoms of depression. There is strong evidence that the absence or elimination of negative mood states alone does not constitute happiness (Diener & Lucas, 2000). Seligman et al. (2005) said, “Even if we were asymptotically successful at removing depression and anxiety and anger, that would not result in happiness. For we believe ‘happiness’ is a condition over and above the absence of unhappiness”
Thus, therapists have to carefully consider their goals of treatment: Is the greater goal to reduce depression or to increase happiness? To reduce pathology or to expand wellness?

Therapists working with depressed clients must have a keen understanding of what happy people do that contributes to their sense of happiness and experience of well-being. Effective therapeutic interventions in this area are not simply about removing the symptoms of depression and assuming that happiness will automatically follow. Rather, they involve looking to a person’s specific goals and how they can best be achieved. In previous writings, I have discussed the problems associated with seeing the therapeutic goal as simply that of symptom elimination, which I referred to as the “goal of neutrality” (Burns, 1998, pp. 163–165). Working with clients to set approach goals that are specific, clearly defined, process oriented, and unconditional in terms of their happiness both provides an appropriate model for our clients to replicate and engages them in the process of developing successful coping skills. Given that this is important to do, our next question becomes “Where do we begin?”

THE BENEFIT OF DEVELOPING AN OUTCOME-ORIENTED ASSESSMENT

There are many legitimate concerns about taking a “one-size-fits-all” approach to the treatment of depression—the chief one regarding employing an approach that is too narrowly prescriptive or follows the simplistic model: If infected, prescribe an antibiotic; if fractured, set in plaster; if depressed, administer a selective serotonin reuptake inhibitor (SSRI), or perform cognitive-behavioral therapy (CBT) or, indeed, any other single therapeutic intervention. Depression and happiness are multidimensional phenomena involving many different facets, including biochemical, psychosocial, cognitive, behavioral, affective, and/or spiritual ones (Burns & Street, 2003; Yapko, 1997, 2001). Although there are common characteristics that people may share in a general or statistical sense, there can also be significant individual differences that directly or indirectly affect their quality of life. One person may build better coping skills by learning healthier patterns of cognition, whereas for another it might be through the acquisition of prosocial skills, and still another may be better assisted through the modification of specific behavioral patterns. To offer a one-dimensional prescriptive approach can thus be analogous to throwing darts at a wall where the target is invisible. There is a low probability that one will hit an undefined or ill-defined target, and a high probability that one will miss. The more specifically targeted the therapeutic interventions are to the individual needs of the client, the more efficient is the process of therapy, and the more effective is the outcome.
A case example can help answer this question. Mary (not her real name) was a 50-year-old, significantly depressed woman who presented a complicated history so potentially overwhelming that even an experienced therapist might ask, “Where do I begin?” Mary had a life story to tell that she needed to be sure was heard. Worried about her memory and concentration problems, she first saw her physician, who then referred her to a neurologist who, in turn, referred her to my clinic for a neuropsychological assessment in order to differentiate between a diagnosis of early dementia or a pseudo-dementia resulting from depression. Mary’s higher cognitive functioning appeared to be intact, but her score on the Beck Depression Inventory (Beck, Steer, & Brown, 1996) suggested a “potentially serious” level of depression, with significantly depressed affect and high levels of both self-denigration and self-criticism. Additionally, Mary reported that she was indecisive, withdrawn, irritable, and fatigued. She ruminated over most things she did, felt guilty, and described passive suicidal ideation.

Life had certainly dealt Mary a full hand of challenges. She reported being sexually abused as a child by her father and a close family friend. Her marriage had been a long-standing challenge, but despite its stressful nature, she was able to maintain it. Two of her four children had congenital growth disorders, received growth hormone treatment, and were now at risk of developing the fatal Creutzfeldt-Jakob disease (CJD) from contaminated hormone batches. She joined a CJD society, received their typically depressing newsletters, and generously volunteered to counsel other affected families but, of course, worried whether her kids would be next on the list to die. As if this was not enough, in the preceding 4 years she had been injured in two motor vehicle accidents, suppressed her grief while she supported family and friends through the deaths of several people to whom she had been close and reluctantly but dutifully nursed her father (who she said she hated because of his having abused her) during a terminal illness. Mary’s problems were clearly very complex, long-standing, and real. Despite them, she was always there for everyone else, like a universal mother. (A more detailed account of this case is in Burns, 1998, pp. 165–170.)

In such difficult cases, it is not going to help for the therapist to be as overwhelmed as the client. If we feel as helpless and as hopeless as Mary was about reaching a satisfactory outcome, we fall into the client’s pattern of thinking and are less likely to be helpful. We are more likely to assist our clients if we can identify and incorporate a process that will facilitate some changes in their subjective experiences, if we hold some realistic hope, and if we believe that, in one way or another, our clients can improve. The power of hope as a motivating force in both medical and psychological treatments has long been an interest of researchers. Jerome Frank’s work (1968, 1975) over the last 4 decades has identified hope as a core element in all psychotherapeutic processes and Hubble and Miller (2004) claim that the curative effects of
therapy “come (more) from the positive and hopeful expectations” a client has about treatment than from the treatment method itself (pp. 341–342). Based largely on the work of Snyder (1989, 1994, 2000, 2002), Lopez et al. (2004) were more specific, stating that hope facilitates an individual’s capacity “to (1) clearly conceptualize goals; (2) develop specific strategies to reach those goals … and, (3) initiate and sustain the motivation for using those strategies,” p. 388). Thus, if we believe, on good therapeutic grounds, that realistic hope is possible and help foster that hope in our clients, they are more likely to form a similar belief and, consequently, are more likely to achieve their desired therapeutic outcome.

HOW DO I ASCERTAIN THE GOALS OF THERAPY?

The first question I asked Mary, “What is going to be helpful for you to gain from this session?” is clearly an outcome-oriented one. It includes an assumption that if a client says, “I am feeling depressed,” as Mary did in her story, he or she is not simply wanting to know more about depression but is really saying something like “Tell me about feeling happier.” When people make the effort to make an appointment, show up, walk into our office, and sit in the chair opposite us, they are generally seeking a real change in their experience, and a change for the better. They want things to be better in their lives, but usually don’t know what to do to make improvement possible.

Although a therapist’s training may have provided him or her with the skills to understand the nature of the problem and the strategies or processes that may be useful to help resolve that problem, the goal or outcome that the client wants from therapy needs to come from the client and should be carefully considered. If Mary had replied to my question with something like “I want to know why I am feeling so depressed,” it may help to examine whether the important thing for the client is to have an understanding of what has led to that situation or whether it is more important to develop the skills and strategies necessary to bring about a desired change.

WHAT IF A CLIENT’S EXPRESSED GOALS ARE NEGATIVE?

It is not uncommon for clients to answer an outcome-oriented question in a negative or avoidant way. After all, this is one of the common coping styles associated with depression and may well be expected. Mary exemplified a negative reply when she said, “I don’t want to be feeling so forgetful, irritable, or withdrawn.”

As discussed earlier, avoidance goals (i.e., trying to avoid what you do not want), compared with approach goals (i.e., seeking what you do want), are often associated with depressive symptomatology. For a therapist to accept an avoidance goal may unintentionally reinforce this aspect of the depression because it does
HYPNOSIS AND TREATING DEPRESSION

not provide the client with effective strategies for either the direction of therapy or the direction of life.

The depressive symptoms may have served as the person’s only coping strategy, albeit not the most effective one, for a long time. Even if it was possible to eliminate ineffective coping strategies, like excising a tumor, what is the client left with? It is both unrealistic and impractical to offer to remove the current coping strategies, leave the client in a state of neutrality, and not use the context of therapy to build more appropriate or effective coping skills. Therapeutic goals will be more attainable and the therapy process more pragmatic when directed toward creating the desired goal rather than eliminating a problem.

Thus, if clients express a negative or avoidant goal, it may be helpful to gently question and guide them as to ways they may shape this into an approach goal: “If you don’t want to feel so irritable, how do you want to feel?” or “If you don’t want to be so withdrawn, what would you rather be doing?”

WHAT IF MY CLIENT IS NOT SPECIFIC ABOUT GOALS?

Global thinking is a common cognitive style associated with depression (Yapko 1997, 2001). Thus, it is likely that depressed clients will come up with a too-global response to questions meant to help them shift their goals in a more approach-oriented direction. For example, Mary stated that she wanted to feel more relaxed and be more outgoing. Having such global (i.e., nonspecific) goals brings us back to the earlier analogy of throwing darts at a blank wall. Consequently, in an effort to develop some specificity about her goals and ways to reach them, I began to ask her about any times in her life when she felt most relaxed, what helped contribute to those feelings of relaxation, and what she could do to currently recapture some of that previous sense of relaxation. Through such specific questions that remind the client that he or she has valuable resources, the therapist is inviting the client to think more specifically, act more specifically, and thus start to shape more desired coping skills.

In such ways, the therapist can help the client clearly define the “target on the wall” and explore the concentric circles that lead closer and closer to the “bull’s eye” of the therapeutic outcome. What would be helpful for this particular client sitting in front of me at the moment? Would he or she feel happier and less depressed by building more appropriate social skills, by having a better cognitive style for viewing the world, by broadening and building his or her emotional repertoire, by changing patterns of behavior, by focusing on appropriate ways of relating in family structures, by becoming more action oriented, by seeking greater levels of stimulation, by building skills of mindfulness, or by enhancing a sense of spirituality? Any and all of these may be appropriate targets for intervention.
Having defined the general target area, it is helpful to be specific about the intervention or interventions to be employed. Consider the first example above of building more appropriate social skills. What does that mean, specifically, for this particular client? Would it be helpful to build skills in social communication? Would it be useful to learn skills of relaxing in the company of others? Would it be beneficial to learn how to relate more comfortably with the opposite sex? Might it be helpful to join appropriate interest groups? Would the client benefit from learning to shift focus away from the self toward others? Would it help to learn the use of open-ended or presuppositional questions in relaxed conversation? Only by being specific about defining the goal can we increase the probability of actually attaining that goal.

Mary said she felt happiest and most relaxed when gardening. “What is it specifically about the gardening?” I inquired. “Tending my roses,” she replied. “And what is it about the roses you find so enjoyable?” I asked. Mary described her sensory experiences of the sights and smells of tending the roses, but still I wanted her to be even more specific. “What are the particular sights you enjoy?” “What are the fragrances you associate with pleasure and comfort?” Such details provide more intervention opportunities and open the options for clients to examine their own specific pleasurable experiences.

Mary was a prolific letter writer. After that first session, in which we did little more than explore her specific outcome goals, she wrote to me,

Yesterday I was so embarrassed. I got such a shock that I wished myself anywhere but there [a reference to her suicidal ideation?]. But, it was so funny when I was on the train later. I was sitting there visualizing making my husband rose petal sandwiches, marinating his meat in rose perfume, rose petals in the stew, lighting rose candles, sprinkling rose petals all around the room, some other ideas that I won’t write down. I started to giggle, people next to and opposite me moved and put a lot of space between us, all were giving me funny glances. By the time I got off the train I was laughing out loud while walking down the street. I found a freedom of spirit that hasn’t been there for a long time. Thanks for letting me find my own way through it. The rose petals are a great idea.

Of course, “stopping to smell the roses” did not resolve all the complex issues with which Mary was dealing. But reminding her of some of the specific resources she had did help her quickly discover that there were other, more positive ways of dealing with them. Instead of thinking ruminatively about her worries, she could be mindful of positive experiences. Instead of being negative and avoidant, she could be more positive and outcome oriented. Instead of thinking globally, she could think in more positive and specific terms. She discovered different skills and methods of coping than what she had been using, and by acknowledging that she had found her own way through it, she was taking ownership of the skills she had discovered.

The process of an outcome-oriented assessment is an invitation to the client to specifically examine the exemplified type of questions above. In simply
undertaking an assessment, the client can be helped to shift global, ruminative, and avoidant styles of thinking. The therapist’s questions about defining desirable outcomes models appropriate (i.e., positive and action-oriented) coping skills and may assist the client to find the processes necessary to achieve their desired therapeutic outcome. (A more detailed account of how to undertake an outcome-oriented assessment with an adult case example can be found in Burns, 2001, pp. 233–237. Using this approach with children and adolescents is described in Burns, 2005a, pp. 256–258.)

SPECIFIC HYPNOTIC INTERVENTIONS

In working with a client, there are generally four sequential questions that I have in my mind to guide the process of forming an intervention. They are as follows:

1. What is the client’s specific therapeutic goal? This is the question addressed in the discussion above of an outcome-oriented assessment. Let us use the example of a depressed client whose express goal is to no longer be depressed. Is the specific therapeutic goal to enjoy better social relationships, solve problems more effectively, think more positively, become more other-focused, create more potentially positive experiences, or participate in enjoyable physical exercise? And what are the specific aspects of that specific goal? If it is to enjoy better social relationships, would the client benefit from enhancing communication skills, becoming more other-focused, changing negative self-talk, finding groups of like-minded people, modifying past patterns of social behavior, or strengthening concepts of the self?

2. What therapeutic model might best help achieve that goal or goals? Is it going to be cognitive behavior therapy, family therapy, strategic therapy, solution-focused therapy, or a model of positive psychology?

3. What interventions within that particular model may be most beneficial? Is it one that addresses a particular cognitive or attributional style? Is it an intervention for changing patterns of behavior? Will it be directed at building social skills?

4. How do I most effectively communicate those interventions to my client? Do I tell my client in a direct manner to participate more in physical exercise? Do I permissively coach him or her through a process for building greater social skills? Do I tell a metaphor as an indirect method about another client who had a similar problem and the steps he followed to reach his goal? This fourth question is crucial if we are to ensure the interventions are effective. Unfortunately, though, it is not often addressed in some therapeutic models that are very good in telling the therapist what to do but not necessarily how to communicate it most effectively.
One big advantage of employing hypnosis and hypnotically based strategies, such as metaphor, lies in their ability to communicate, at an effective and personally relevant level for the client, those therapeutic interventions that can be recommended with confidence on the basis of the empirical evidence for their effectiveness. Within hypnosis, there is a broad range of communication styles. Suggestions can range from direct to indirect (Hammond, 1990; Yapko, 2003) and involve a style of suggestion based on what the client is most likely to respond to. Most often, by the time clients find their way to our office, they have already been given many direct suggestions as to how to change or improve. Many of them often have well-intentioned family, personal friends, or work colleagues who may have advised them that they should “stop feeling sorry for yourself” or “get on with life.” They may even have seen a physician who prescribed them an SSRI and also offered well-intentioned advice—perhaps based on sound evidence—that they should exercise more, engage in more social activities, or find some new positive interests in life. The fact that they are in our office is an indication that the goals may not have been defined clearly enough. Or, if they were, either the strategies offered or the ways that they were communicated were not effective for that person. Having determined the client’s particular goal and the strategies most likely to help, then, we also need to find the way of communicating this most effectively. If direct suggestions have not helped previously, then we need to consider indirect approaches. As an indirect, or just less direct, approach, metaphors, both within and outside the structure of a formal hypnosis session, may be effective.

Even before our species developed the level of verbal communication we enjoy today, our ancestors expressed themselves through stories painted on the walls of the caves in which they dwelled. With speech came verbal stories, legends, and parables, some of which have lingered with us for millennia. In that time, stories have been effective and preferred methods for communicating information, teaching values, entertaining, and sharing the important lessons of life (Burns, 2001). Just hearing those often expressed four words “Once upon a time …” is like an instant switch from reality to pretense, or an altered level of processing. They are words that have been repeated so many times and with such associations for many people that they act like a hypnotic induction, an invitation to participate in a unique relationship with both the teller and the story’s characters. They are words that invite the listener on a journey into a world of imagination where reality may be suspended, but learning can be potent. They are an invitation into the phenomenon of hypnosis where listeners are entranced, attention is focused, time is distorted, and the client can share the challenges, problem-solving strategies, and goal attainment of the fictional hero.

Stories contain many of the important elements of effective communication (Burns, 2005a) that are especially relevant and helpful for working with a depressed client who may feel helpless, be passive, lack self-direction, or have concrete, global thinking. Therapeutic stories can be employed to teach in a way that is engaging and attractive and thus help bypass what is often labeled as
resistance. They invite the client into the process of searching for meaning: Why is my therapist telling me this story, and how is it relevant for me? Through appropriately structured metaphors, clients can learn to develop problem-solving skills, open new opportunities for viewing and dealing with a problem, engage in independent decision-making strategies, and create outcome possibilities. The sharing of stories can build relationships, challenge ideas, provide models for future behavior, and enhance understanding. It has been said before that once we have heard a story we can never unhear it, that in having heard it something may have changed forever. An example of how this can work in an applied way is provided later in the section titled An Illustrative Metaphor.

CREATING A METAPHOR

Creating a client-specific metaphor once the therapeutic outcome is defined is usually a relatively simple process. A metaphor, like any story, has three basic components: a beginning, a middle, and an end. The main difference with a therapeutic metaphor is that those three elements of the story are treatment oriented, seeking to help move the client from the problem to the outcome. Thus, the metaphor will usually start with a problem (the beginning) situation similar to that described by the client and with a character matching (to some degree) the characteristics of the client. The middle part of a therapeutic story is what I think of as the resources section: It provides the vehicle, the processes, the resources, the skills, the abilities, the styles of thinking, or whatever other means the client may need provided in order to reach the appropriate outcome. The outcome is the end, and it is what will match the client’s desired therapeutic goal. This model is what I call the PRO (problem, resources, outcome) approach, and I offer it as a simple, structured way to think about, plan, and present therapeutic metaphors. The PRO approach is described in more detail in 101 Healing Stories (Burns, 2001) and 101 Healing Stories for Kids and Teens (Burns, 2005a).

In therapy you are likely to tell a metaphor in the above order, beginning with the problem, moving through the appropriate resources, and concluding with the desired outcome. In thinking about, planning, or creating the metaphor, however, it may actually be easier to begin at the end, starting with a clear definition of the desired therapeutic goal. This is something you will have already defined through the outcome-oriented assessment. With the outcome in mind, the next question becomes “What resources will my client need to reach this goal?” This and the following questions model a common process by which we all go about making decisions and taking positive actions in our lives. For example, as a reader of this book, I assume that you have a goal or objective to learn more about depression and the hypnotic interventions that are useful for dealing with this common clinical condition. That is your desired outcome. In other words, you have decided what you want. If you are going to reach that goal, you must then make choices about how you do it. You look for the means or resources that
enable you to fulfill that objective: Do I attend conferences on the subject? Do I observe videos of experts working in the field? Do I seek supervision from a colleague skilled in this area? Do I pick up the very book that is in my hands now and read it? These are the resources, means, and processes by which you are likely to achieve your desired outcome. What initiated this process may have been that you saw a depressed client who triggered your desire to learn more about this topic and interventions, or you foresaw the need to develop such skills because of the likelihood that you will encounter or work with depressed clients in the future. This is the problem that initiated the process. So the questions that may be most helpful to ask yourself in planning and structuring a metaphor are as follows:

1. What is the outcome or positive goal that my therapeutic story needs to help the client reach?
2. What are the resources, skills, or processes my client will need to attain that goal? On the basis of my knowledge of therapeutic models and interventions, what approaches are going to be the most helpful to achieve that?
3. What is a problem that can best help my client identify with the process and outcome of the metaphor?

AN ILLUSTRATIVE METAPHOR

Each metaphor we construct as therapists to address issues of depression or, indeed, any other problem needs to contain sound therapeutic characteristics. The following is an example, a metaphor based on a real case.

Two men were referred to me by their workplace physician following an industrial accident in which both were involved. (In telling this metaphor, their names have been altered and specific details of the accident and workplace environment deleted so as to protect their identity.) This metaphor describes the processes each person went through in coping with what happened. These reflect an almost “textbook example” of coping styles that are likely to be helpful as well as ones that are less likely to be helpful. Juxtaposing the two, as they occurred in the real-life case, highlights for the absorbed and focused client the differences in coping strategies, the resultant differences in outcome, and the positive choices a client may have to better manage stressful, depressing, or traumatic situations. The metaphor also illustrates very clearly that it is not so much a matter of what occurs to a person that is depressing as it is a matter of how the person handles what happens. A core skill in living a satisfactory, meaningful, enjoyable life is knowing that it is not the events that occur in our lives but rather how we experience those events and what we conclude from them. This, above all other things, determines how well, or unwell, we adjust to the demands of life.
Following the induction of hypnosis, which focuses the client and enhances receptivity, the metaphor may be introduced with something like this:

As you rest back in those feelings of comfort, I’d like to tell you a story … a story that illustrates well a valuable lesson that can really make a difference in your life....

Bill and Bob were buddies, in fact close buddies. They were close buddies with Jim as well. All three worked together, went camping and fishing together, and enjoyed social family times together with a barbecue or picnic. One day one of those things they hadn’t expected—and would not have dreamt of happening—happened. As Bill was to tell me later, “Sometimes shit just happens.” An event occurred outside of their control.

There was nothing they could have done to prevent it, though I know Bill and Bob later went over and over it, many times in their minds, wondering if there had been anything they could have done differently.

Bill, Jim, and Bob had been working together, almost shoulder to shoulder, when there was a sudden, loud, deafening noise. A machine with which they were working exploded. Jim, who was in the middle, sustained the full force of the sudden eruption. Bill and Bob were stunned by what should not have been, and they felt helpless and powerless as they witnessed their best buddy suffer a violent and horrific death. Bill and Bob miraculously escaped any significant visible injury, but they had been witness to, and personally involved in, something that was terrifying and traumatic. In some ways, it was only natural to expect that they would have a distressed reaction to their experience as well as to the grief of losing such a good buddy.

I saw Bill and Bob separately soon after this incident. When I saw Bob, he would say things to me such as “I am constantly thinking it could have been me,” “It keeps running round and round in my head,” and “I could be dead, too.”

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<tr>
<th>The Problem</th>
<th>The Resources</th>
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<td>The unexpected or unwanted can happen.</td>
<td>Thinking optimistically.</td>
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<td>Not everything is in our control.</td>
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<td>Experiencing ruminative thoughts.</td>
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<td>Something frightening and traumatic occurs.</td>
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<td>Feeling helpless, hopeless, and powerless.</td>
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<td>Experiencing terror and trauma.</td>
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Bill, who had been standing side-by-side with Jim and witnessed exactly the same event as Bob, told me something almost completely different. Bill said things such as “I keep thinking how lucky I was to survive”; “I feel deeply sad for Jim yet thankful for myself, my wife and kids that I am alive”; and “If I slip back into negative thoughts or am struggling to get off to sleep, it helps to remind myself how lucky I am.”
I felt deeply for them both and at the same time was amazed that they each could react so differently. Bob was asking himself unanswerable questions such as “Why do these things always happen to me?” and “Why is it always one thing after the other?” and making statements such as “My life has been a mess from day one” and “I will never get over this.” The more he said these kinds of things, the more he seemed to slip into a darker and darker hole of despair, thinking that this is the way his life always had been and would always be. To Bob, it was just another cruel blow that fate had dealt him, and it was the way his life was sure to continue forever.

Thinking globally.

Thoughts can influence feelings and experience.

Bill needed time to work through his natural reaction of grief, fear, and uncertainty. There is no doubt that such powerful incidents can affect us in profound ways. And when we lose someone or something dear to us, grief may serve as a way for us to adjust or adapt to that circumstance: Feeling our sadness, being aware of the loss and its implications, shedding tears, having feelings of rage, and needing time to process what has happened are all healthy and to be expected. In this process, Bill seemed able to put things into compartments more readily than Bob. He said to me, “I sure as hell miss Jim. It is really terrible what happened to him and his family, but there are other things that haven’t changed. I still have my other buddies. I can forget about it for a while when I am out in the boat fishing with them. My family has been there for me with their great support.”

Bob made comments such as “Nothing will bring Jim back,” “Nothing is going to change,” and “How can I ever expect to feel any differently?” He felt angry and bitter as he relived the memory of the accident over and over in his mind. He felt powerless and helpless that he had not been able to save his friend, and thinking like this, he gradually became more and more withdrawn. He stopped seeing friends, he began to think of death and suicide, and his wife found his attitude and behavior so unbearable to live with that she warned him if he didn’t shake himself out of his misery, she would have to leave him. When he didn’t, she did leave him, and he then found even more reasons in his mind to think that life had dealt him a mean hand. And he was sure that nothing was likely to change it.

Bill, on the other hand, didn’t see things as fixed and unchangeable as Bob did. He even said at one point, “Yes, life is tough at the moment, but it will pass.” He could see that after the night there would another dawn, that after the rain the sun would shine once more. He saw that things could and would change for the better. He looked on life as being flexible rather than fixed and rigid.

Thinking specifically.

Grief is natural.

It is okay to feel loss and the accompanying emotions.

Thinking inflexibly.

Experiencing resultant feelings of powerlessness and helplessness, withdrawal, suicidal ideation, and relationship difficulties.

Thinking flexibly.

Experiencing resultant feelings of hope.
In contrast to Bob, Bill had hope that things would begin to change. He started to look forward again to times he would spend with his family and began to plan his next camping and fishing vacation. He also spoke to the human resources manager about returning to his work. He wasn’t ready to go back to where the accident occurred, so the company, showing some understanding, allowed his gradual return into another section of the company.

Bob did not see a future. He held no hope of change and spent his time looking back not only on what had been, but especially on what had been negative. His statements did not speak of a potentially positive future, and he saw no light at the end of the tunnel. He reminded me of a poster I once saw in a shop when we were going through an economic downturn. It read, “Due to the recession, the light at the end of the tunnel has been turned off.” It was the sort of thing that I could too easily have envisioned Bob sticking on his wall.

Both the direction and nature of Bob’s focus were not proving helpful to him. On the contrary, because he was focused on himself only and, worse, on himself in a very negative way, he constantly dwelt on the bad things that had happened to him and the bad ways that he was feeling. He lived at home by himself and, despite offers of assistance by his company, did not go back to work.

Bill’s focus was more outward. He said to me at one stage, “I need to think of my family. The kids need a normal dad who is fun to be around, and my wife doesn’t want to be living with a miserable man.” Thinking of others was helpful and constructive for Bill. His family felt better, and thus he felt better.

And I found myself wondering what Bob could do to think more like Bill. If I had said something such as “You have to change the way you think,” I am sure he would have replied with something like “It is not that easy,” and, of course, he would have been right—in part. It was not simple when he had been thinking that way all his life and did not know how to change. I doubt he was aware of some of the recent research in the area of neuroscience that is showing how, when you think pessimistically like Bob, you exercise a part of the brain called the right prefrontal cortex, and when you think more positively like Bill, you activate more the left prefrontal cortex. Like going to the gym, if you lift a weight with your right arm most of the time, you become pretty good at it, but try to lift the same weight with your left arm and you may not do as well until you exercise the left arm more.

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**How Do You Shift Your Style of Thinking?**

It may not be easy. The phrase in part allows for an exception or new possibility.

Offering a scientific metaphor to validate that change is possible (Davidson, 1995, 1998, 2005; Davidson, Pizzagalli, Nitschke, & Putnam, 2002).
SUMMARY

My aim in this chapter has been to provide a process for working with metaphors that will help clients both acquire and build the essential coping skills to prevent or overcome depression and, more importantly, enhance their personal levels of happiness and well-being. The steps I have described for this process are as follows:

1. Undertake a detailed, specific, outcome-oriented assessment to clearly define the therapeutic goals and ensure that the process of therapy is focused, not like throwing darts at a blank wall.
2. Explore what therapeutic model, grounded in sound evidence, is most likely to help achieve those goals.
3. Define the specific strategies or therapeutic interventions within that model that will be most specific and relevant for your client.
4. Structure those strategies into a client-relevant metaphor based on the PRO approach that describes the problem (to engage the client in a search process and identification with the story), the resources (to provide the means, resources, and processes that are helpful for the client to acquire and utilize), and the outcome (to reach the client’s desired therapeutic goal).

Exercise your brain with a lot of negative thoughts, say the neuroscientists, and you become pretty good at thinking negatively. To become better at thinking in a helpful way, it is a matter of exercising that part of the brain, and doing it and doing it and then doing it some more—just as you did in learning to ride a bike or drive a car or acquire a new skill at work. The more you do it, the better you become; and the better you become, the easier it is.

Meeting both Bill and Bob left me wondering how two people could respond so differently to the same thing. Maybe there was some level of choice they each had about how they respond to their situation in the present. Maybe there were things they could learn from their experience that would better equip them to handle life’s unexpected events in the future. I was particularly curious about Bill, about what he did that helped him to adjust so much better. Something Bill and Bob reminded me is that though only one thing may occur, there are many possible ways to deal with it. Some things that occur, we may not have control over, yet how we feel about and respond to them are things over which we do have control. Some of the ways we respond may not be all that helpful, but some can be very helpful.

Drawing on past learning experiences to provide the means for change.

The Outcome

Opening up choices.
Learning from others’ experiences.
Discovering it is not the event but the way we respond to the event that makes the difference.
My emphasis on using metaphors to build positive coping skills that go beyond the aim of just removing depressive symptoms is perhaps best summarized by Seligman et al. (2005) when they said,

[T]here are many positive benefits that come along with experiencing high amounts of pleasure, engagement and meaning, one of which is enhanced coping. It seems that positive emotions have the ability to buffer individuals against stress and depression, and for this reason we believe that positive interventions have potential as interventions for treating and preventing depression (p. 281).

EDITOR’S SUMMARY

- Happiness is not merely the absence of depression. Personal factors giving rise to happiness are considered, especially skills for coping with stress and adversity, the focus of this chapter.
- Avoidant coping is highly correlated with depression; avoiding problems does not increase either effective problem-solving behavior or the proactive seeking out of positive experiences.
- Conflict avoidance leads to distressed relationships with others, decreasing relationship satisfaction.
- Rumination as a coping style can reinforce depression by reducing the likelihood of taking effective action, instead promoting an “analysis paralysis.”
- A vital skill to teach in therapy is the ability to discriminate when a coping strategy is effective versus when it is merely familiar or reflexive.
- Happier people are generally more proactive in most areas of their lives than are those who are unhappy.
- The position that therapists take regarding the goals of therapy—reduce depression or increase happiness—has profound implications for the direction and quality of treatment.
- Developing an outcome-oriented framework involving well-defined goals for therapy can model effective problem-solving strategies and encourage a more proactive approach to living.
- Metaphor can be an especially valuable means of imparting therapeutic teachings within an outcome-oriented framework, as illustrated in a case example.

REFERENCES


BUILDING COPING SKILLS WITH METAPHORS


Hypnosis and the Treatment of Dysphoria: The 5-Finger Technique

STEVEN JAY LYNN, ABIGAIL MATTHEWS, STEVEN M. FRAIOLI, JUDITH W. RHUE, AND DAVID I. MELLINGER

Mood and anxiety disorders exact a dear price on the American public. Depression and anxiety each affect more than 19 million Americans (National Institute of Mental Health [NIMH], 2001, 2002), qualifying them as among the most commonly diagnosed psychiatric conditions. Approximately one in four people will experience a bout of depression at some time in their lives (Kessler et al., 1994). At any given time, 4% of the population contends with dysthymia, a mild yet chronic form of depression (NIMH, 2001). Each year, the symptoms of panic (e.g., racing heart, dizziness, sense of unreality) afflict between a third and half of the people in the United States (NIMH, 2001), and social fears—one of the most widespread anxiety conditions—unsettle the lives of an estimated 13.5% of the population (Kessler et al., 1994). Among children 16 and younger, anxiety is the most prevalent psychiatric diagnosis (Dacey & Fiore, 2000). The deleterious consequences of these conditions are legion, and include the following: (a) impaired interpersonal relationships; (b) elevated suicide rates, especially in the case of depression; (c) co-occurrence with illnesses including heart disease, stroke, cancer, and diabetes; and (d) billions of dollars a year in lost productivity and income, and concomitant financial burdens on the family and society in general (Lynn & Kirsch, 2006; Mellinger & Lynn, 2003).
HYPNOSIS AND TREATING DEPRESSION

COMORBIDITY OF DEPRESSION AND ANXIETY

What is not evident from these statistics, and the recitation of the grim repercussions of these disorders, is the fact that symptoms of depression and anxiety often occur together. In fact, statistically speaking, the co-occurrence or comorbidity of these disorders is the rule rather than the exception. Indeed, epidemiological studies have indicated that up to 59.2% of lifetime cases of major depressive disorder (MDD) occur concomitantly with an anxiety disorder, and approximately 56% of individuals with an anxiety disorder also experience a depressive disorder (Joiner, Voeltz, & Rudd, 2001; Zajecka & Ross, 1995). Moreover, comorbidity rates vary among the specific anxiety and mood disorders. For instance, Brown and Barlow (2002) reported that MDD, dysthymia, generalized anxiety disorder (GAD), and posttraumatic stress disorder (PTSD) were the most frequently comorbid disorders, whereas panic disorder had the lowest comorbidity rate. Furthermore, studies have shown that up to 79% of individuals with GAD, approximately 70% of individuals with panic disorder, up to 85% of individuals with obsessive-compulsive disorder, and between 35% and 70% of individuals with social phobia have a present or past mood disorder history (Zajecka and Ross, 1995).

Which is primary: anxiety or depression? There is a consistent temporal relation between depression and anxiety (Dozois & Westra, 2004). That is, anxiety is more likely to be primary in the anxiety–depression link. Belzer and Schneier (2004) found that anxiety was primary in 67.9% of comorbid cases. The first episode of anxiety generally occurs in childhood and adolescence and uncommonly after the age of 20. Compared with nonanxious children, anxious children are 2 to 4 times more likely to develop depression (Dacey & Fiore, 2000). In contrast, the rate of depression increases sharply in late adolescence and continues to rise after the age of 20 (Wittchen, Kessler, Pfister, Hofler, & Lieb, 2000). Anxiety typically precedes depression by years and serves as an early warning signal of being at a higher risk for eventually developing comorbid depression.

In general, the onset of depression is associated with the number of anxiety disorders present, the persistence of anxious avoidance behavior, and the degree of psychosocial impairment (Wittchen et al., 2000). Indeed, depressive symptoms often appear to be a reaction to anxious symptomatology. Anxious individuals may feel bad about themselves, their environment, and their future, facilitating the development of depression (Sanderson & McGinn, 1997). Alternatively, an individual’s depressive symptoms may reflect a reduction in external reinforcement subsequent to anxious avoidance strategies, or may develop as a consequence of the negative effects of anxious symptomatology on self-esteem (Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Brown, Schulberg, Madonia, Shear, & Houck, 1996).

Yet another possibility is that adverse environmental circumstances and an inherited propensity to experience emotional dysregulation potentiate the risk of both anxiety and depression (Kaufman & Charney, 2000). Suggestive evidence
for common etiological influences includes the fact that anxiety and depressive conditions both respond to SSRI antidepressant medications and cognitive behavioral therapy, and treating one disorder often leads to the remission of the other (Barlow, 2002).

When depression is primary, anxiety often reflects fears and worries that the depression itself will not subside, concerns about family members who are dependent on the patient who is not functioning at a high level, and the combined weight of tasks and obligations that are not completed or addressed satisfactorily. Research further suggests that the temporal order of onset varies with the specific anxiety disorder. Whereas GAD and social phobia are more likely to precede MDD than the reverse, panic disorder is more likely to develop subsequent to depression (Brown et al., 2001).

Depression Versus Anxiety

In general, vegetative symptoms (e.g., anorexia, weight loss, and diminished libido) are more conspicuous in depression, and symptoms associated with sympathetic overactivity (e.g., tachycardia, sweating, and hyperventilation) are more prevalent in anxiety conditions (Maser, Weise, & Gwirtsman, 1997). When anxiety is primary, sleep-onset insomnia accompanies a predominantly anxious mood, there are no significant changes in psychomotor activity, and there is no therapeutic response to exercise (Clayton, 1990). In contrast, when depression is primary, depressed mood prevails, and there are indications of terminal insomnia (i.e., early morning awakening), psychomotor agitation or retardation, and a positive therapeutic response to exercise (Clayton, 1990).

These signposts can be very helpful in determining an initial treatment focus when symptoms of both anxiety and depression are present and constitute a brew of disquieting symptoms we hereafter refer to as dysphoria—a condition of general unhappiness, dissatisfaction, pessimism, restlessness, and tension, and a pervasive feeling of discomfort (Barker, 1999). Indeed, anxiety and depression symptoms are correlated above $r = .61$, reflective of a moderate to high degree of association (Dobson, 1985), and a number of symptoms span diagnostic categories including sleep and appetite disturbance, impaired concentration, irritability, fatigue, and nonspecific somatic complaints (Zajecka & Ross, 1995). Anxiety and depression are also both associated with negative cognitions and impaired behavioral functioning, negative self-concept, and negative predictions and biases (Sanderson & McGinn, 1997).

The combination of depression and anxiety is a significant treatment concern in that dysphoria tends to be chronic, relapse is common, and it is characterized by greater functional impairment than either depression or anxiety alone (Belzer & Schneier, 2004; Clayton et al., 1991; Dozois & Westra, 2004). Furthermore, dysphoria is associated with an increased risk of suicide and more intense suicidal ideation, alcohol abuse, occupational and social disruption, and poorer short-term and long-term outcomes (Belzer & Schneier, 2004; Joiner et al., 2001).
Poor clinical prognosis indicates the need for more effective treatment options for dysphoria. Whereas the majority of treatment research on this condition focuses on pharmacological interventions (e.g., Belzer & Schneier, 2004; Goldberg, 1999; Rapaport, 2001), dysphoria has been shown to be somewhat amenable to psychosocial treatments, including cognitive behavioral therapy, problem-solving therapy, and interpersonal therapy (Belzer & Schneier, 2004; Goldberg, 1999; Joiner et al., 2001; Sanderson & McGinn, 1997). Unfortunately, we could not locate a single well-controlled study that has investigated dysphoric patients’ responsiveness to any treatment, and also parsed the independent effects of anxiety and depression.

In this chapter, we present case material that illustrates how hypnotic techniques can be integrated into a treatment for dysphoria in which the patient collaborates actively in devising a multifaceted, highly individualized protocol. The treatment is grounded in empirically supported principles and procedures of cognitive-behavioral and interpersonal therapies, and acceptance-based approaches for preventing relapse. The “5-Finger Technique” we describe represents an “operator’s manual” that is at once uniquely tailored to the patient who assisted in creating it, and a general template for patients with a wide range of concerns associated with dysphoria. In the course of our discussion, we will underscore the need for a comprehensive assessment and treatment plan based on an integrative conceptualization of shared elements of anxiety and depression.

HYPNOSIS AS AN ADJUNCT TO EMPIRICALLY SUPPORTED METHODS

Cognitive Behavior and Interpersonal Therapies

Lynn and Kirsch (2006) contended that hypnosis can maximize treatment gains of empirically supported methods for the amelioration of anxiety and depression. Consideration of hypnosis as an adjunctive treatment for anxiety and mood disorders in the context of cognitive-behavior therapy and interpersonal therapy will provide the necessary framework for our discussion of the case of Ms. S. and the 5-Finger Technique that follows.

Cognitive-behavioral therapy (CBT) and interpersonal approaches are the most widely studied and seemingly effective psychological interventions for both depression and anxiety disorders (Barlow, 2002; Chambless & Ollendick, 2001; Deacon & Abramowitz, 2004). The focus of CBT is on identifying and modifying (a) irrational (e.g., inflexible, distorted, and/or exaggerated), highly negative beliefs about the self, the past, and the future (i.e., catastrophizing); (b) rumination about problems, failure experiences, and future events; and (c) the idea that depressing or anxiety-producing life circumstances are “unchanging and even unchangeable” (Yapko, 1993, p. 344).
Studies have consistently found support for Beck’s (Beck, Rush, Shaw, & Emery, 1979) cognitive-behavioral treatment of depression. Research has shown that CBT is at least as effective as antidepressant medication (Elkin et al., 1989; Hollon et al., 1992; Rush, Beck, Kovacs, & Hollon, 1977; Simons, Murphy, Levine, & Wetzel, 1986), and more effective than a placebo in treating atypical depression (Jarrett et al., 1999). Up to 70% of patients initially diagnosed as suffering from major depression no longer satisfy the criteria for depression after participating in a course of CBT (Craighead, Hart, Craighead, & Ilardi, 2002). An important bonus of CBT is that it reduces relapse rates relative to antidepressant medications (Hollon, Shelton, & Loosen, 1991).

Cognitive-behavioral therapy in the treatment of anxiety is equally promising. Over the past decade, seven meta-analytic reviews, which synthesize the findings of studies with multiple trials, have documented the effectiveness of CBT for panic with and without agoraphobia (see Deacon & Abramowitz, 2004). Over the same period, four meta-analytic views have supported the effectiveness of social phobia treatment, revealing that treatment gains persist after treatment (Federoff & Taylor, 2001; Feske & Chambless, 1995; Gould, Buckminster, Pollack, Otto, & Yap, 1997; Taylor, 1996). Consistent with these trends, three meta-analytic reviews indicate that CBT is effective for generalized anxiety disorder (Borkovec & Wishman, 1996; Gould, Otto, Pollack, & Yap, 1997; Weston & Morrison, 2001).

In contrast with CBT, interpersonal therapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) addresses conflicts and problems in interpersonal relationships, rather than distorted cognitions, and targets the areas of interpersonal disputes, unresolved grief, role transitions, and interpersonal deficits (e.g., lack of empathy and/or social skills). Interpersonal therapy was developed as a treatment for major depressive disorder and has been shown to be a promising approach in two randomized controlled trials (Weissman et al., 1979; Elkin et al., 1989), which also indicate that IPT can have a salutary effect in cases of treatment-resistant depression when combined with antidepressant medication.

Recently, an interpersonal approach has been used with patients who suffer from anxiety disorders, spurred by recognition of the importance of emotional processing of interpersonal feelings. More than any other topic, patients with GAD worry about interpersonal matters (Roemer, Molina, Litz, & Borkovec, 1997). In Newman, Castonguay, Borkovec, and Molnar’s (in press) integrative therapy for GAD, patients are informed that they may be so bent on avoiding what they fear from others that they fail to pursue their own interpersonal needs, inadvertently creating the very situations that engender not only anxiety but also negative outcomes. For example, by protecting themselves from others by failing to disclose their needs and feelings, they may be perceived as unapproachable, disinterested, and cold. The goal is to shift the patient’s focus “away from anticipating danger and toward openness, spontaneity, and vulnerability to others, as well as toward more empathic attention to the needs of others” (Newman et al., p. 329).
Hypnosis and Cognitive-Behavioral Therapy

The available evidence indicates that hypnosis can enhance the effectiveness of empirically supported approaches. Meta-analyses have shown that hypnosis augments the effectiveness of cognitive behavioral psychotherapies (Kirsch, Montgomery, & Sapirstein, 1995). A special issue of the *International Journal of Clinical and Experimental Hypnosis* on the topic of hypnosis as an empirically supported clinical intervention documented the effectiveness or promise of combining hypnosis with a variety of interventions in treating psychological and medical conditions ranging from acute and chronic pain to obesity (see Lynn, Kirsch, Barabasz, Cardena, & Patterson, 2000).

With respect to anxiety, Schoenberger, Kirsch, Gearan, Montgomery, and Pastynak (1997) compared a cognitive-behavioral intervention that involved cognitive restructuring and in vivo (“real-life”) exposure for public speaking anxiety, with a treatment that was identical in all respects except for the fact that relaxation was replaced with a hypnotic induction and suggestions. Participants were asked to give an impromptu speech, during which they rated their anxiety. Compared with no treatment, both treatments resulted in changes in anxiety; however, on both behavioral and subjective measures during the speech, only the hypnosis group differed from the no treatment condition. Moreover, anxiety dissipated more quickly when participants were hypnotized compared with the nonhypnotic cognitive-behavioral treatment. In a review of the literature on hypnosis and anxiety, Schoenberger (2000) concluded that cognitive-behavioral hypnotherapy is more efficacious in the treatment of anxiety disorders than no treatment.

Although there are no well-controlled studies that systematically evaluate the effects of hypnosis as an adjunct to the treatment of depression, Lynn and Kirsch (2006) contended that there is indirect evidence that it should be effective. That is, the placebo response seems to be particularly strong in the treatment of depression (Kirsch & Sapirstein, 1998), and conditions that are responsive to placebo treatment generally seem to be responsive to hypnotic treatment as well. Moreover, Yapko (1992, 1993, 2001) has developed a creative and promising approach to the use of hypnosis to treat depression that combines cognitive-behavioral and interpersonal methods.

ASSESSMENT AND REVERSE ENGINEERING

Before we discuss the specifics of the case of Ms. S., we will present a brief scheme for assessing and treating symptoms of both anxiety and depression that centers on the process of “reverse engineering,” that is, working backward, in effect, from the causes of anxiety and depressive reactions to the treatment of dysphoria (Mellinger & Lynn, 2003). By working backward in order to figure out how to get a malfunctioning device functioning again, we can often learn in the process what “makes it tick.” Reverse engineering helps keep things ranging
from children’s bikes to artificial hearts running smoothly. When applied to the treatment of dysphoria, we will contend in this chapter that reverse engineering involves (a) analyzing, challenging, and modifying the catastrophic thinking and dysfunctional thought patterns that give rise to dysphoria; (b) enhancing expectancies for change in demoralized patients; (c) undercutting patients’ tendencies to avoid what is feared in the case of anxiety, or to avoid engaging in meaningful activities and challenging situations in the case of depression; (d) enhancing patients’ abilities to accept whatever experiences arise in the course of living and making meaningful choices to improve the quality of life; and (e) employing techniques that address dysfunctional interpersonal relationships and restore and maintain healthy functioning.

### Negative and Catastrophic Thinking

Catastrophic thinking is a critical feature of anxiety and depression (Beck, 1976; Ellis, 1962; Ellis & Dryden, 1997). Catastrophizing is a fundamental error of dysphoric thinking in which people exaggerate how negative an outcome will result or has resulted from entering into anxiety or depression-provoking situations. Anxious people often predict that terrible events will happen, even though objectively they have a low probability of actually occurring. If a person thinks an elevator is unsafe and will crash to the ground, it is understandable that he or she will experience an increase in heart rate in that situation. Thinking about past failures predicts negative outcomes in depression. If a person convinces him or herself that he or she will fail at whatever he or she attempts, and magnifies negative outcomes before or after they occur, depressive feelings are virtually guaranteed.

The catastrophic and negative thoughts that fill the dysphoric person’s mind are often unbidden, seem to “come out of nowhere,” and are known as automatic thoughts (Beck, 1976). In depressed individuals, automatic thoughts typically focus on themes of loss, rejection, and failure, whereas in anxiety disorders, the focus is most often on the perception of threat. In particular, depressed patients tend to have automatic thoughts that belong to what Beck has described as the cognitive triad. These are persistent negative thoughts about the self, the world, and the future. Assessing, challenging, and changing negative thoughts and the cognitive distortions that give rise to them is a key feature of cognitive therapy (Lynn & Kirsch, 2006).

### Negative Expectancy

Anxiety expectancy—the apprehension of having an uncomfortable physiological stress reaction—is a self-confirming response expectancy that is at the heart of catastrophic thinking (Kirsch, 1985; Reiss & McNally, 1985). Goldstein and Chambless (1978) realized that agoraphobic patients were not really afraid of the bridges, elevators, or shopping malls they were avoiding. Instead, they were afraid
of the panic attacks that they anticipated experiencing in these situations. The expectation of a panic attack is frightening enough in itself to induce panic.

Likewise, a depressed person’s expectation—“I am never going to get better; I’ll always feel like this”—is bound to elicit hopelessness and exacerbate depression. In short, being depressed is depressing; hopelessness begets hopelessness. Dysphoria can thus be described as a self-confirming expectancy disorder: People with significant anxiety have a fear of fear, whereas people who feel depressed are convinced they are “bad” or worthless because they are depressed, or convince themselves they will not recover (Kirsch, 1985; Kirsch & Lynn, 1999).

**Avoidance**

Ongoing assessment and monitoring of expectancies are integral to the treatment of dysphoria. In fact, the stronger the anxiety expectancy, the stronger the avoidance (Kirsch, 1985; Kirsch & Lynn, 1999). Because avoidance allows escape from what is feared, anxiety is reinforced and becomes more ingrained (Mowrer, 1960). Moreover, avoidance precludes the opportunity to learn from direct experience that fears are unrealistic or exaggerated. In this way, anxiety and hopelessness become stubbornly entrenched. Assessment of anxiety-related avoidance maneuvers includes not only specific situations but also thoughts and feelings associated with anxiety.

A comprehensive assessment of depressed feelings should encompass the avoidance of risk, challenges, work and personal responsibilities, and recreational activities due to concerns about failure. The threat of loss, rejection, and abandonment is often associated with the avoidance of potentially rewarding interpersonal relationships. In time, the depressed person’s world shrinks, as self-imposed constraints limit opportunities to “undo” a sense of pessimism, self-doubt, and failure.

Another avoidance maneuver that merits attention is rumination. As involvement in life recedes, patients often spend a great deal of time ruminating about the possible meaning of events and place a negative spin on them (“Does his not calling mean he will reject me?”), or they dwell on past negative events (“Men always reject me and can’t be trusted”). Rumination intensifies depression, justifies avoidance, creates a sense of immobilization, precludes effective problem solving, and layers anxiety on top of depressed feelings (Morrow & Nolen-Hoeksema, 1990; Nolen-Hoeksema, 2000).

An interesting aspect of avoidance is that the attempt to suppress a particular thought or action tends to increase the propensity to engage in the thought or action (Polivy & Herman, 1985; Strauss, Doyle, & Kreipe, 1994; Wegner, Schneider, Carter, & White, 1987). Attempts to consciously suppress thoughts can make them all the more demoralizing when they recur, asserting their strong presence. Relatedly, when emotions are suppressed or concealed, rather than fully experienced and expressed, memory (Richards, Butler, & Gross, 2003) and problem
solving (Baumeister, Bratslavsky, Muraven, & Tice, 1998) are compromised. Moreover, physiological markers of stress increase (e.g., electrical conductivity of the skin, constriction of blood vessels; Richards & Gross, 1999, Study 2) in the face of emotional suppression. In short, dysphoria only grows stronger as it incubates.

By determining what is avoided and learning to confront, rather than avoid, what is feared, a sense of personal effectiveness can replace hopelessness. A high level of acceptance and experiencing of emotions is associated with positive psychotherapeutic outcomes (e.g., Greenberg & Safran, 1986). Techniques that promote mindfulness and acceptance of negative as well as positive experiences as they unfold have an important role in the treatment of anxiety as well as depression (see Baer, 2003; Hayes, Jacobson, Follette, & Dougher, 1994; Shapiro & Walsh, 2003).

THE CASE OF MS. S.

Ms. S. is a 26-year-old, unmarried medical student with no history of prior psychotherapy. Her presenting concern was depression punctuated by weekly panic attacks that included symptoms of dizziness, tight chest, a fear of dying, and racing thoughts. The triggers for her first session of psychotherapy were her failing a major comprehensive examination and receiving advice from her scholastic advisor to receive psychological help. She confided that she was feeling “unmotivated, worthless, and hopeless,” with recurrent ruminative thoughts about failing her medical boards and her lack of suitability for the medical profession. She consulted one of the authors (S.J.L.) because he had helped one of her acquaintances in medical school pass her medical boards using self-hypnosis and cognitive-behavioral strategies.

Apart from her first year of undergraduate studies, Ms. S. was an excellent student, and she was recently reassured by her advisor that she “had what it takes” to be a doctor. However, her poor grades during her freshman year seemed to serve as a touchstone for catastrophic thoughts of academic failure, and constant invidious comparisons of herself with her medical student peers. After failing her comprehensive exam, she reported she was “work phobic” and “filled with intense shame.” She also engaged in solitary, excessive drinking on a number of occasions, and became very disorganized and failed to clean up her apartment to the point that she worried aloud that she was becoming a “compulsive hoarder.” Moreover, every time she tackled an assignment, she felt she was not up to the task and, in the past month, reported feeling constant muscular tension, which she contended with by spending increasing amounts of time watching television and engaging in what she termed “totally frivolous” behaviors (e.g., knitting and “cruising the Internet”). When she was not involved in avoidant behaviors, she was flooded with guilt, accompanied by memories of “past failures” when she failed to fulfill what she stated were her parents’ high
expectations for her, many of which centered on her being what they referred to as the “genius” of the family.

After several sessions, information about Ms. S.’s history revealed that her problems ran deeper than her feelings about failing one exam. She reported that her father was a salesman who lost a major account due to binge drinking and the repercussions of a manic episode, and the family was on the edge of bankruptcy on many occasions due to her father’s inability to manage money. Emotionally speaking, her home life was not stable. Her older brother had committed suicide by overdosing after the breakup with a girlfriend when Ms. S. was 19 years old. About a month before his death, Ms. S. learned that he was abusing cocaine, but “did nothing about it,” and felt responsible for his death. After his death, she reports that her parents were devastated, and she resolved to be the “success story” of the family, despite feeling like a “total failure” for “killing her brother.” In fact, her guilt spilled into her relationship with her parents, whom she felt more intent on pleasing than ever because she had “taken their son from them.”

Ms. S. kept her emotional pain to herself, afraid of further wounding her emotionally fragile mother, who wanted her and her younger brother to be “happy at all costs.” At dinner, any meaningful discussion of problems or feelings was thwarted; unpleasant topics were invariably skirted, and her mother “cried at the drop of a napkin.” This attitude of maternal avoidance of conflict, combined with her father’s challenging, argumentative, and defensive nature, resulted in Ms. S. suppressing feelings of sadness, guilt, and rage, much of which was directed toward her father, who she felt never validated her and questioned everything she did that he could not control. In recent years, however, her father had achieved abstinence from alcohol as well as job security, and he had made efforts to establish a more supportive relationship with Ms. S. She did not completely trust in her father’s transformation and expressed fears that he would revert to his “old self”; however, she did spend more time talking with him about religious and spiritual matters, an interest they shared.

Ms. S. described herself as a shy child who was high strung and prone to worry. She was a voracious reader, excelled in the classroom, and was active in orchestra, but she never felt like she fit in very well socially, although she played on a regular basis with a neighbor and had a number of “good acquaintances” in orchestra. She was often teased for being “teacher’s pet,” and, for a year in middle school, was a self-described hermit. Although she yearned to date, she became very anxious when approached by boys, and was uncomfortable flirting or making “small talk.”

In high school, Ms. S. retreated from her feelings by escaping into school work, practicing scales on her violin, and reading fantasy and science fiction. She did have a few friends, but she felt emotionally imprisoned by her perceived need to keep secrets about her family, her failure to trust others due to her vulnerability to criticism and intolerance of conflict, and her need to maintain a confident facade to compensate for feelings of inadequacy.
Ms. S. is attractive, intelligent, and possessed of a dry, sarcastic wit. In the month prior to starting therapy, she met a fellow medical student she “clicked with,” and considered him to be her first boyfriend, although she did not describe her relationship as serious.

The Treatment of Ms. S.: The 5-Finger Technique

Ms. S.’s stated goals at the outset of therapy, beyond passing her exams and attaining her medical degree, were to rid herself of dysphoria and to be able to express her feelings with impunity. As with many cases of dysphoria we have treated, Ms. S.’s negative mood states could be traced to long-standing characterological and family-related issues, as well as maladaptive thinking and coping responses and the inability to tolerate and confront feelings and develop a positive, problem-solving approach to life’s challenges. Nevertheless, we agreed that we could make significant strides toward achieving her goals in 20 sessions, with the possibility of negotiating additional sessions prior to termination.

In the first few sessions, the reverse-engineering approach was described and welcomed by Ms. S. Given that she inquired about hypnosis in the first session and seemed excited about the prospect of being hypnotized, we agreed to explore the possibility of using hypnosis as an adjunctive treatment. Hypnosis was presented as a means of channeling her resources in an efficient, effective manner to accomplish her goals. We adopted Sanderson and McGinn’s (1997) individually tailored approach to the treatment of concomitant depression and anxiety to the extent that we initially treated “symptoms” in a sequential manner, before we devised the more integrative 5-Finger Technique. From the outset, the emphasis was on collaboration. We agreed that we would experiment with a menu of individualized strategies until we felt confident that the protocol we developed would constitute a durable “operator’s manual” for achieving her goals.

The Physical Prong: Self-Control Relaxation Training. After gathering data in the first two sessions, it became apparent that weekly panic attacks were especially demoralizing; they robbed Ms. S. of a sense of control over her life and were increasingly limiting her activities. We therefore proceeded to treat panic in sessions 3 through 5 with hypnotically augmented self-control relaxation training (SCRT; Mellinger & Lynn, 2003), with breathing retraining being an important component of the intervention. Because Ms. S., like many patients we have treated, felt that she was a failure if she did not “relax completely,” she was given permission to hold onto a modicum of tension in the process of relaxing. Self-hypnosis was introduced as a means of orchestrating the experience of hypnosis with the goal of implementing hypnotic techniques in many real-life situations. Suggestions along the following lines were given to Ms. S.:
Remember how you learned to ride a bike? If you were like me, at first you might have wondered whether you could do it. ... Whether you could experience the pleasure of riding a bike. ... Coasting along, feeling the gentle wind. ... And after a while, you learned that you COULD do it. ... And you were able to just get up on the seat and ride, and feel the wind in your hair and the pleasure of moving along ... at your own pace ... going in a direction of your choice. ... And didn't it become easier and easier, so that after a while, you didn't even have to think about staying in control, but you knew that you were in control of where you went and how you got there? ... And, you know, it's the same thing with hypnosis. ... You do it, you go in a direction of your own choosing. ... You decide whether to respond or not ... to cooperate or not ... to imagine or not ... to try to make the suggestion seem real. ... And it gets easier and easier ... just like riding a bike. ... After we practice with me giving you suggestions at first, you realize that all hypnosis is self-hypnosis. ... You make it happen, you create the experiences for yourself. ... I can't do it for you. And you, too, can devise helpful suggestions tailored just for you ... made just for you, by you. ... I can help if you like, but you can do it too. ... After all, you know yourself even better than I know you. ... But for now, just relax, settle in, and I'll give you some suggestions that you can make seem real ... real to you, in your own mind, in your own way. ... And after that, after you experience hypnosis for yourself, you can begin to generate suggestions of your own ... suggestions that can and will help you to achieve your goals, just for you, your suggestions. ... Not mine, but yours. ... And we can work together too, to devise suggestions, and these suggestions can be “ours.”

We will start with me giving you some suggestions that you can use to hold onto only as much tension as you need, and no more ... just enough to feel comfortable and relaxed, safe and secure. ... Actually, you have had a lot of experience in holding on and letting go. ... When you were a child and learned to walk, you held onto the walls when you needed support. ... The stronger you became, the more agile and confident you became ... and as you sensed you could release, you did ... and you were able to let go of the walls. ... You had to hold on less and less as you became more confident in your abilities. ... You learned to train your muscles to support the activities your mind wanted you to engage in. ... And today, you can walk on your own. ... You can talk on your own. ... You can stand on your own two feet and make decisions for yourself. ... And today, you can become more confident in your abilities to experience hypnosis as you experience yourself holding on and letting go ... releasing and relaxing.

You know that you need a certain amount of tension in your body to sustain your everyday functions. ... You need a certain amount of tension in the muscles of your mouth to talk, but you don’t have to talk during hypnosis ... unless you want to. ... You need a certain amount of tension in your legs to walk, but you don’t have to walk during hypnosis, unless you want to. ... And you need a certain amount of tension in your eyes to open them and keep them open, if you want to. ... But you don’t have to open your eyes during your hypnosis today, unless you want to. ... In fact, I would like to invite you to close your eyes right now. ... Release all of the tension in your eyelids and eyes that you do not need ... relax your eyes and let them close ... let them close, knowing you could summon up just as much tension.
as you would need at any time to open them. ... Now create just enough tension to open your eyes a little and then release the tension in your eyes and let them relax even more completely ... more completely, let them close comfortably, and let your body begin to release some of the tension that it does not need ... And as you begin to do this, you notice that your body relaxes. ... Actually, you need to have very little tension in your body for you to breathe, walk, talk, and see because much of these basic processes occur automatically, with little conscious awareness and relatively little tension required to sustain these activities ... So, if you want, your body can become relaxed, very relaxed, perhaps even more relaxed than when you sleep. ... Today, we will discover just how much tension you need while your body releases and relaxes as much as it possibly can.

And as your body begins to relax ... I would like to draw your attention to your breathing. ... As you notice your breathing, perhaps you notice a certain amount of tension when you breathe in, and then a relaxation of tension when you breathe out ... although your breathing may be very effortless, and you may not even notice the steady rhythm of breathing in and out ... in and out. ... But for now, I would like you to take in a very deep breath and hold it for as long as you can. ... And then you will notice some tension I am sure. ... And when you can hold that breath no longer, let it out. ... Release the breath completely. ... See how good you can feel. ... Let the tension out and experience how deeply relaxed you feel when you release the breath completely ... release the breath completely and hold onto only as much tension as you need to feel relaxed and comfortable, comfortable and at ease. ... And now take another breath ... hold it for as long as you can and then release it, just as you did before ... tensing and releasing ... releasing and relaxing ... holding on and letting go. ... And now feel your breathing becoming easier and easier ... easier and easier ... with each breath you release tension you do not need and you become more and more relaxed, peaceful and relaxed. ... If you feel yourself becoming more tense than feels right for you, at any time during the day or night, slow down your breathing ... way slow ... in this way you control the balance of oxygen and carbon dioxide in your body ... and you can calm down, and feel more at peace. Give yourself suggestions to feel calm, and at peace, as you be sure to breathe deeply and slowly, deeply and slowly, from deep down in your belly, slow and relaxed breathing. Breathe as slowly, as easily, as rhythmically you can. ... If you breathe only 7 or 8 times a minute, that's all right. ... Feel yourself beginning to feel more at ease as you slow your breathing.

Suggestions for progressive muscle relaxation were then given, with suggestions for letting go of muscle tension in each of the major muscle groups of the body. This exercise was repeated at the beginning of the next two sessions, and Ms. S. was also taught a physical cue (i.e., bringing her thumb and index finger together) to trigger a relaxation response at will. Additionally, Ms. S. was instructed to practice SCRT as many times during the day as possible, and to imagine and contend with stressful situations such as studying for her comprehensive examination, and then quell her anxiety with SCRT.
In session 3, she was also taught to scan her body for “tension spots,” and to practice letting go of as much tension as she did not need in those particular spots. She was instructed to observe that dysphoric feelings come and go, wax and wane, and would, as a rule, eventually be replaced with more positive feelings. Another exercise that proved very helpful in short-circuiting rumination and fears of future failures, was for Ms. S. to practice focusing on sensory impressions (e.g., sounds and sensations) “in the present,” if she found herself becoming anxious or descending into a dark mood. Ms. S. requested a tape of hypnotically augmented SCRT and agreed to use the tape to fortify her skills on an as-needed basis.

By session 4, Ms. S. no longer felt intimidated by fears that she would panic. Indeed, she had not experienced a panic attack for the previous 3 weeks, and felt that she had an “intellectual and emotional” understanding that many of the physical sensations of panic did not presage a catastrophic event, but instead reflected her “fear of fear,” and the hyper-awareness of the physiological effects of muscle tension and shallow rapid breathing.

The Cognitive Prong. In session 4, we made a commitment to develop a personal “self-help manual,” with relaxation being the first prong of the approach that was beginning to take shape. Over the course of the first three sessions, Ms. S. self-monitored thoughts with the goal of identifying and ultimately challenging dysphoria-related automatic thoughts and distorted ideas and expectations (e.g., personalization, mind reading, overgeneralization, black or white thinking; see Lynn & Kirsch, 2006).

Sessions 4 through 8 focused on negative self-suggestions that Ms. S. identified, and we deemed it worthwhile for her to use self-hypnosis and cue-controlled relaxation to achieve a receptive state in which she used conscious, deliberate exposure to distorted or illogical thoughts to weaken their malign power to sway her emotions and actions. Although she was continuing to be aware of her breathing, it was suggested that she imagine that she could “turn up the volume” to make a conscious effort to nag and criticize herself so that she could experience her purposeful control of her internal dialogue, while becoming increasingly aware that the “old tapes in her brain” amounted to nothing more than negative self-suggestions. Once she realized that she was responsible for generating the thoughts she struggled with, she was instructed to “turn down the volume” and engage in cognitive rebuttal. With some practice, she was able to slow her breathing, trigger deep relaxation while she experienced one thought at a time as she inhaled, and think or say aloud a “rebuttal” statement as she exhaled. Some examples of maladaptive thoughts and her rebuttals are presented in Table 4.1. Note that it was further suggested that she identify the “healthy intention” associated with each problematic thought as well as the negative or “unhealthy effect” of each thought.

In the course of identifying and rebutting negative self-suggestions, Ms. S. became increasingly aware of the need to talk to her parents about her lingering
Table 4.1 Examples of Maladaptive Thoughts and Rebuttals

<table>
<thead>
<tr>
<th>Maladaptive Thought</th>
<th>Type of Thought</th>
<th>What It Tries to Do (healthy intention)</th>
<th>What It Does (unhealthy effect)</th>
<th>Rebuttal</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I should have done more work earlier today.”</td>
<td>Should statement</td>
<td>Tries to motivate me, albeit though guilt.</td>
<td>Makes me feel guilty, worthless, and depressed. I become less active.</td>
<td>“I needed physical exercise and quality time with my fiancé. Now I can do better work as a result.”</td>
</tr>
<tr>
<td>(While looking at my apartment and the piles of work to do): “What a mess!”</td>
<td>Magnification</td>
<td>Tries to muster, mobilize, and marshal my attention, awareness, and focus.</td>
<td>Makes me feel discouraged, overwhelmed, sad, and anxious.</td>
<td>(As I smile): “I’m happy there is a place for everything, and everything is falling into place. I’m getting there, one step at a time.”</td>
</tr>
<tr>
<td>“Oh, no! This is due!”</td>
<td>Magnification</td>
<td>Tries to muster my positive action.</td>
<td>Makes me panic. I freeze in paralyzed fear.</td>
<td>“I’m on it. It’s a process. I trust the process.”</td>
</tr>
<tr>
<td>“It’s hopeless. No use trying any more.”</td>
<td>Magnification</td>
<td>Tries to save me from wasting effort; tries to save me from further failure.</td>
<td>Gives me a license to get intoxicated, give up trying, stop working, and so on.</td>
<td>“I’m open to the possibilities. Let’s see what happens. In some ways, the future is promising.”</td>
</tr>
<tr>
<td>“You lazy bum!”</td>
<td>Overgeneralization</td>
<td>Tries to motivate me, albeit though guilt.</td>
<td>Makes me feel guilty, worthless, and depressed. I become less active.</td>
<td>“I’m doing the best I can under the circumstances.”</td>
</tr>
<tr>
<td>“You’re so screwed up! You’re a nutcase!” (etc.)</td>
<td>Magnification</td>
<td>Tries to avoid failure by limiting my challenges.</td>
<td>Gives me a license to get intoxicated, give up trying, stop working, and so on.</td>
<td>“I’ve had some past issues that I’ve resolved. That was then; this is now. I’m moving forward with my life.”</td>
</tr>
</tbody>
</table>
guilt feelings about her brother’s suicide. Interpersonal therapy emphasizes resolving conflicts and barriers to openness and constructive dialogue as an important treatment goal. Accordingly, we discussed the possibility of having a family meeting to talk about how her brother’s death affected all family members. In session 9, with the therapist acting as facilitator of a meeting with her parents, it became apparent that Ms. S. was not alone in harboring guilt. As soon as she stated that she felt responsible for his death, both of her parents burst into tears and detailed how they were to blame, and subsequently distanced themselves from their feelings and Ms. S. because of their emotional pain. The session ended with the acknowledgment that there was little anyone in the family could have done to prevent his death, given that they were not aware of the seriousness of his drug problems or the magnitude of his depression. In session 10, Ms. S. reported that she had several poignant discussions with her parents during the week, and she felt as if a “dark cloak of pain has been lifted from my shoulders.”

*The Behavioral Prong.* By session 11, we had settled on the idea that Ms. S. would practice these steps in sequence at least twice a day. That is, she would first engage in self-hypnosis, then SCRT, and then the process of identifying and rebutting negative self-suggestions. With practice, it was possible for Ms. S. to do this in approximately 10 minutes. It became clear, however, that adding an action or behavioral activation component would be necessary in order to minimize avoidance of unpleasant tasks. In sessions 11 through 13, Ms. S. developed many of the following suggestions, including the shark and loaf of bread imagery, which were added to the tape of SCRT training, supplemented by the following instructions for identification and rebuttal of negative self-suggestions:

*Continue to observe your breathing, calm and at ease, and with a sense that you are moving forward in your life … moving forward, forward, as a sleek shark must move to get its oxygen from the water … yet you are aware and accepting of the fact that some tension may be necessary to accomplish what you feel and know is important for you to do … some tension is necessary for effort, as when lifting a heavy object … and now, imagine a blackboard and you can make a brief list, with white chalk, of no more than three items, in order of importance, of activities you will feel better knowing they are completed … and as you do so, you can ask yourself this question: “What’s the next right thing to do … the next right thing to do?” … Break each task into small manageable pieces, … Focus on one doable piece, and build in a subsequent break, as you take a deep breath right now. … Then do the next piece. … Keep each task separate, doable, like eating whole-grain bread you love … don’t overwhelm yourself by eating the entire loaf, eat only one slice at a time … keep each task separate … see yourself completing each task, give yourself permission to feel good about what you have accomplished, you deserve it … take responsibility for validating yourself … set the standards for yourself, take responsibility for living according to your values … take ownership of your life … moving forward, forward, forward in your life, moment to moment … each day fresh, new, …*
HYPNOSIS AND THE TREATMENT OF DYSPHORIA

each day creating yourself, with freedom and flexibility to create yourself in the moment, anew ... moving forward in your life, one step at a time ... asking yourself, “What's the next right thing to do?” as you create yourself moment by moment.

The Spiritual Prong. In session 14, Ms. S. stated that she noticed that she felt more focused, had less resentment about studying, and felt “more efficient,” and that she also felt less resentment toward her parents, especially her father. She also reported a sense of longing for what she described as a “spiritual aspect of myself I disowned because I think I've hated myself, and didn’t feel I deserved to feel a sense of spirituality, a sense of connection with God.” In this and the subsequent session, we added another prong to our protocol, with suggestions along the following lines, generated mostly by Ms. S.

While you observe your breathing, connect to a benevolent power that is greater than yourself, as if you're turning a radio dial ... fine-tune this connection to this benevolent power ... and as you do, you also create a deep connection with your highest self ... your values, your goodness, kindness, caring, ability to experience life to its fullest ... your awe of nature, as you imagine a beautiful bird, a chickadee, landing on your finger to grab a sunflower seed in your palm ... imagine the wind cleansing you, freeing you to be you, as you think of the people in your life who are important to you ... connect to them, envision that you share their air, their connection with life, nature, what is essential ... and focus now on your courage to transcend fear and anxiety, your strength to transcend feelings of fatigue, pain, or discomfort ... your patience to accept what is, when frustrated or angry ... your hope to transcend sadness and depression ... and your wisdom to know the difference between what you can change and what you cannot change ... and now tap into your inner core of health, resilience, and strength ... your inner core of sanity and wisdom.

The Acceptance and Mindfulness Prong. In session 16, we reviewed Ms. S.'s progress, and decided it would be possible to conclude treatment in the 20 sessions agreed upon at the outset. Ms. S. reported that she no longer felt much anxiety, she made a firm commitment to not use intoxicants, and she was able to work efficiently most of the time and refrain from self-recrimination when she was not studying. Moreover, she felt that her relationship with her boyfriend was deepening and that her relationship with her parents was “transformed.” Wanting to maintain and even expand upon her successes, we decided to add mindfulness strategies as a fifth and final prong to the protocol, given that previous research has demonstrated that the use of mindfulness techniques is particularly effective in preventing relapse of depression (Segal, Williams, & Teasdale, 2002).

Kabat-Zinn (2005) defined mindfulness as a nonjudgmental awareness that emerges through purposeful attention to the unfolding of experience on a moment-by-moment basis. Mindfulness implies a radical and unvarnished acceptance of unpleasant as well as pleasant experiences. It teaches individuals to relate to
thoughts and feelings in a wider, “decentered” perspective as “mental events,” rather than as aspects of the self or as necessarily accurate reflections of reality (Teasdale, Segal, & Williams, 2003). Elsewhere, we (Lynn, Lama Surya Das, Hallquist, & Williams, in press) have contended that mindfulness training can easily be incorporated into hypnotic treatment to assist patients in accepting and becoming comfortable with evanescent emotional states and learning that there is no imperative to continue to react in habitual, maladaptive ways, including the avoidance of deep emotion. The following examples are among the range of mindfulness suggestions that can be given patients in hypnosis and subsequently reinforced in self-hypnosis:

Imagine that your thoughts are written on signs carried by parading soldiers (Hayes, 1987) or that thoughts “continually dissolve like a parade of characters marching across a stage” (Rimpocher, 1981, p. 53). Observe the parade of thoughts without becoming absorbed in any of them. Imagine that the mind is a conveyor belt. Thoughts, feelings that come down the belt are observed, labeled, and categorized (Linehan, 1993). The mind is the sky, and thoughts, feelings, and sensations are clouds that pass by; just watch them (Linehan, 1993). Imagine that each thought is a ripple on water or light on leaves. They naturally dissolve (Rimpocher, 1981, p. 44).

In sessions 17 and 18, we added the following suggestions to the tape and the protocol we had created:

_While continuing to observe your breathing, go deeper into your self-hypnosis and observe all of your thoughts, and yet, be detached from them. ... Don’t ignore any thoughts that bubble up, notice them, don’t react to them. ... Just observe. ... Realize they are just thoughts, just “tapes,” just conditioned responses you have learned in a lifetime of learning, and let them pass by. ... Let each flow by as a detached, floating object ... moving along a peaceful stream. ... Imagine your breathing is like a pump that makes the stream’s water flow. ... Even if your thoughts are pleasant, and you want to cling to them, just let them go as well ... watch them move down the stream, and notice that the stream is always changing, it is never the same ... a stream of consciousness, thoughts and feelings that you can observe ... knowing all the while that you can react to any thought or feeling if you wish, or just let it flow by, knowing that it will be replaced by another thought or feeling in the ever changing stream of awareness that is your life._

During the final two sessions, we reviewed Ms. S.’s progress and accomplishments, and the need to fine-tune the protocol in response to the shifting requirements and demands of living. A final suggestion was given that at the end of each 20-minute daily practice of the technique, she bring all of her fingers together in a tight fist, and feel her personal strength and power. Ms. S. herself
coined the term 5-Finger Technique because she wanted an easy, portable means to remind herself of each of the five components of her successful intervention: physical, cognitive, behavioral, spiritual, and mindfulness/acceptance. At any time, anywhere, Ms. S. could step through each component, prompted by the fingers of her own hand to stay on track. Possession of her own 5-Finger Technique allowed Ms. S. to realize that her psychotherapist’s intervention was now internalized with independent carryover into her future. This eased the angst of therapy termination and gave Ms. S. a concrete, integrated self-approach that improved with time and experience. In reflecting on her treatment, Ms. S. identified a key principle of psychotherapy: “A therapist can tell a patient what to do, which is okay, or a therapist can facilitate self-discovery by prodding, nudging, and sometimes jarring a patient until she sees what needs to be done, which is better.”

CONCLUSIONS

Two years after the final session, Ms. S. called and happily reported that she passed her medical boards and that she continues to practice the 5-Finger Technique. In fact, Ms. S. stated that during a halfway break in her medical board exam, she used an abbreviated version of her 5-Finger Technique, and she felt it made all the difference in her passing the exam. Dysphoria can hinder a client’s ability to clearly remember and implement previously learned techniques. With her 5-Finger Technique now literally at hand always, Ms. S. faces her future with confidence.

The 5-Finger Technique is ideally suited to use with hypnotic procedures. It is inherently collaborative, flexible, transparent to the public, and usable in a wide range of situations, and it involves imagery, relaxation, behavioral rehearsal, and self-suggestions. “Prongs” can be customized to individual patients. For example, some patients may benefit more from exposure-based techniques (e.g., systematic desensitization) than from cultivating enhanced spiritual awareness. Any 5-pronged object or concept can be substituted for a hand (e.g., 5 days in a work week—Monday through Friday—to get the job done).

Whatever shape the protocol takes ultimately, hypnosis and hypnotic deepening techniques (e.g., “You will have a deeper and deeper experience of hypnosis” or “With each step down the staircase you will go deeper and deeper”) can be used to heighten expectations of treatment efficacy. Of course, systematic research is necessary to evaluate the 5-Finger Technique and the unique contribution of hypnosis to its efficacy. However, based on our clinical experience, we believe the technique promises to enhance the generalization and durability of treatment effects of empirically supported therapeutic approaches for treating co-morbid anxiety and depression.
EDITOR'S SUMMARY

- Depression and anxiety are most often found together as comorbid conditions, affecting more than 19 million Americans.
- Anxiety usually precedes the onset of depression temporally and may thus serve as an “early warning” for the risk of later depression.
- Whether to treat anxiety or depression as primary in the comorbid adult can be determined by such signs as sleep disturbance, client description of predominant mood, psychomotor change, and response to physical exercise.
- How hypnosis can enhance the effects of cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) is reviewed. Special attention is paid to the patterns of catastrophic thinking, negative expectancy, and avoidant coping.
- Hypnosis can be used to address various aspects of anxious and depressed symptoms; the 5-Finger Technique is presented as a concrete means of building therapeutic associations with each finger symbolizing a different dimension of personal experience (in this case physical, cognitive, behavioral, spiritual, and acceptance and mindfulness “prongs”).
- A detailed case example illustrating the use of the 5-Finger Technique is provided.

REFERENCES


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Section II

TARGETED APPLICATIONS OF HYPNOSIS IN TREATMENT
5

Treating Depression: A Remedy from the Future

MOSHE S. TOREM

Man has his future within him, dynamically active in this present moment.

Abraham Maslow (1968)

INTRODUCTION

It has been said that when there is no hope for a better future, people perish. This maxim reflects the seriousness with which the sages and wise leaders of many cultures have regarded the importance of hope for the mental and physical health of human beings. There is ample evidence for the legitimacy of their concern, for among the most common manifestations of clinical depression are feelings of helplessness, hopelessness, and futurelessness. According to Melges and Bowlby (1969), hopelessness can be defined as the lack of hope about outcomes expected to occur within minutes, hours, or days. Futurelessness refers to the lack of hope about positive events expected to occur within weeks, months, or years into the future. Depression negatively affects the thoughts, feelings, and overall physiology of our bodies. Depression jeopardizes health and relationships, and increases the likelihood of impairments on any and all levels of functioning and well-being. This chapter explores the relationship between one’s orientation in time and the onset and course of depression.

Melges and others (Melges, 1972, 1982; Melges & Bowlby, 1969; Melges, Anderson, Kraemer, Tinklenberg, & Weisz, 1971; Melges & Weisz, 1971) wrote extensively on the subject of time and its relationship to health and illness. He insightfully asserted that depression blocks our access to the future, riveting people to the immediacy of their discomfort. Many people suffering from depression have a sense of futurelessness and lack any realistic, detailed, and compelling
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orientation to the future. Many depressed patients speak the language of hopelessness fluently, in spite of other positive realities being available that are perceived differently by the most loving and caring members of their family, people who know well and love the depressed person.

When steeped in hopelessness, depressed patients don’t often yield to the logic that “it’s not really hopeless; it’s just your perception.” Despite the evidence for the merits of cognitive interventions, I have had numerous experiences of using cognitive therapies and providing rational feedback to depressed patients who did not respond well to such interventions. Sometimes clarity and rationality are elusive in all people, but they are especially so when people are in the throes of depression. Their dismissive responses to feedback that challenges their unrealistic sense of hopelessness may be better understood by the concepts of first- and second-order change described in the literature on strategic therapy (Watzlawick, Weakland, & Fisch, 1974).

In attempting first-order change, the clinician’s emphasis is on using a variety of techniques and approaches that focus on resolving the patient’s present difficulties, believing that a change in attitude or taking some particular action will lead the patient to a recovery. However, there are many patients who cannot easily relate to such goal-oriented interventions; they cannot internalize them and do not implement them in behavioral actions. Instead, they remain stuck in their ongoing depressed state of hopelessness and futurelessness.

Second-order change attempts the transformation of the total situation, including the environment and the person within that environment. The use of hypnosis has a particularly powerful impact with those patients who do not respond to first-order change interventions. Hypnosis can promote second-order changes by transforming the patient’s experience in totality, including the patient’s internal experience as well as the patient’s external environment in which it takes place. In a state of hypnosis, clinicians can capitalize on the patient’s capacity for dissociation and natural separation from the present reality by using healing imagery focused on the future. Such imagery can be internalized by the patient and generate an awareness of new, life-enhancing possibilities.

Yapko (1986, 1988, 1992, 1993, 1997, 1999, 2001a, 2001b, 2001c, 2003) has written extensively on the use of hypnosis in the treatment of depression and has placed a particular emphasis on future-focused hypnotherapy as a way to counter the symptoms of hopelessness. In the past (Torem, 1987), I reviewed the use of hypnosis in the treatment of depression. Over a decade ago (Torem, 1992a), I first described a future-focused hypnotherapy technique I call “Back from the Future.” This intervention is effective for a variety of conditions and has been found to be especially useful for patients with depression who experience hopelessness and futurelessness.

This chapter provides important information on identifying the patient who will likely be a good candidate for future-focused hypnotic therapy. In addition, it describes the rationale and offers specific reasons for using future-focused
hypnotic interventions with depressed patients. This chapter also provides specific sample transcripts for future-focused hypnotic interventions. Finally, it identifies the contraindications and possible pitfalls in using future-focused hypnotic therapy with depressed patients.

**ASSESSMENT STRATEGIES**

When interviewing a patient who suffers from depression, I observe the patient’s body language, and I listen to verbal communications (e.g., word choices and phrasing) on both manifest and latent levels. There are many ways of phrasing a sense of hopelessness, and the following are some typical examples:

“Doctor, I believe I am a lost case. There is no hope for me. You might as well give me some poison and put me out of my misery.”

“I have been to several doctors, I have tried all the pills, and my body cannot tolerate anything. I have given up.”

“I cry all of the time. It is so embarrassing, look at me and how pitiful I am. I am worthless, I am just a burden to my family. I don’t know why my husband still stays with me. I’d be better off dead and he would be better off with another woman.”

Following a comprehensive interview and a complete, in-depth mental status examination, I then move on to assess the patient’s view of the future. I might ask, “What do you see happening in your life a year from now?” Many depressed patients respond by saying that they cannot relate to, much less answer, this question because they are simply not able to project that far into the future. Some say they believe they will most likely be dead, whereas others just continue to predict “gloom and doom,” that is, a continuation of their current misery and suffering. When patients cannot respond meaningfully to the question regarding a year from now, I may shorten the time frame to six months, then reduce it to three months, one month, or even just a week. Some depressed patients cannot even respond to the question focused on tomorrow. Such impoverished answers indicate to me how severely these patients are blocked from the future and from experiencing any hope of getting better.

Another element I find important to assess is the patients’ history of repeated attempts to change the present predicament and immediate environment, as well as the reasons they believe they have not yet been successful in producing any desirable results. Their failed attempts fuel the cycle of hopelessness and futurelessness and seem to justify their sense of being a failure. There are, however, some patients who respond to the request by reporting an image of the future. Nonetheless, it is almost inevitably filled with gloom and doom and continued suffering with no change seemingly possible.
Teens and a Future Orientation as an Example

Sometimes the hopelessness is related to age and age-related circumstances, and the assessment focuses on whether to employ first- or second-order change intervention strategies. For example, many teenagers who live in dysfunctional family environments develop a variety of psychopathological conditions, including depression, with the associated feelings of hopelessness and helplessness, and sense of futurelessness. Teenagers are generally more responsive to future-focused interventions because many of them already daydream about the future and have specific events they look forward to (e.g., obtaining their driver’s license and graduating from high school). I have used future-focused hypnosis interventions with eating disorders, depression, anxiety, panic, and other conditions in the teenage population with positive results.

There have been teenagers I have treated who did not respond to first-order-type interventions that included such techniques as teaching the teenager to be more assertive with a dominating, dysfunctional, controlling parent, or teaching the teenager skills to improve his or her interpersonal communication. Many of these kinds of interventions (i.e., those focused on first-order change) are likely to fail simply because the adult parents (or other adult parental figures) continue their rigid, dysfunctional behaviors. In such instances, the teenager is truly powerless to change such patterns in his or her parents. When personal effort due to current external circumstances is unlikely to succeed, the use of future-focused interventions enhanced by hypnosis, such as a “Back from the Future” technique, provides an excellent vehicle for a therapeutic intervention promoting second-order change. The person is able to “step outside” the confining boundaries of current realities. Thus, teenagers are able to “travel into a future time” (subjectively experienced during hypnosis) where they have grown up to be adults, now live on their own, have their own families, are able to support themselves, and are well away from the dysfunctional family of origin. Many teenagers relate very well to such an intervention simply because they have already been daydreaming and fantasizing about some aspects of it on their own.

Suggestions to experience detailed and realistic future imagery are easily enhanced with hypnosis. Hypnosis allows the process to be more intensely experienced by the teenager, more likely to be internalized on conscious and subconscious levels, and more likely to be brought back from the future as “gifts” to be enjoyed and utilized in the present. Such interventions “hook” the depressed teenager into a future that provides realistic hope for a better life, better health, and a better environment compared with the unhappy present. This hook into the positive future can help break the cycle of hopelessness and alleviate the symptoms of futurelessness.

Generally, the more “fantasy prone” a patient is, the better the response to future-focused hypnotic interventions. This can be assessed in a variety of ways, including listening to the patient’s use of metaphorical-symbolic language in describing his or her symptoms and life story as well as a structured questionnaire.
such as the Tellegen and Atkinson (1974) Absorption Capacity Questionnaire, which is based on Hilgard’s (1970) imaginative involvement and its correlation to the capacity for hypnosis. One additional way I found helpful in assessing a patient’s favorable response to future-oriented suggestions is the extent to which patients use metaphorical language when describing their symptoms. For example, a patient with depression may say, “I have lived in the cold of winter … for the last three years there has been no spring in my life”; or, “I have lost the ability to see colors … everything is just black and gray”; or, “Since I lost my job, I have been up a creek with no paddles. The water is rushing and I am afraid I am getting close to the abyss.” However, I must add that there have been some patients who, in spite of their plain, literal, nonmetaphorical language, have also responded favorably to future-focused interventions with or without the use of formal hypnosis.

In sum, the primary variable to assess is the patient’s sense of the future: Is it positive and compelling, drawing the person into growth? Or is it negative and demotivating, generating apathy and stagnation? Or is there none at all, generating a frozen immobility? A goal of treatment is to engender hopefulness and optimism, and hypnotic strategies can be of great help in this regard.

HYPNOTIC AGE PROGRESSION INTERVENTION STRATEGIES

Rationale

Age progression, as employed in the “Back from the Future” technique described later, has been used in many ways over the years. Milton Erickson (1954) described a technique of age progression facilitated by hypnosis. He calls this intervention a “pseudo-orientation in time as a hypnotherapeutic procedure” (p. 261). Erickson would first guide the patient into a state of hypnosis and then have the patient travel forward into the future to a time and space in which the patient had already achieved a resolution of the current problem. Erickson would suggest that the patient accept the future time as the present, and then he would inquire as to what the patient had learned and had done in the interim that helped to solve the problem. When Erickson obtained this information, he facilitated amnesia for having done so and used this information as a therapeutic strategy.

D. Corydon Hammond (1990) listed under the term age progression the following other terms that he had found in reviewing the literature: time projection, mental rehearsal, process imagery, goal imagery, success imagery, and end result imagery. Hammond stated that “all of them refer to future-oriented therapeutic work” (p. 515). He conceptualized mental rehearsal facilitated by hypnosis as a technique in which the patient is asked to replay mentally and covertly an anticipated future situation. Zilbergeld and Lazarus (1987) have referred to mental rehearsal as process imagery in which the patient imagines the process and means by which one eventually accomplishes the desired end result.
Hammond believed that the difference between end-result imagery and age progression is comparable with consciously remembering an event from childhood versus undergoing a complete age regression and having a revivification of a childhood experience while in deep hypnosis.

Erickson similarly emphasized the merits of incorporating hypnosis into the process when he compared conscious fantasies (obtained through mental rehearsal and success imagery) with more powerful unconscious fantasies (utilizable through age progression). Hammond (1990) echoed this point when he went on to ask, “When we consider the research that documents how utterly real and convincing a confabulated (or therapist-suggested, but inaccurate) age regression may feel to a subject, why shouldn’t age progressions have the potential to feel just as actual and real?” (p. 515). Hammond also pointed out that age progression is a form of goal-directed hypnotherapy and is compatible with Alfred Adler’s future-oriented approach to treatment as described by Ansbacher and Ansbacher (1990). This is based on Adler’s belief that human beings are basically goal oriented and generally see themselves as moving forward toward goals in the future.

Orienting the Patient to the Future: A General Strategy

Over the many years of my clinical work with depressed patients, I have found that it is not necessary to announce to the patient that formal hypnosis has to be used in order to help them. Future-focused interventions with healing imagery suggestions can be done with what has been described in the literature as “guided imagery” (Acterberg, 1985; Brigham, 1994; Kroger & Fezler, 1976; Torem 1992b; Zilbergeld & Lazarus, 1987). For some patients, this terminology is more acceptable and less threatening.

I begin the induction process by asking the patient to “take a trip in your mind to your favorite place associated with calmness, peace, and tranquility.” Many patients choose the image of an ocean beach, others choose their favorite trail in a national park, whereas others image climbing their mountain of desire. Some choose to be in the comfort of their own home listening to their favorite music, some are energized and inspired by experiencing themselves dancing to the rhythm of their favorite musician, and others may choose an image of meditating in prayer at their place of worship. Based on the patient’s choice, I then enhance this experience with suggestions of imagery utilizing all five senses (i.e., visual, auditory, tactile, olfactory, and gustatory). This is combined with “ego-strengthening” suggestions focused on developing a sense of mastery and the accomplishment of one’s goals and aspirations.

I also practice the technique of interactive guided imagery by conversing with patients when their eyes are closed and asking them to describe to me what they experience in their “new environment.” I encourage them to describe their environment using all their five senses. The information they provide is then used to further enhance the depth of their experience by choosing to integrate the best
suggestions that are compatible with their own experience. I then guide the patient
back to a “regular state” of consciousness.

Most patients report a significant change in their state of mind from having
had the experience. People who were anxious report a state of calmness with a
smile on their face. Some make spontaneous statements such as “Doctor, I feel
so relaxed—this is faster than Valium!” I then ask the patient to practice this
guided imagery exercise several times a day at home on his or her own. The
length of the exercise can be as short as 5 minutes and as long as 20 to 30 minutes.

In the following session, they report on their practice, and I answer their
questions and clarify any concerns in a supportive manner. Then, we proceed to
a future-focused interaction. For example, I might ask a mother of two children
if she would like to be present at their high school graduation. Most mothers say
yes. I then begin the process of guiding the patient into a state of calmness using
the imagery of their choice from the previous session, which they also practiced
at home. This is followed by the “Back from the Future” technique, focusing on
the experience of the high school graduation ceremony of their firstborn child
(an event that may actually be several or even many years away).

The patient is encouraged to report on the experience with an awareness for
what’s going on in all five senses (interactive guided imagery). The process is
enhanced with intermittent suggestions for deeper, more meaningful experiences
combined with ego-strengthening suggestions.

“BACK FROM THE FUTURE”: A SPECIFIC STRATEGY

The “Back from the Future” technique was first described by me in an article
published in the American Journal of Clinical Hypnosis. (See Torem, 1992a, for
more details.) This technique is based on the utilization of age progression
interventions in hypnosis as described above.

Using the “Back from the Future” technique requires an understanding of
and familiarity with the patient’s condition and life circumstances. A discussion
is held with the patient about developing a desired future image in which the
patient would be comfortable, better, healthier, happier, or somehow greatly
improved. Once this desired state is identified, the patient is guided into hypnosis,
and then age progression is facilitated by suggestions for “time travel” into a
specific time in the future. The future reality is hypnotically enhanced by sug-
gestions focused on visual, auditory, tactile, olfactory, and gustatory senses that
add both experiential power and realism to the experience. In addition, the
patient’s ongoing experiences are enhanced by ego strengthening as described by
Hartland (1965, 1971), Torem (1990), and Frederick and Phillips (1992). This
involves providing suggestions for positive thinking and pleasant feelings of joy
and pride in reaching a solution to a specific problem. This is also accompanied
by suggestions for a sense of health, strength, accomplishment, and inner
resourcefulness and creativity in coping well with life’s daily stresses.
The patient is then instructed to store these positive feelings, images, and sense of accomplishment and to internalize them consciously and unconsciously. Patients are told that these positive images, sensations, and feelings are a special gift that they can take with them on their trip “back from the future” into the present, and that these gifts will guide them on conscious and subconscious levels in their journey of healing and recovery. Then, the patient is guided back into the present time. When the patient comes out of hypnosis, a brief discussion is conducted about the patient’s experience. This is followed by a homework assignment in which the patient is asked to write about the experience and describe what it was like to take such a “voyage” into the future. This written assignment may be requested while the patient is still in hypnosis. The patient is asked to bring the written assignment to the following session and to read it aloud. The symptoms of futurelessness, helplessness, and hopelessness are usually significantly reduced, replaced by a sense of new hope, strength, inner resourcefulness, self-mastery, and belief in the possibility of making a recovery.

SAMPLE TRANSCRIPTS OF FUTURE-FOCUSED INTERVENTIONS

The following are some clinical case examples of depressed patients who were treated with future-focused therapeutic interventions enhanced with hypnosis.

Case 1: Jessica

Jessica (not her real name) was a 16-year-old high school student who was suffering from depression associated with bulimia nervosa. She lived in a dysfunctional family with a cold, rigid, withdrawn, and depressed father and an overinvolved, controlling mother. Jessica’s mother saw her daughter as a narcissistic extension of herself and had very poor boundaries in her relationship with Jessica. Jessica had previously been in treatment with several counselors and one psychiatrist. A variety of treatments had been used, such as various antidepressant medications, cognitive behavior therapy, family therapy, interpersonal therapy, and psychodynamic therapy. However, Jessica continued to remain depressed, and her feelings of helplessness, hopelessness, and futurelessness persisted and dominated her clinical presentation. When asked to describe how she sees her future, she answered, “What future? … Life sucks … this is hell, there is no future.” I asked her if she would be willing to learn how to improve her methods of daydreaming as a way of escaping her hell. She answered, “You mean daydreaming is not bad? You can actually teach me how to do that better?” Jessica readily learned how to formally use imagery of being at the beach as a way of temporarily escaping her stressful environment at home. She regularly practiced the beach scene imagery, enhanced with self-hypnosis, and was soon able to
quickly activate a state of calmness, relaxation, and tranquility. The following is a transcript of what was said to Jessica:

Jessica, please go ahead and take a deep breath … and as you exhale, let your eyelids close and let your body float. … Keep on breathing comfortably in and out at your own pace [I match the words in and out with the patient’s actual breathing, saying the word in when the patient inhales, and saying the word out when the patient exhales] … as you continue to sit here … breathing comfortably in and out … with each breath that you take … as you inhale, in comes the calmness … and as you exhale … out goes the stress and the tension. … As you listen to my voice and focus on the words, you may know that you were born with a deeply endowed wisdom for creative imagination … which you already have used on your own to escape and detach yourself from difficult and stressful situations at home and at school. … As we discussed before, you may wish to take a special trip to the ocean beach … as a way to relax and recharge your batteries … and gain a new perspective. … Allow yourself now, if you wish, to experience your special ocean beach. … It is a beautiful day in early summer [the season is chosen by the patient in the prehypnotic discussion] … the temperature is comfortably warm, just right, the way you like it. … The sky is clear and blue … as you look at the sky you wonder to yourself … with awe at the endless depth of the blue sky. … You look at the ocean, and you can wonder on the similarity and differences … between the color of the sky and the color of the ocean. … You look at the two as they merge together at the horizon, far, far away. … Now take a look at the ocean again and notice the waves as they are breaking and receding, white and foamy in rhythm. Look at the beach and notice the color of the sand … is it yellow? … is it white? … is it gray? … or perhaps a blend of two or three of these colors. … You may look around and notice … can you see any seagulls floating up and down with the currents of the air? … Can you see some of them diving down into the waters of the ocean to catch their fish? … If you look closely, you may see some of the seagulls are standing together … in a group on the beach at a distance … basking in the sun. … As you zoom in closer … you may wonder at the color of their beaks … are they white, gray, or orange in color? … Some may be standing on only one foot, and others on both feet … some have orange-colored feet and others have gray feet. … Isn’t it interesting how much variability there is in nature, and yet all these seagulls are healthy and normal? … And now, you may wish to experience your special ocean beach with your sense of hearing. … Listen to the sounds of the waves as they are breaking and receding in rhythm … the surf of the ocean is so predictable and calming. … Listen to the seagulls … can you hear their special chatter as they communicate with each other? … And now, you may wish to proceed by experiencing this ocean beach with your sense of touch. … Allow yourself to touch the dry sand with your bare feet … notice the sensation of the sand under your feet, over your feet, and between your toes. … Notice the sand as it is soft, dry, and comfortably warm. … Allow yourself, if you wish, to be playful about it … you may even touch the sand with your hands and fingers. … You may now proceed by taking a walk on the sand toward the waters of the ocean. … Notice as you get close to the waters of the ocean … the waves are breaking on the beach. … Notice how the sand becomes more wet, not as dry and more firm, not as soft and more cool, not as warm as the dry sand. … Isn’t that change interesting in the sensation you experience under
your feet? … If you wish, you may now allow yourself to be touched by the waters of the ocean where the waves are breaking on the beach. … Notice the sensation of wetness and coolness on your feet touched by the waters of a breaking wave. … Compare it to the rest of your body that is exposed to the sun … where you experience the sensation of dryness and warmth from the sun rays touching your skin. … Notice the contrast of sensations, wetness and coolness on your feet compared with a dry, warm sensation on the rest of your skin touched by rays of the sun. … You may keep on walking gently on the beach … and as you do, notice the breeze of clean and fresh ocean air touching your face and your hair. … And as we move on, you may now experience the ocean beach with your sense of smell. … Take a deep, deep breath through your nose, and as you do, inhale this fresh, clean ocean air … notice the unique scent of a blend of aromas combining the smell of seaweeds, fish, salt, and much, much more than that … which is unique to ocean beaches. … And as you keep on walking … gently and comfortably … on the beach, you may now experience your ocean beach with your sense of taste. … Allow yourself, if you wish, to touch your lips with your tongue … as you do, you may notice the special salty taste on your lips so typical to ocean beaches. … Now that you have experienced your special ocean beach with all of your five senses … you may find yourself a nice comfortable spot either in the shade under a beach umbrella … or in the sun sitting comfortably and looking at the ocean … seeing the waves breaking and receding in eternal rhythm … watching the seagulls soaring and floating in the air. … Notice the sensation of inner calmness, tranquility, and peace … and remember that you can do this exercise on your own … Any time you wish to take a break in a safe place where you can close your eyes safely … you can visit this ocean beach and recharge your batteries for calmness, tranquility, and peace … The more you do this exercise, the easier and easier it becomes for you … and the more it has a lasting effect of calmness on your mind, body, spirit, and soul. … As you continue to practice this exercise on your own everyday … in every way you are getting better and better … healthier and healthier, stronger and stronger … your mind becomes more clear, your thoughts are more focused … your feelings are more positive … you find yourself using this gift to ease yourself into natural sleep at night … you find yourself smiling spontaneously, knowing that you have this special gift of hypnotic imagery that always stays with you … and you can shift your focus and visit your beach where it is safe. … And now … whenever you are ready … we can count back from three to one … and you can return from the ocean beach back to this office … and as you do, you bring back with you these wonderful gifts and memories of calmness, inner peace, tranquility, and new hope. … And now let’s count together. At the count of 3, you get ready to shift gears into the regular state of consciousness … at the count of 2, you look up with your eyes while you keep your eyelids closed … go ahead and do so now, and at the count of 1, you let your eyelids open … that’s right … notice your eyes come back to focus … you become fully alert and awake right here in this office. … You are ready to assume all the regular functions of day-to-day living in the most adaptive and healthy way. …

Jessica was then asked how she had been feeling. Her response was “Relaxed and comfortable,” which she said with a smile. She was given the opportunity to ask questions about the exercise and get any clarifications she might need. Jessica
was asked to practice this exercise at home at least twice a day, and then the session was ended.

At the following session, Jessica came in with a report on how well she did her exercise and how well this worked for her in reducing her anxiety and improving her sleep at night. We then proceeded with a future-focused intervention. This began with a discussion whereby Jessica was able to participate in describing a particular time in the future when she had already moved out of the house, seeing herself as a 20-year-old college student, living in her own apartment, and attending college. This phase of the therapy is very important because it is the task of a responsible clinician to assess whether the patient’s desirable future is realistic and obtainable. The therapist must be careful to support only realistic, plausible scenarios with the future-focused imagery interventions.

One way to secure a positive, plausible future is by using imagery within a set of highly structured positive suggestions. The unstructured approach has within it the potential risk of being drawn into the patient’s negativism and hopelessness. By asking the patient to describe these states of negativism and hopelessness in detail, the therapist may indirectly and unintentionally reinforce them.

The following is an example of a future-focused intervention using the “Back from the Future” technique with Jessica:

Now, Jessica go ahead and put yourself in a comfortable position as you are sitting in this chair. ... Take a deep breath ... and as you exhale, go ahead and guide yourself into a meditative state of calmness and tranquility. ... You may take a trip to your ocean beach and experience it with all of your five senses. ... On the ocean beach, you regain your sense of total tranquility in your mind, body, spirit, and soul. And now, you may wish to open up a new channel of concentration ... whereby you focus on taking a special trip into the future. ... Experience yourself in your special imaginary time machine. ... You can now push the button that takes you into the future when you are 20 years old. ... You have already successfully graduated from high school ... this is your second year of college ... you were successful in completing your first year of courses you chose to study. ...

You feel proud of your grades. ... You moved out of your parents’ house, and you now live on your own, in your own apartment. ... You managed to decorate it using your creative style and taste. ... You found a part-time job earning an income that allows you to support yourself ... and you have spending money to meet your extracurricular needs. ... You have found a circle of friends that make you feel accepted ... they treat you with respect and dignity ... they appreciate your company as well as the delightful ways of your personality. ... You may want to focus now on an activity whereby you have been chosen to be the leader of a group project assigned by one of your professors. ... This group project involves gathering research data ... comparing the data with other sources from the literature ... putting together a hypothesis, and then integrating the results of the data that test the veracity of the hypothesis. ... All of this has to be put in writing and submitted
to the professor. ... There is an activity meeting in your own apartment. ... Six other students are there with you, and all of them report on their material based on the tasks that have been assigned by you as the project leader. ... Notice how well the dialogue and conversations flow ... including the creative exchange of ideas interlaced with humor and fun. ... Experience the sense of mastery, pride, and comfort with yourself on how well you are guiding, coaching, and leading the group members in bringing the project to its successful completion. ... At some point, the group takes a break ... pizza has been ordered with soft drinks, and the doorbell rings ... the food has been delivered and the table has been set for the meal. ... Notice how well you handle the food in a comfortable, natural way, without any of the discomfort that used to accompany eating when you were living in your parents' house. ... Notice how much you can enjoy the taste of the food ... and as you chew the food and swallow it, you experience a gradual satisfying sensation in your stomach ... giving you the feelings of fullness and satiation. ... At that point, you comfortably stop the eating and continue to interact with your friends in a social, appropriate manner. ... Experience the sense of inner comfort and joy in your accomplishment. ... Internalize these feelings and physical sensations. ... Internalize your feeling of mastery and control, delight in your accomplishment of leading the group to the completion of the project ... including the typing of the final manuscript, which is submitted on time by the assigned due date. ... Now take a deep, deep breath again ... and as you exhale, reexperience your enhanced tranquility ... and get ready to travel back from the future in your imaginary time machine. ... As you come back, bring with you all of these positive experiences of joy, comfort, delight, and accomplishments in college and with your friends. ... Bring them back as your special gifts from the future, and let them stay with you consciously and subconsciously ... guiding you on your own journey of healing and maturation. ... And now, your time machine has arrived to the present, and you can now come out with these special gifts that you have brought with you. ... We are going to slowly count from 3 to 1. ... At the count of 3, you just get ready to shift gears; at the count of 2, with your eyelids closed ... you look up with your eyes ... go ahead and do so now ... and at the count of 1, you let your eyelids open ... and as your eyes come back to focus ... you become fully alert and awake ... ready to continue with the tasks of the day in the most adaptive and healthy way. ...

This was followed by a discussion with Jessica about her experience and what it was like for her. She verbalized her experience using the past tense by such statements as “When I was there, I felt in charge; I knew it was just right for me to be with these friends” and “It was so good to live on my own and to be away from my parents.” She was then asked to write an essay about her experience and bring it in for the next session. In her written essay, Jessica continued to use the past tense in describing her future-focused imagery experience. In my experience, when the patient uses the past tense about a future-focused event, that typically indicates the patient’s internalization of the experience on a subconscious level. The patient then begins to transform day-to-day living by beginning to act and behave differently as if the future has already happened.
Case 2: Michael

Michael (not his real name) was a 36-year-old married man and the father of three children ages 12, 10, and 8. He was diagnosed with severe depression associated with suicidal thoughts. He had a history of previous treatments that included a combination of antidepressants with some supportive psychotherapy. In the process of the evaluation, it was found that his depression was characterized by feelings of hopelessness with a sense of futurelessness. He specifically felt discouraged due to the fact that several trials of antidepressant medications in various combinations had not worked for him, in part due to intolerable side effects and in part due to the lack of a therapeutic response. In the process of establishing rapport with this patient, I found that a previous therapist told him that he would never recover from his depression unless he fully remembers all the details of his childhood abuse growing up in a dysfunctional family.

When Michael consulted me for psychotherapy, he was focused on his past, assuming this focus would eventually help him resolve his feelings about the childhood abuse he suffered. However, on the contrary, the more he focused on all of the unpleasant memories of his dysfunctional childhood, the more depressed and hopeless he was feeling in his present day-to-day living. At times, he was afraid that he might act upon his suicidal thoughts and end up killing himself by an impulsive act of momentary desperation and anger. Thus, orienting Michael to a positive future with new coping skills was an essential part of his treatment. He learned to use the structured guided imagery I taught him, which focused him on the beach scene using all his five senses to induce a state of calmness. That self-soothing strategy also helped him to reach an improvement in the quality and length of natural sleep at night. He was pleased with these results because it gave him a new sense of mastery. He regained some trust in his inner resourcefulness when he learned that he could calm himself and could also use his new imagery skills independently to resolve his insomnia problem.

Michael’s relationship with his wife was described as generally good. However, he repeatedly stated that he felt “she got a bad deal,” explaining that he frequently felt undeserving of her kindness and loving nature. He repeatedly kept asking her, “Why do you love me? You could have done so much better with another man.” Her direct statements of “I love you and I don’t want anyone else—you are the best man for me” provided reassurance that was only short-lived at best. He stated that he loved his children but would sometimes get abrupt with them. When he would later apologize for his short temper, he would add that perhaps they should have another father. His firstborn daughter would frequently say, “You are the best dad for me; I don’t want another father.” These reassurances were, predictably, also short-lived in effect.

In the process of discussing a plan for his recovery, Michael responded very favorably to a dialogue focused on the future. This dialogue began with the following series of suggestions:
HYPNOSIS AND TREATING DEPRESSION

Michael, let us suppose that you and I work together and somehow you recover from this depression. And let us suppose that when your daughter Erin (age 12) is a senior in high school, you have fully recovered from your depression, and you have reached a new level of healthy functioning in day-to-day living, not only at home, but also at work. ... You found a way to separate yourself from the memories of your childhood and liberate yourself from the past to live your own life in greater freedom from the past ... knowing that you have a right to experience your own happiness with your wife and children as a mature adult, husband, and father. You experience a sense of mastery over any dysfunctional thoughts or feelings. ... You know how to handle these feelings, you recognize that anger is a feeling and you know how to identify its meaning ... and how to be assertive in expressing your needs appropriately without losing your temper. ... This has improved your sense of self-worth and self-respect. ...

As we talked about it, his face communicated a focused attentiveness and there was a new twinkle in his eyes I had not seen previously. I asked if he was interested in taking a trip into the future when his daughter Erin is 18 years old on the day of her graduation from high school. He agreed to do so. I asked him to describe in some more detail what such a day would be like, and then we followed with the “Back from the Future” intervention. This time, the intervention was presented with structured suggestions coupled with ego strengthening. Additional suggestions, such as “Experience the comfort of Erin hugging you and telling you, ‘Dad, I love you. Thank you for being there for me all these years.’” He was instructed to see the sparkle of joy in her eyes as she was dressed in cap and gown holding the diploma in her hand. This was then followed by the family getting together for a meal. He was instructed to experience the meal with all of the five senses and with a focus on the color and shape of the food, its smell and taste, and to experience the chewing and swallowing of the food. As these suggestions were given to him, I carefully observed the front of his neck and noticed that he was swallowing several times (this is a literal sign of swallowing one’s saliva in response to a particular suggestion and may symbolically indicate an act of internalizing the suggestions). He was then instructed to internalize the feelings of joy, comfort, and pride in the accomplishment of his daughter and, in addition, the overall experience of being there with his family. He was then instructed to bring these gifts back with him from the future and to let them guide him consciously and subconsciously on a daily basis as he continues to change and transform his reality internally and externally to match this man of the future. As he was guided out of this hypnotic state, he was asked to write an essay about the experience and bring it back with him to the following session.

In the following session, Michael reported that his energy was coming back and that he and his wife began walking together every evening after dinner. He said that for the first time in a long time, when his wife was holding his hand, he did not withdraw from her. He said he felt comfortable holding her hand and felt the love and care from her warm touch. At that point, the moving thought occurred to him how fortunate he was to have her as his wife and partner.
Years later, I received a letter from Michael following the graduation of his daughter from high school, updating me on all of his accomplishments at home and at work. He reminded me of the visualizations and imagery we did and how those images had become reality for him. He thanked me for caring for him and promised to stay in touch in the future. In Michael’s case, the shift from a past orientation of an unchangeable history to a future orientation featuring some of the best experiences life can offer was vital to his recovery from depression.

Case 3: Naomi

Naomi (not her real name) was a 35-year-old divorced mother of two sons, ages 16 and 13. She was suffering from severe depression with suicidal ideations associated with self-critical thoughts. Her depression developed following the breakup of her marriage, whereby her husband of 17 years had left her for a much younger woman. Naomi blamed herself entirely for the marriage breakup, stating that “I am not attractive enough … look at me, I am ugly with wrinkles all over my face and neck. He said I was not a good wife to him and I was a bad mother to the kids. He was right; I am just a hopeless case.” Naomi had been in counseling with a therapist who, apparently, indirectly reinforced Naomi’s sense of failure by asking her to continue to explore within herself the reasons for her failed marriage. Presumably, the therapist had the idea that this would give her greater insight and motivation to change.

Even though Naomi recognized many of the effects of the dysfunctional family from which she had come, she continued to blame herself and take responsibility for her parents’ emotional and verbal abuse of her. Several trials of treatment with antidepressant medications produced intolerable side effects that caused Naomi to stop the medications and declare herself a “hopeless case.”

Naomi had an unusual talent for imagination, and her language was loaded with descriptive metaphors. Because she suffered from insomnia, she agreed to learn the use of the beach scene imagery enhanced by self-hypnosis in order to improve the quality of her nighttime sleep. After the successful use of this imagery on her own, she was ready to engage in a dialogue about the future. She first successfully internalized the experience of being present at her older son’s high school graduation, experiencing it with all of her five senses. She successfully internalized this image and reported her experience in a written homework assignment using the past tense to describe her son’s high school graduation ceremony. The following is an excerpt from her written assignment:

Today I had the opportunity to travel into the future with the imaginary time machine. I actually saw my son Aaron dressed up in cap and gown, holding the diploma in his hands and smiling with joy on his face. I felt happy and proud of my son and his accomplishments. We went out to a restaurant together with my parents and my younger son, Joseph. We had a wonderful time together laughing and joking and eating.
The food tasted just right and we all got to choose our favorite dishes. My parents looked so happy and proud of Aaron’s accomplishments in high school.

Following the successful “Back from the Future” intervention with her first son, we then discussed events of a future occurring even later in time. She expressed a desire to be married again, and she described in detail what kind of man she would want for a husband. We then constructed another imaginary trip into the future, this time to the age of 43 (8 years later). In her state of hypnotically guided imagery, she described in great detail the house, the furniture, and the decorations where the 43-year-old Naomi was residing. Positive suggestions laced with ego strengthening were given to enhance the experience. A second trip into the future was then constructed in which the present-day Naomi was to meet the 43-year-old, remarried Naomi and her husband for a special meal together. The present-day Naomi was described as a visitor from the past, and she was instructed to engage in a dialogue with the 43-year-old Naomi. The meal was cooked and prepared “just right” to match Naomi’s favorite dishes. In the dialogue between the present day Naomi and the 43-year-old Naomi of the future, the present-day Naomi learned how well the 43-year-old Naomi’s life has been going. The 43-year-old Naomi was able to restructure her life in a new way. This was framed as a reflection of her new refined skills in thinking, perceiving, and understanding people in her immediate environment; knowing how to keep healthy boundaries between herself and members of her immediate family; liberating herself from the negative experiences of her childhood; and reframing them as positive experiences that have “toughened” her up to meet the challenges of life more effectively.

Naomi of the present was also asked to interview the 43-year-old Naomi’s husband and ask him what caused him to fall in love with Naomi and want to marry her. He described in detail the many positive attributes he had found in his wife (the 43-year-old Naomi) and how fortunate he was to find his “soul mate.” The 43-year-old Naomi was then asked by the present-day Naomi (35-year-old Naomi), “Do you remember this depression you had suffered eight years ago? What did you do then that helped you to recover and arrive at where you are now?” The 35-year-old Naomi listened carefully to the response she received from the 43-year-old Naomi. She, in essence, communicated a message of hope:

Hang in there; things will get better for you. ... You must learn new ways of thinking, feeling, and understanding. You must learn to take action to bring about the change in your own life; don’t just wait for others to do it for you ... you must take charge of your life and implement a new strategy for success. Remember, you are intelligent, creative, knowledgeable, motivated, and capable of learning from your mistakes. Stay focused and determined, and you shall reap the fruits of your perseverance.
This dialogue is an example of an indirect form of ego strengthening. It encouraged internalizing a desirable future and healthier ego state and making it an internal resource to be utilized for better and more adaptive functioning in the present. The results of this and the other interventions were expressed in a written assignment whereby Naomi was using the past tense to describe a future event that she had experienced with hypnotically enhanced guided imagery. The internalization of such an experience produced a number of significant transformational changes in this patient: an alleviation of her suicidal thoughts, and a significant improvement in her mood, her sleep, and her eating behaviors. In addition, hopelessness was replaced by new feelings of hope for a better future that was already “experienced” in the patient’s mind as a real event. Most importantly, Naomi transformed herself from being a victim to being in charge of her life.

Case 4: Robert

Robert (not his real name) was an 82-year-old man suffering from depression associated with several chronic medical conditions including osteoarthritis, chronic obstructive pulmonary disease with emphysema, hypertrophy of the prostate gland, and hypertension. He felt that his life was coming to an end. He felt so desperate and hopeless about his life, and was especially worried about becoming a burden to his children. He repeatedly verbalized his feelings that he had lost the reason to live and that life had no meaning for him. He also expressed a sense of futurelessness, believing that his death was near and there was nothing more for him to do.

I initiated a discussion about his family, more specifically about his grandchildren. This led to a discussion about future great-grandchildren who have not yet been born. I asked him what he would like to be remembered for by his grandchildren and great-grandchildren. He replied that he had never thought about it before. I gave him an assignment to write about what legacy he would wish to leave of his life to future generations of his family. I asked him to close his eyes and visualize a trip in an imaginary time machine that would take him to the future where he could see one of his great-grandchildren doing a special project in researching the ancestors of his family. The following is a transcript of my instructions:

Take a deep breath, and as you exhale, let your eyelids close and let your body float. ... Experience this calmness as you inhale. ... As you exhale, let all the tension and stress leave your body. ... And as you continue to breathe comfortably in and out, with each breath that you take ... let this calmness spread all of the way from your head to your toes, top to bottom. ... And now, go ahead and open up a new channel of concentration ... whereby you visualize yourself in this imaginary time machine that takes you on a special imaginary trip into the future ... Your time machine lands at a place where one of your great-grandchildren lives. ... Your grandson has become an adult, he is a married man and a father of three children of his own ... these are your great-grandchildren. ... One of these
great-grandchildren is doing a project in which he is researching his ancestors. ... He comes across the name of Robert ... this is you, of course ... and he attempts to find out as much as possible about you and your life. ... He sits in front of a computer screen and looks at pictures of you at different times in your life. ... He then comes across a special file that contains in it your life story ... how you achieved what you did ... and what was special about your personality and character. ... He looks at the file and actually sees you talking to him ... and sharing with him the wisdom, skills, talents, and life experience. ... Your great-grandson is so grateful to have found this special file ... in fact, he is able to see you talking to him on video and telling your life story ... where you were born ... how you were raised ... who your parents and grandparents were ... what were your favorite colors ... favorite foods ... and favorite subjects in school ... what made you tick ... what were your hobbies and interests ... how you found your wife and started dating her ... and who were your kids and grandkids ... what you did for a living and what your passions in life (personal and professional) were. ... He has a chance to listen to your wisdom and philosophy of life that you have attained over so many years ... and what you really wanted to pass on to future generations. ... This story is accompanied by a booklet that he now has in print. ... This feels so real to him that at times ... a thought crosses his mind of wanting to send you an e-mail thanking you for this very creative and innovative project that you did. ... Notice that observing and looking at your great-grandson and his response to viewing and listening to your story on the computer screen make you feel a sense of joy and satisfaction. ... Notice the smile on your face and the sense of pride you feel in your great-grandson and his interest in your life. ... Now internalize these experiences and feelings on conscious and subconscious levels, and bring them back with you as special gifts from the future. ... Let these images and experiences guide you on both conscious and subconscious levels whether you are awake or asleep, whether you are aware of it or not aware of it. ... Let these images and experiences you brought back from the future help you in finding a new passion and meaning in your life. ... As that is happening, notice how your mood changes ... and your hopelessness is replaced by a sense of new hope and that life is worth living. ... Notice the new passion that you now have ... and how this passion is affecting your activities in day-to-day living. ... Now take a deep, deep breath and get ready to shift gears ... and come back from the future into the present. ... At the count of 3 ... just get ready to shift your attention ... at the count of 2, with your eyelids closed look up with your eyes ... and at the count of 1, let your eyelids open and as your eyes come back to focus ... notice how you become fully alert and awake and ready to move on with the rest of today in the most positive way. ...
to subside and were being replaced with feelings of enthusiasm and inner resourcefulness.

**INDICATIONS AND CONTRAINDICATIONS**

The unambiguous indications for a future-focused strategy in the treatment of depression include those patients who experience symptoms of hopelessness and futurelessness as part of their clinical presentation. Such approaches require that the patient has some ability for abstraction; it seems the patients with a creative imagination typically respond best to such approaches.

Special attention must be given to patients with suicidal ideations and a history of suicide attempts. Such patients do better with a strategy that constructs future-focused imagery as close as possible to plausible reality and uses a highly structured technique in constructing such future-focused imagery. The approach with such patients needs to also be enhanced with ego-strengthening suggestions that focus on mastery, inner resourcefulness, and self-efficacy.

In my opinion, it is generally contraindicated to use future-focused imagery as a tool for exploration in an unstructured manner in depressed, suicidal patients. Unfocused suggestions may unwittingly serve to enhance their feelings of hopelessness, negativism, gloom, and doom. Other contraindications for future-focused hypnotic imagery include patients with depression as a result of terminal-phase diseases such as cancer, congestive heart failure, AIDS, systemic lupus erythematosus, end-stage liver disease, and systemic incurable infections. Building realistic hope is the greater goal, not fueling unrealistic ones. In addition, patients with delirium and dementia are also poor candidates for such interventions due to a severe impairment in their cognitive functions. An additional group of conditions where this approach may be contraindicated includes patients with acute psychosis manifesting with active hallucinations or delusions. Patients with a paranoid personality should also be treated with extra care before such an approach is used. In general, patients who have an impairment in differentiating between inner and outer reality are also not good candidates for this treatment strategy.

**SUMMARY AND ADDITIONAL CAVEATS**

All communications between clinicians and patients involve embedded suggestions, whether direct or indirect. Even simple questions in the first evaluation session that are focused on the past may communicate the idea that the past holds the clues to the present and the future. This is a potentially hazardous message. As Michael’s case (above) illustrates, an excessive focus on the past, especially in patients with a history of an unhappy childhood, can reignite and bring back images and experiences of sadness, hopelessness, and despair.

One of the pioneers of strategic therapy, Paul Watzlawick (1993), elaborated on the idea of how self-fulfilling prophecies may be a powerful force influencing
peoples’ choices and behaviors. He said, “It is the future, not the past, that
determines the present; the prophecy of the event leads to the event of the
prophecy” (p. 13). This philosophical stand is crucial in the practice of psycho-
therapy because it puts a great responsibility on the behavior, speech, and com-
munication of therapists toward their patients to orient people as much as possible
to the best the future can hold. Blaming patients for their own misery under the
guise of forcing them to accept responsibility for their feelings and actions is not
necessarily a solution-oriented strategy. A focus on the future and its possibilities
has the power of transforming the present with the force of second-order change
(Watzlawick et al., 1974).

A special consideration and warning to therapists using future-focused
hypnotically enhanced imagery is to be fully aware and knowledgeable of the
patient’s abilities and limitations. Constructing future-focused imagery must take
into account the present reality of the patient and the plausibility for change
considering the patient’s intelligence, age, education, and economic reality. For
example, a patient may have the fantasy of becoming the head of the neurosurgery
department in a large general hospital; however, the reality is that this may be a
person over the age of 50 who has never gone to college and is still working on
getting a GED. It would be highly irresponsible for a clinician to engage the
patient in a future-focused imagery involving the attainment of such unrealistic
goals. No one wants to understate a patient’s potentials, but neither do we want
to overstate them.

There are patients who refuse to participate in any therapy that involves formal
hypnosis. Is it still possible to help these patients with a future-focused strategy?
My answer to this question is yes, it is possible to help them by using language
that is focused on the future. Therapists can employ a solution-focused strategy
by engaging the patient in future-focused language and imagery, thereby helping
him or her to internalize a new future that involves a solution to his or her current
depression.

For example, I had a patient who suffered from feelings of hopelessness and
despair who felt disgusted, angry, and disappointed with himself for not being
able to stop smoking. All his attempts in the past had failed even though he was
successful in many other endeavors in his professional and personal life. He
refused to participate in any therapy using formal hypnosis. We engaged in a
dialogue whereby I asked him to assume that our work together produces a
desirable result of his overcoming the habit of smoking. I further asked him to
imagine himself a year from now having conquered his nicotine dependence.
I enhanced this image with ego-strengthening suggestions and asked him to carry
on an imaginary dialogue with this person of the future who had already con-
quered the habit of smoking. In this dialogue, he was instructed to ask his future
self how he had conquered the habit of smoking, and then write an essay about
what he learned and bring it in the following session for further discussion. The
patient came in the following week and announced that he had stopped smoking
on his own and had no desire for any more cigarettes. This approach is not new and was described previously by Watzlawick (1985) and Yapko (1992, 2003).

The future holds all kinds of possibilities. This simple truth holds hope for the hopeless as an invaluable, even life-saving path out of depression.

EDITOR’S SUMMARY

- Hope for the future is a vital and motivating life force, one that is too often missing in depression sufferers.
- Hopelessness is an orientation to the future, albeit a negative one, that indicates a need for a positively future-oriented intervention.
- Hypnosis as a multidimensional approach catalyzes a more experiential shift in the direction of hopefulness than more single-dimensional interventions.
- The author presents a technique he calls “Back from the Future,” a hypnotic intervention for building realistic optimism and hopefulness. Its rationale, structure, and method are detailed, and four case examples of its effective application are provided.
- A key distinction between realistic and unrealistic hope is made, emphasizing the importance of any hopefulness generated through the use of the “Back from the Future” technique being identified as realistic.
- Suicidal or psychotic patients, and patients with dementia, are identified as poor candidates for the “Back from the Future” intervention.

REFERENCES

HYPNOSIS AND TREATING DEPRESSION


Utilizing Hypnosis in Addressing Anger Issues in Treating Depression

JORDAN I. ZARREN

Clinicians usually cannot help but notice the presence of angry feelings in their depressed clients. Depressed people are often characterized as being negative and irritable, perhaps even explosive at times with angry outbursts. Their anger, if poorly managed, may have many negative consequences that can further deepen their depression (Hammen, 1991, 1997). This is particularly true when individuals feel shame and guilt for having lost their tempers and attacked others, especially those they love and to whom they are most attached. Relationships that are already strained by the difficulties associated with being around a depressed person (e.g., the steady stream of negativity, the loss of a sense of humor, the lack of enthusiasm for shared activities, and the diminished range and quality of communication) can easily reach the breaking point when anger surfaces and is expressed destructively (Semmelroth, 2005). Addressing the depressed client’s angry feelings and developing a variety of ways for the client to better manage them may thus become a vital part of treatment.

In this chapter, I will consider the relationship between anger and depression. In particular, I will focus on how hypnosis might be integrated into an effective treatment plan for depression by empowering the client not only to better cope with but also to even reduce his or her angry feelings.

The close relationship between depression and anger has been explored in depth from a variety of perspectives. Nearly a century ago, psychoanalyst Karl Abraham theorized that hostility about the loss of a loved one whom one either identified with or introjected would lead to depression if the hostility became self-directed (1911/1985). Sigmund Freud, just a few years later in Mourning and Melancholia (1917/2000), picked up the theme of loss and hostility but added
guilt into the mix. Freud suggested that the guilt over the loss generates a need to suffer that lowers one’s self-esteem and again leads to the classic—but largely erroneous—“anger turned inward” formulation.

Social psychologist and author Carol Tavris, Ph.D., in her superb book *Anger: The Misunderstood Emotion* (1989), crystallized the observations made in careful research, especially those of cognitive therapy pioneer Aaron Beck, M.D., that have led to the effective dismantling of the Freudian position. She wrote, “If depressives are ‘turning anger inward,’ we should find that they are not expressing anger or hostility ‘outward’ verbally. But it turns out that most depressives do express anger and hostility to others” (p. 109).

Tavris (1989) pointed out, “Just as there are different causes of anger, there are different depressions, and different relationships between the two emotions” (p. 108). Author Dean Schuyler (1998) agreed:

Irritation, annoyance, and hostility can all be found on a continuum of anger. For some depressives, anger may indeed be hypothesized to be ‘turned inward’ and expressed anger will be rarely observed, while for others overt hostility is quite common. (p. 10)

The clinical implications of the above cannot be overstated. Just as depression can have many different causes and many different appearances, so can anger. In the next section, I will consider some of the factors known to influence anger associated with depression.

**VIEWPOINTS REGARDING THE PRESENCE OF ANGER IN DEPRESSION**

As the mental health profession has tackled the issues of domestic violence, bullying at school, violence in the workplace, and other such arenas in which anger can turn to frighteningly explosive rage, more has been learned about the factors that place people at risk for mismanaging their anger with destructive consequences. Many of the insights derived from such research have immediate relevance for addressing issues of anger in depressed people. Some of these are described below.

*Learning Anger as a Tool in the Family*

In his book *Angry All the Time* (2004), Ron Potter-Efron described anger as a learned response for managing others that most likely arises in the context of an angry home. He described the angry home as having three primary characteristics: (a) Family members think that intense anger is normal and to be expected; (b) interactions are such that people don’t listen to each other until someone gets very angry; and (c) family members use anger displays to solve
problems. In this social learning viewpoint, anger is both modeled and reinforced as a means of getting acknowledged. One might receive negative attention for one’s anger displays, but negative attention is, to many people, better than no attention.

In an earlier book, *Letting Go of Anger* (1995), Potter-Efron also described the “payoffs” for anger: the power that comes from intimidating others, the image that is established as someone not to be trifled with, the emotional distance that permits an avoidance of intimacy, and the ability to avoid other feelings that may be more threatening (e.g., vulnerability). For example, anger has been viewed as a defense against sadness: “Anger is easier than sadness” (O’Connor, 2001, p. 53).

The evidence strongly suggests that anger has greater intra- and interpersonal value than surface appearances might suggest.

**Anger as a Means of Controlling Others**

As the character Don Corleone illustrated in the classic gangster movie *The Godfather*, when “you make someone an offer he can’t refuse” (i.e., threaten him with violence or death unless he complies with your wishes), such threats are usually effective in getting one’s way. In current times, terrorism is an effective means of gaining control over others’ actions. Although anger in relationships isn’t so extreme as terrorism, it can function similarly by intimidating others into compliance with one’s wishes.

In his book *The Anger Habit in Relationships*, Carl Semmelroth (2005) described the role of anger in relationships this way: “Anger is preparation to control by threatening to attack others” (p. 3). He discussed the role of criticizing others in anger at length, pointing out that such criticism is a way of exerting pressure to comply, and said bluntly, “The purpose of your criticism is to prevent your partner from straying away from doing what you think is the right thing for him or her to do” (p. 24).

When people are depressed and feeling out of control themselves, as they typically do, they may well attempt to assert control over others around them, expressing their dissatisfaction through a constant barrage of criticism that others find painful. It’s one of the reasons why depressed people’s relationships suffer so greatly. Not many people are willing to endure the chipping away of their self-esteem. They’d rather leave. It’s no wonder that depressed people often damage the relationships they value the most.

**Anger in Response to Threats**

When people are afraid, their fear often manifests as anger. The mother who is terrified when her child wanders away in a crowded mall and then angrily spanks her child for the transgression is a simple but effective example. As John Lynch stated in his book *When Anger Scares You* (2004), “Anger and rage are responses to a feeling of being out of control, and they seek to restore a sense of control”
There are many different kinds of threats, including physical, relational, financial, emotional, and spiritual ones. When someone is threatened in some way, whether the threat is real or merely imagined, the adrenaline starts to flow and someone’s feelings can easily escalate to wholly irrational levels.

In depressed individuals in particular, threats to one’s sense of competence and threats to one’s security are especially powerful triggers for depressive episodes. As depression expert Peggy Papp of the Ackerman Institute described in her research on depression and gender (1997), the most common triggers of depression for men are threats to their ability to function as providers (such as a job loss or a demotion), and for women they are threats to their intimate connections (such as a divorce or a best friend moving away).

**Anger and Learned Helplessness**

The seminal research of Martin Seligman, Ph.D., on the relationship between depression and perceptions of helplessness continues to be of great significance in our understandings of depression (Peterson, Maier, & Seligman, 1993). When people perceive they are being harmed or victimized in some way and feel unable to do anything about it, they may feel trapped, angry, and, ultimately, helpless. The circumstances that victimize people may be external ones (e.g., being stuck in a traffic jam or having a computer “crash”). But, more often than not, they are internal ones, such as believing one is worthless or destined to fail so no meaningful efforts need be made to improve one’s circumstances (Ellis, 1985). In the case study of George, presented later in this chapter, you will see how his sense of helplessness to cope with his fears about what a childhood trauma might mean resulted in not only depression and anger, but also a somatic symptom in his hand that had endured since the original episode.

Aaron Beck and his colleagues (Beck, Rush, Shaw, & Emery, 1979) discussed at length the common disconnect between the depressed patient’s inability to express emotion and the intensity of frustration and helplessness that is expressed as a loss of control and a loss of personal power. They suggested that helping the patient recognize and express anger appropriately is an important part of treatment. Michael Yapko (2001) agreed, further discussing the anger component as sometimes being a matter of clarifying the issue of “secondary control,” that is, helping the person change his or her interpretation of the meaning of situations when the situations themselves are not changeable. The distorted perceptions that people have about what is and what is not controllable were explored at length by Yapko in his books, *Treating Depression with Hypnosis* (2001) and *Breaking the Patterns of Depression* (1997). The hypnotic and behavioral strategies that he suggests for clarifying what is and is not controllable are useful for reducing and even preventing anger stemming from feelings of victimhood. Suggesting new perspectives or ways of interpreting the meanings and degrees of controllability of life experiences is a general strategy that can be enhanced with hypnotic intervention (Haley, 1973; Schoenberger, 2000; Yapko, 2003).
Anger and Unrealistic Expectations

One of the most reliable triggers for depression and anger is when someone is emotionally invested in attaining a particular outcome, in other words, has an expectation about how things “should” be, and then is hurt and angry when things don’t go as hoped for or expected. As Peter Kramer discussed in his book, Should You Leave? (1997), so often the anger and despair people experience in their lives come not simply from others who are disappointing, but instead from unrealistic expectations about how others feel or will behave. There is no doubt that sometimes people deliberately mislead others (and even themselves), but it seems to be the case even more often that people just don’t assess others very realistically, instead seeing them through the filter of their own moods and expectations. Kramer pointed out that too many divorces happen because of depression that has gone undiagnosed and the associated unrealistic expectations.

W. Robert Nay, in his book Taking Charge of Anger (2004), said, “When you conclude that someone else has acted outside of [your] expectations, whether factual or not, you’re likely to experience anger” (p. 60). Social psychologists have long studied the well-known connection between frustration and aggression: frustrating someone by not doing as he or she expects will likely provoke an aggressive response. But lashing out, as some do, begs the bigger issue: How does one develop one’s expectations in the first place? Why don’t people make some effort to determine whether their expectations are realistic before they suffer disappointments? Such a preventive approach advocated by David Burns in The Feeling Good Handbook (1999a), where he shifted the emphasis from whether one tends to internalize or externalize anger to a preventive strategy of first examining one’s beliefs and expectations and assessing how realistic they are in light of external evidence. Burns strove to help angry people stop creating their anger by better understanding the nature of moods and by learning ways to recognize and defuse triggers for anger. Nay (2004) had a similar emphasis when he wrote, “When an unwanted event catches you by surprise, as is often the case, it helps to identify your expectations as soon as you realize you’re becoming angry” (p. 72).

GOALS OF ADDRESSING ANGER IN DEPRESSED INDIVIDUALS

Anger feeds on itself. Contrary to the popular notion that expressing one’s anger is a healthy and positive thing to do, the evidence indicates quite the opposite: “Expressing anger doesn’t decrease anger; quite the contrary, it increases it” (Semmelroth, 2005, p. 6). Tavris (1989) summarized much of the salient scientific literature attesting to the hazards of focusing on anger, especially those approaches that lead people to mistakenly believe if they pound walls and beat on chairs, they will “get their anger out.” As experts in hypnosis know,
focus on, you amplify; and such intense focus on anger may well serve to escalate it in many people. Tavris reviewed the evidence that showed that the more clinicians focus on anger, the angrier the client may get, but not necessarily better. As a result, simply encouraging clients to vent their anger is no longer seen as a viable sole intervention. The seminal work of Susan Nolen-Hoeksema (2003) on the dangers of rumination, another depressive pattern that amplifies negative feelings, lends further support to the observation that there is a danger of escalating negative feelings by focusing on them.

So what, then, are the goals of addressing anger in treating depressed individuals? The previous section describing a few of the many pathways into depression and anger makes the point that the goals will differ with each individual client. For some, the goal will be to help them develop more realistic expectations; for some, the goal may be learning impulse control and containment strategies; for some, the goal may be learning to deal with others in healthy, positive ways that foster true closeness; and for still others, the goal may be removing or taking themselves away from legitimate threats in their environment. There may be many other goals beyond those stated here (Kassinove & Tafrate, 2002; McKay & Rogers, 2000).

Episodes of throwing tantrums or even just having angry outbursts (i.e., “loss of one’s temper”) may well serve to fuel negative self-judgments and poor self-esteem (O’Connor, 2001), damage relationships with others (Emery & Campbell, 1986), and generally reinforce a sense of personal incompetence (Burns, 1999b). Likewise, missing opportunities to assert oneself, thereby defining oneself as a helpless victim of others’ insensitivity, can easily reinforce poor self-esteem, anger, and depression (Yapko, 1992, 1997). Thus, recognizing and managing angry feelings skillfully are clearly important parts of empowering people, especially depressed people who typically feel disempowered (Meichenbaum, 1977).

**Empowering People Hypnotically to Manage Anger More Skillfully**

There are many strategies of intervention that have been described in the literature for helping people become more skilled in managing their feelings rather than being depressed victims of their emotions. However, hypnosis as a vehicle of treatment in this regard has not received much attention. Zarren and Eimer (2002) did consider it, though, and emphasized the use of clinical hypnosis to teach the patient to quickly recognize his or her angry or negative feelings and strategically interrupt and direct them in a beneficial manner. Patients can be taught through hypnosis to (a) recognize personal triggers for angry feelings, (b) recognize their irritable feelings before they escalate, (c) self-soothe and reduce frustration, (d) delay reacting for a moment (i.e., impulse control) in order to choose a deliberate and constructive response, and (e) build more realistic expectations so eventually anger is less likely to get generated in the first place.
Other experts have described the use of hypnotically based strategies, but these have been more general in nature: (a) visualization strategies such as the “Golden Healing Light” for reducing stress and healing hurt and angry feelings (Middleton-Moz, Tener, & Todd, 2004), (b) physical relaxation to interrupt the escalation of angry feelings (Lynch, 2004; Nay, 2004), and (c) self-hypnosis, directed imagery, yoga, and breathing exercises to generate calmness and develop perspective (Jones, 2004). Such focusing strategies can help restore a sense of personal control and an ability to detach (dissociate) from angry feelings as well as depressive ruminations.

As is evident above, there are obviously many different ways to apply hypnosis and hypnotically based strategies in treatment, ranging from very structured and direct approaches to less structured and more indirect approaches (Lynn & Kirsch, 2006; Yapko, 2003). In the following case example of working with a depressed man’s anger, a highly structured approach was used that matched well with the client’s preference for a directive and “no-nonsense” approach.

A CASE STUDY: THE CASE OF GEORGE

In the preceding discussion, anger was associated to unrealistic expectations, frustration, a sense of being victimized, and feeling out of control. These and other dynamics will be developed in the case study to follow. In this instance, George (not his real name), the patient, experienced anger that seemed to be related to an early trauma he had suffered. He had been sexually abused as a child. He apparently established a distorted sense of helplessness and hopelessness, a common consequence of such early adversities. He was diagnosed as dysthymic, essentially suffering a prolonged depression (American Psychiatric Association, 1994). This man was also mildly abusing drugs. Drug abuse as a comorbid condition is not uncommon, generally reflecting a poor style of avoidant coping with depressed feelings and life stressors (Abraham & Fava, 1999).

George was treated with hypnosis and a blend of some of the cognitive-behavioral approaches mentioned above. The general goals of George’s treatment were to (a) interrupt his experience of helplessness that his anger and other symptoms reinforced by teaching him self-empowering hypnotic skills; (b) clarify, if possible, the causative experience(s) underlying his anger, process his feelings about it, and reframe its meaning; and (c) teach him how to manage his feelings directly with self-hypnosis skills in order to prevent future recurrence of symptoms. Singly and in combination, these goals of treatment all served to actively teach George skills that could enhance his coping, decision making, and relationships.

The specific values of hypnosis as a treatment tool will be described throughout the various stages of treatment.
Background of the Case of George

George was referred to the author by a colleague in another city who had treated him before his move to my state. George is a 55-year-old professional musician who has a studio, plays jazz piano with a small group, accompanies vocalists, composes music, and also teaches piano to students of varying ages. His wife is 47 years old and is an English teacher. George revealed his wife supports them both economically because she has a more dependable income.

During the initial contact phone call, he was asked why he wanted to see me. He said,

I often get very angry and swear and throw things. My wife is afraid it might get out of control and I may hurt her, myself, or someone else. I am feeling very depressed and unable to accomplish the goals I set for myself. I feel trapped in an odd cycle of daily behavior. I am having problems with my piano playing and want to change the direction of my professional playing.

As is typical of patients seeking treatment, there were multiple problems needing to be addressed. Of these, it seemed apparent that George’s anger held the greatest potential for harm and so was considered a high-priority target for intervention.

Session 1. During the initial intake, I asked George to elaborate on his comment about his having an “odd cycle of daily behavior.” He explained,

My daily rituals involve taking care of the household duties in the morning while my wife is at work. I start practicing piano at 11:00 a.m., and then start seeing students for lessons in the afternoon. About 5:00 p.m. I usually have a glass of wine before dinner. After dinner I have two or three more glasses of wine and follow this with smoking one or two bowls of marijuana. During the rest of the evening, before going to bed at 1:00 a.m., I snack on sweet and sugary foods. My wife smokes marijuana with me. I also go to monthly evening parties with a group of 10 friends where large quantities of marijuana and alcohol are consumed.

I asked him if he had seen a doctor to check on his physical health. He told me he’d recently had a thorough physical examination and was found to be in good physical health. When asked how he feels about engaging in drinking alcohol, smoking marijuana, and eating poorly, George said that he has mixed feelings: Part of him doesn’t care, but part of him hates himself and gets angry with himself for his careless behavior. We discussed the negative effects of the various substances he consumed and how they might affect his mood and his ability to face and resolve his problems. George cautiously agreed he would need to curtail his substance abuse, an agreed upon goal of treatment.

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happened to him. Asked about his experience with hypnosis, he said his therapist took him into the “trance state” with an eye fixation and counting method. He said he sometimes did a self-hypnosis process of taking some deep breaths and relaxing before practicing piano. Asked if he was taught to use these same self-hypnosis skills for coping with the problems he had previously and was having now, his answer was “No, I never thought about doing that.” As Yapko (1992, 2001) pointed out, the concrete cognitive style of the depressed patient can often preclude the transfer of skills from one context to another without assistance from the therapist, as was the case with George. Helping him make this transfer would be another goal of our sessions.

George said that anger was his foremost concern and described it this way:

I frequently get so frustrated and angry with myself that I go nuts and have a temper tantrum. I swear and yell and carry on until I am exhausted and then slowly I’ll calm down. This frightens me and my wife.

He said he never hits anyone, but admitted he sometimes throws things and hits the wall with his fist.

I described to George what he could expect from therapy with me. I said,

I can begin helping you by teaching you some immediate coping skills to deal with your first priority, the anger outbursts. Hypnosis can be helpful in teaching you ways you can control your anger. Hypnosis can also help you choose to reduce your use of various substances, learn the skills to reduce your depression, and become more productive in your music career.

These direct statements were meant to define positive goals and establish an expectancy that these goals could and would be reached. This is a vital step toward countering the typical negative expectations of depressed individuals (Beck, 1967).

An approach called “waking state reframing” (Zarren & Eimer, 2002) was used to give the patient information to begin to understand, reframe, and change beliefs and labels that have been imprinted by trauma and through their repetition. The theoretical premise of waking state reframing is that the therapist is communicating directly and simultaneously with both conscious and unconscious mental processes in a focused but relaxed patient despite the absence of a formal hypnotic induction. This absorption has been called a “waking” or “active-alert trance state” (Wark, 1998). During this waking state, many of the indicators of hypnosis are present, such as infrequent eye blinking, breathing changes, increased blood flow to the extremities, relaxed facial expression, and relaxed body posture (Barabasz & Watkins, 2005). The key portion of this “prehypnosis hypnosis” was verbalized as follows:

*George, for our purposes, we can think about the mind as having a conscious part over which you have control, and an unconscious or subconscious part over which*
you currently feel you have little or almost no conscious control ... there are three ways of communicating with the unconscious. The first way is by repetition. ... The second way of communicating with the unconscious is when there is a traumatic experience that is imprinted into the unconscious. This can create fear, anxiety, anger, depression, and so on. And a third way is the use of clinical hypnosis. You already have some experience with this. When a person is in a deep state of physical and emotional relaxation, somehow during that relaxation the doorway to the unconscious opens, and with your permission I can give it information it needs to have to help you change the things you want to change. ... During hypnosis, the physical and emotional buildup of stress that has been going on for so long can be reduced, and changes can begin to occur more quickly and easily. ...

George was attentive and nodded his acceptance, paving the way for the formal induction and therapy intervention to take place, the key portions of which were as follows:

George, you can begin by looking at the large photograph hanging on the wall ... and you can focus your eyes on the details of the photograph. ... When your eyelids get so heavy that you find your eyes wanting to close. ... And now that your eyes are closed ... and you're growing more comfortable ... you can pay attention to your breathing ... with your eyes closed, you will also hear a special jazz tune softly in the background ... it could be an original piece of your own, played perfectly, or one of your best liked tunes played by one of your favorite jazz musicians ... and it can be so comfortable to build a receptive state of mind ... and allow the music to be in the background, while you relax deeper and deeper ... and allow your anger and frustration and depression to literally melt away ... dissolve away ... while all the emotional overlay melts with it, allowing you to feel free and comfortable and safe. ... This very comfortable feeling might be called the "Neutral Place" or, perhaps, the "Healing Place" ... a special place inside of you where your body–mind system is in balance ... without any wasted energy on stress or distress ... all of your precious energy can now be used for healing, growth, and change. ... You will notice very soon, probably even today, how much better you feel. ... You can establish a clear memory of what it feels like to be really deeply relaxed and comfortable, physically and emotionally. ... You can borrow back this memory from your experience of deep comfort that you feel today by doing this for yourself at home or in your studio two times a day. ...

When George was realerted, I asked what the experience was like for him. He said, “I have not felt that relaxed ever, as far as I could remember. Not even when I was in trance with my previous therapist.” To empower George to use this kind of procedure independently, I suggested the following: “Put yourself back into relaxation, on your own, without my help, the same way I helped you do it before. When you feel very relaxed, nod your head so I will know.” When he nodded his head, I offered the following suggestions.
You have just done your own self-hypnosis, your own relaxation. ... It was very easy to feel this way on your own. ... Every time you do this for yourself, you continue the process of healing and change. ... In fact, you will find that you no longer want to put unhealthy things in your body ... and you will immediately recognize that you are much slower to anger. ... This feeling of relaxation you're beginning to master is better, more satisfying, than almost any other experience ... because when you focus yourself ... you are in charge. ... You are more focused and alert. ... You are more coordinated. ... You are much calmer. ... You are more in charge. ... Most importantly, you will recognize that you are taking better care of yourself. ... That you are treating yourself ... and others, too ... with more care ... with more dignity ... with more respect, and with more love. ... And you will continue to feel better and better about yourself as each day goes by. ...

George’s reaction after opening his eyes was “Wow! That was great, and so easy. I will practice that way of relaxing. It really feels good.”

Our treatment goals for the first session were to (a) change George’s rigid and erroneous mind-set that he was trapped in his helplessness, (b) provide him with an experience of being physically and emotionally comfortable by building a positive memory of deep relaxation, (c) teach him how to use the skill of self-hypnosis as a new and effective coping skill, and (d) start the change process by interrupting some of George’s behaviors that were causing him so much distress. We ended this first visit amiably and scheduled another appointment for 2 weeks later.

Session 2. When George returned for the second visit, he reported that he was feeling more positive and less depressed.

Wanting to establish some specific behavioral goals to focus today’s session on, George said, “The major problem I want to deal with today is immobility.” This was a label that George used to describe his seeming lack of drive. I explained, “Your immobility is a common part of feeling depressed. We will focus on ways to get mobilized today.”

George then added, “The second major problem is the use of my right hand.” I knew what he was referring to, because when George came into the office the first time and I reached out to shake his hand, he grasped the fingers of my right hand with the fingers and thumb of his left hand, not in a normal handshake. We discussed what was troubling him about his right hand, and he said it seemed very fragile and sensitive. He went on to say he had trouble using his right hand when playing the piano, and this was “one of the many things that frustrate me and make me angry.” He had no insight as to what the problem with his hand was about, either medically or psychologically.

I suggested he walk over to the large glass jar on the credenza that is full of marbles and “pick one that could be your special ‘magic marble’ that you will keep with you. When you decide which one you want, bring it with you and come sit back in your chair.”
I continued,

The choosing of a marble and holding it for many people facilitates a regression to childhood, going back to a time when there were fewer problems, a time when children play and have fun and feel safe. Over the years while working with marbles, that is what most of my patients have described.

With the frame for the session to follow now established, I began the induction, the following of which was a key portion:

Sit comfortably in the chair, and hold the marble in your hand and look at it. ... Keep your eyes focused on the marble. ... Roll it between your thumb and first two fingers. ... Feel the slight imperfection you will find somewhere on the marble. ... Marbles are very beautiful, but they are never perfect, like people can never be perfect, but can be beautiful in their own way. ... If your mind starts to wander ... bring your focus back to the marble as it gets warmer and warmer. ... In fact, the warmer the marble becomes, the more relaxed you become. ... You can even judge how relaxed you are by how warm the marble becomes. ... Let it happen, and enjoy the experience. ... What is interesting is that the marble is outside of you but you control it. ... Just as you control other things that are outside of you, such as the piano keys. ... Often, when good hypnotic subjects like you feel the positive energy enter the marble in the form of warmth ... they can also feel other movement down that same arm in the form of negative energy. ... Problems, stress, anger, insecurity, guilt can move down into the marble. ... The marble can attract these negative forces but cannot hold on to them ... so they are dissipated harmlessly into the air like smoke. They are cleansed from your body and mind. ... Now, move the marble from your right hand to your left hand, and let it warm your left hand very quickly. ... As you control the marble, which is outside of you, with your right and left hands ... you can also control those other things that are outside of you in more balanced and coordinated ways.

George said, “The marble is becoming soft and is disappearing from my left hand like it did when it was in my right hand.” He had not mentioned this earlier. Taking advantage of the feedback from patients’ experiences during hypnosis is very important. They are cues for further change work. This led to the next variation of the marble-based trance process.

I then suggested, “Give me the marble to hold for you for a little while.” He handed it to me. I continued, and the key portions were as follows:

Now close both hands, and turn them palms faced down, and place them softly on your upper thighs. ... This will allow you, to create a greater balance between both hands. ... This also strengthens each hand and creates a coordinated balance between them. ... This increased balance that you now feel and will continue to feel will also contribute to your becoming much more mobilized. ... No longer hesitating or procrastinating. ... Feeling more balanced creates a feeling of more confidence
After he opened his eyes, we talked about this experience. He said, “I feel very positive in general, but have a lingering sense of anxiety about the eventual outcome.” I told him, “Practice working with the marble, and also practice without the marble just as you have been taught today.” He scheduled another appointment for 2 weeks later.

The goals for this second session with George were to (a) encourage a feeling of “mobilization,” that is, allowing George to feel motivated to do what needed to be done to help him improve his life; (b) develop new, easy, and more powerful skills he would feel motivated to use that work for him; (c) teach him how to use the “powerful marble technique” as a symbolic ritual in order to accomplish these; and (d) help him overcome his right-hand problem, which had been causing some of his anger and frustration, especially by limiting his music abilities. We will see during the third session how addressing these issues would lead George to develop new self-awareness and understanding.

Session 3. As George came in to the office for his third visit, he said that today was his 56th birthday and that last night he’d had his first “crash and burn” experience since we started working together. I asked him to sit down and explain.

He said, “Things have happened. Last night I felt angry and demoralized … there are a lot of memories and feelings I haven’t dealt with.”

I reframed George’s feeling of having “crashed and burned” as having succeeded and said,

This new secure feeling you had brought back memories and feelings you had that need to be dealt with. If you didn’t bring these memories back, then you could not deal with them. They came back because you felt strong enough to deal with them. That’s great. So, tell me more about these memories and feelings.

He said,

When I was a kid, there was one time we were visiting our family for Thanksgiving dinner. There was a concert pianist invited to dinner. Sometime during a lull, he and I were in another room and he played with my penis. I got scared. I was afraid to tell anyone, and so I avoided him for the rest of the day. I come from a musical family.

At this point, I interrupted and asked George, “Did he ask you to touch his penis?” With some surprise, he asked me, “Yes, how did you know?” I then asked George, “Did the pianist take your hand and place it on his erect penis?” He said, “Yes. But I didn’t want to go into that kind of detail because I feel bad enough.” I then asked George, “Which of your hands did he place on his penis?” George
looked at me in shock, and then said, “It was my right hand. I didn’t remember that until just now.” I commented, “Now that you remember, do you think that may have been the reason for your right hand being so sensitive and fragile?” George’s response was “I can’t believe this! Yes. It is possible.”

I said, “George, let that new awareness rest for a while. Tell me more of what you didn’t finish when you started talking about your piano-playing problem when you were younger.”

He closed his eyes for a few moments, and then continued,

*I said I came from a musical family. At age 11, I tried piano lessons. I wanted to play the piano, but was afraid that if I did I would become a homosexual because of what happened at dinner that time. So, at age 17, I took up the drums and played with a small band in high school. At age 20, I was in the military in Germany and started to study the piano with a German teacher who was a woman. That was a fond memory, but I was not a good student. I had problems practicing. She didn’t really teach me how to practice, or maybe, now that I remember, I was still afraid of becoming a homosexual. Thinking about that now makes me angry as hell. I want to blow.*

I said, “Go ahead, and blow. No one can hear you here.” He said, “No, I don’t have to, but it makes me really depressed.”

We were reaching some very important material, but there was too little time left to deal with it in detail, so I asked George to put himself back in hypnosis using the marble.

I said, “When you feel deep enough, nod your head.” When he nodded his head, I offered him many suggestions, the key ones of which follow:

*Allow all of those negative feelings to move down your arm into the marble … and be dissipated harmlessly into the air like smoke. … While the marble gets warmer and warmer, you are relaxing deeper and deeper … and you can also experience positive energy while in the neutral healing place. … You can continue to feel better and better and more in charge as you continue to practice your self-hypnosis and practice your piano. … You will also realize that you know more about yourself now … and this new knowledge will help you to continue to change and deal more constructively with those changes.*

He spent about 10 more minutes in hypnosis without my saying a word, and upon alerting he said, “That was great. It really felt good being able to deal with those memories this way.”

The goals for George’s third visit were to (a) reframe his feelings of failure to feelings of success; (b) recognize the importance of early trauma in imprinting protective behavior; (c) soften the effects of negative coping behaviors, such as maintaining his hypersensitive hand; and (d) reinforce his ability to use a new self-hypnosis procedure to continue the healing process without necessarily having to reveal the details to me.
He scheduled a fourth appointment for 3 weeks later.

Session 4. When George arrived for this visit, he said he was doing very well. He said he was smoking no marijuana at all. He was promoting more accompanying gigs with vocalists, and said he was feeling more comfortable with his piano playing. His wife had also stopped smoking pot. She was now preoccupied with planning what she wanted to do after her teaching job ended.

George felt that his depression and anger had abated and that he was much more in control. He wanted to spend most of this session in deeper hypnosis and requested a strong series of suggestions to further strengthen the changes that had started so well. He again said he loved using the marble as a symbol of his control and would continue to practice his self-hypnosis as he had been doing. He also felt that he would like this to be the last session for a while, so he could continue on his own. He also wanted assurance that he could call or come back if needed.

George was asked to use his marble and go into a deep and comfortable relaxation. The session was delivered, from which the key portions follow:

As the marble gets warmer, you can relax deeper ... continuing to release the remnants of anger ... anxiety ... and depression ... physically and emotionally ... In this neutral place ... this healing place ... feel the quiet ... feel the peacefulness ... feel the safety ... feel the confidence ... feel the power ... feel the freedom ... feel the growth ... feel the maturity ... feel the strength ... feel the change ... Feel the negative remnants attracted to the marble and released harmlessly into the air ... See the future ... positive ... productive ... secure ... and satisfying. ... Continue the healing process on your own as you continue your own self-hypnosis sessions twice daily. ... It is your personal tool for recovery, anger control, lifting depression, personal power, and success. ... Use it ... Do it ... It is time for you to be in charge ... to leave the past behind ... to move into a positive present and future. ... To treat yourself with more care ... with more dignity ... with more respect ... and with more self love. ... 

After about 5 minutes, George opened his eyes, looked at the marble in his hand and then at me, and said, “Wow! That was some experience. I wanted that, and it happened.”

We talked some more as he became more alert. He thanked me and said that he would call me to keep me informed as to his progress and if he needed help. I complimented him on how well he had done in the few sessions we had worked together. We shook hands, and he left the office. Significantly, when he shook hands with me, he used his right hand, not his left as he had been doing. It was a more normal, though not strong, handshake.

Follow-Up. A month later, George called and said he’d had a bad anger episode the night before for no apparent reason. He ranted and swore, and then his anger
seemed to dissipate and go away after an unusually short time. He didn’t know why it started, but it seemed to come under his control so quickly that he was more surprised by that than by the anger episode. I then congratulated him on his successes and suggested he continue to keep in touch.

Three months later, George called again to check in. He told me that he felt stronger and more stable every day. He was doing his self-hypnosis with the marble twice a day on a regular basis.

Two months later, George called again and told me that he’d had no more angry outbursts. George was doing more paid composing for television and radio background music, which was helping him feel he was doing his share financially. Composing is his first love, so he is really enjoying his music more. He also has more adult piano students and is doing much more accompanying for vocalists and for concert and club gigs. He was bringing in more money from his work. “All in all, I am really feeling put together for the first time ever. And I am really enjoying this.” He received more congratulations from me, and I reinforced his success and sense of personal power.

DISCUSSION

As was the case with George, depression and anger may result from emotional trauma. The belief that the memories of the trauma and the current feelings of helplessness and hopelessness will always be as intense or disabling can create debilitating frustration and anger. Negative feelings can build over time and catalyze detrimental physical, biochemical, and behavioral consequences (Brown & Fromm, 1987; Wittkower & Warnes, 1977).

The approach used in the treatment of this client was based upon the concepts described in the book I coauthored with Bruce Eimer, *Brief Cognitive Hypnosis: Facilitating the Change of Dysfunctional Behavior* (2002). In it, we suggested that dysfunctional behavior, including misdirected episodes of anger, is often anxiety based. The brief cognitive hypnosis approach postulates that the individual chooses representative labels for his or her behaviors and that these self-applied labels (e.g., George concluding, “If I play the piano, maybe I’m a homosexual”) can become enduring beliefs that establish absolutes in perception that serve to prevent change. Such rigid and self-limiting beliefs require reframing, that is, some helpful redefinitions of one’s experience (Yapko, 2003). When beliefs are changed, behavior can change (Burns, 1999a).

George’s therapy involved the use of a marble. Of course, the marble is merely a prop, a symbol, a tangible representation of a healthier, more adaptive way of thinking and responding. Hypnosis helps build meaningful associations, and in George’s case the marble was used to remind him of key concepts and techniques that would foster improvement. Specific suggested associations included the following:
1. Viewing the marble as a means of rapid regression to childhood to a
time and place that is happy and safe.
2. Feeling the marble getting warm in the palm of the hand when his or
her fingers are closed. This growing warmth can help the patient gauge
his or her level of relaxation. The warmer the marble, the more relax-
atation is experienced.
3. Seeing the marble as an example of something outside of the patient
yet controlled by him or her, encouraging a healthier internal locus of
control. Too many of a depressed patient's presenting problems are
outside and seem as though they are not controllable.
4. Framing the marble's becoming warmer as evidence that it can absorb
the body's positive energy. If the marble can attract positive energy,
then it can also attract negative energy, but the suggestion is given that
it can't retain it. All of the pain, anger, depression, frustration, low ego
strength, and so on can thus be attracted to the marble. These negative
energies can then dissipate harmlessly into the air like smoke. Thus,
this is an externalization strategy, and there is a symbolic cleansing
process taking place.
5. Changing the hand holding the marble from the dominant to the non-
dominant hand as a symbol of a more comfortable balance in feelings,
behavior, and performance.
6. Using the marble for visual and kinesthetic sensory processing by
looking at it, visualizing it, and feeling it get warmer.
7. Choosing the marble he or she likes best as a present from me that is
taken home. It has, therefore, another symbolic value, that of my
positive regard for the patient.
8. Controlling the marble and its relaxation qualities can quickly reduce
more of the emotional intensity. This helps create a new memory of
deep relaxation that can be accessed when the client does his or her
own self-hypnosis using the marble, thereby further establishing a
greater sense of personal control and ego strength building.
9. Holding the marble as an associational cue during stressful moments
in order to bring about an instant relaxed feeling. This can be used to
interrupt and even short-circuit previous negative coping behavior.
When one is relaxed, one generally cannot be angry, depressed, frus-
trated, or stressed. They are physical and emotional opposites of each
other that tend to be mutually exclusive.

The use of the jazz tune in the background during the initial induction was
a way of enhancing concentration and building pleasant relaxed feelings while
George learned that he could change how he felt.

Hypnosis played an enormously valuable role in George's case as a vehicle
of acquiring new and empowering skills that served to reduce his anger
and depression. When anger is as disabling as the depression associated with it,
people generally feel unable to get past the intensity of their feelings. Throughout each of the hypnosis sessions, George was told either directly or indirectly that he could grow—and outgrow his past limitations. Likewise, he was told that he had more resources than he’d realized and that as he learned to develop these, he would inevitably improve.

It bears repeating that the sources and manifestations of anger are as varied as those of depression. When people are empowered to succeed and equipped with the skills to live life well, they usually discover that life holds many positive possibilities. When absorbed in that expansive frame of mind, anger and depression tend to dissolve.

**EDITOR’S SUMMARY**

- Significant levels of anger are a common feature of depressed individuals.
- Mismanaged anger can lead to negative behaviors that cause negative consequences that serve to worsen depression.
- The classic “anger-turned-inward” model of depression has received little empirical support. In fact, anger associated with depression can have many causes and manifestations, thus requiring many different types of therapeutic interventions.
- Anger can be learned through modeling and reinforcement in angry families: Anger can be a response to perceived threats, can be used to control others, can be derived from feelings of helplessness, and can arise from holding unrealistic expectations that culminate in disappointment.
- Expressing anger can actually increase rather than decrease its level of intensity. Thus, encouraging ventilation alone is not an adequate intervention.
- Hypnosis can be an important means of intervention to teach angry people to relax, recognize personal triggers, derail escalation, choose an effective response, and build more realistic expectations.
- A detailed case example is provided of a structured hypnotic intervention for teaching anger management skills.

**REFERENCES**


HYPNOSIS AND TREATING DEPRESSION


Utilizing Hypnosis in Addressing Ruminative Depression-Related Insomnia

MICHAEL D. YAPKO

The unexamined life isn’t worth living.

Socrates

Neither is the overexamined one.

Yapko

OVERVIEW
Depression is a complex, multidimensional disorder that can negatively affect numerous aspects of the individual sufferer’s life. These include physiological, cognitive, emotional, behavioral, and relational impairments that further exacerbate the condition. Of the many potential difficulties likely to be associated with depression, the single most common symptom, affecting more than 65% of outpatients and 90% of inpatients diagnosed with major depression, is some type of sleep disturbance (McCall, Reboussin, & Cohen, 2000; Nowell & Buysse, 2001).

Sleep disorders can take many forms, including (a) narcolepsy and idiopathic hypersomnia (characterized by excessive daytime sleepiness with episodic sleep attacks), (b) obstructive sleep apnea (featuring a compromise of the upper airway due to an obstruction, most often the pharynx, that leads to respiratory arousals
and oxygen desaturation, causing significant fatigue), (c) restless legs syndrome (manifesting as an irresistible need to move one's legs due to a subjective discomfort in the lower extremities that worsens at night or during periods of sedentary activity, resulting in insomnia or unrefreshing sleep), (d) rapid eye movement (REM) behavior disorder (in which an asleep patient will act out his or her dreams by yelling or gesturing during REM sleep), (e) periodic limb movement disorder (manifesting as small jerking movements in the lower extremities), (f) circadian rhythm disorders (characterized by the inability to sleep at normal sleep-cycle schedules), and (g) insomnia (the primary feature of which is difficulty in initiating or maintaining sleep, or in having nonrestorative sleep) (Cadieux, 2004; Gutman & Nemeroff, 2005; Krahn, 2003). Sleep disorders can be associated with many different medical and psychiatric conditions (e.g., medication and/or substance abuse and anxiety disorders). Insomnia can also be a side effect of other sleep disorders, such as the first six listed above. In fact, 55 of the entries listed in the International Classification of Sleep Disorders can have insomnia as a symptom (Littner et al., 2003). Thus, there is a distinction to be made diagnostically between primary insomnia (i.e., insomnia as an independent disorder) and secondary insomnia (i.e., insomnia that is related to other medical or psychiatric conditions).

This chapter will focus specifically on the relationship between secondary insomnia and major (unipolar) depression. Insomnia is the most common sleep disorder related to depression (Roth & Roehrs, 2003). Insomnia is defined as “a complaint of difficulty initiating sleep, maintaining sleep, and/or nonrestorative sleep that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Littner et al., 2003, p. 754). Thus, an individual may complain of having difficulty initially falling asleep or staying asleep, the latter condition manifesting as either middle-of-the-night or early-morning awakenings. Insomnia is typically characterized by its duration. There are different views among experts as to what constitutes acute versus chronic insomnia. David Gutman and Charles Nemeroff (2005), both from Emory University, suggested the following characterizations: Acute insomnia is when sleep problems last for 1 to 3 nights, and chronic insomnia is when symptoms persist at least 3 nights a week for 4 or more weeks.

The negative consequences of chronic insomnia are substantial.Occupationally, these include a higher rate of absenteeism from work, greater utilization of health services, a higher number of accidents, and decreased productivity. One study from just over a decade ago estimated the cost of insomnia to the U.S. economy at that time to be somewhere between $77 billion and $92 billion, a figure sure to be much greater now (Stoller, 1994). On a personal level, chronic insomnia sufferers also report a decreased quality of life, impairments of memory function, feelings of fatigue, inability to concentrate well, and a diminished interest in socializing or engaging in pleasurable activities, further compounding depressive symptoms (Thase, 2000). Furthermore, a sleep disturbance increases the risk for alcohol-related problems: Using prospective data from the Epidemiologic...
Catchment Area (ECA) program, researchers assessed the risk of alcohol-related problems among individuals with self-reported sleep disturbances because of worry. Survey respondents who had reported sleep disturbances, more than 12 years later, had twice as high a rate of alcohol-related problems (Crum, Storr, Chan, & Ford, 2004).

INSOMNIA AS A RISK FACTOR FOR DEPRESSION

Because insomnia and depression are so often found together, it is logical to wonder whether insomnia causes depression, depression causes insomnia, or they cause each other. The best evidence to date suggests that insomnia and depression share some common pathology that leads to both conditions (Roth & Roehrs, 2003). Although that may be true, it is of critical importance to note that they do not usually share the same temporal onset. In fact, insomnia often precedes depression (Ohayon & Roth, 2003). The onset of insomnia may serve as an “early warning signal” for an impending depressive episode and thus may be considered a significant risk factor for the eventual development of depression. Thase (2000) reported that in a prospective study of nondepressed subjects from the general population, complaints of persistent sleep disturbances were risk factors for the onset of depression within one year. In another study by Breslau, Roth, Rosenthal, and Andreski (1996), there was a fourfold increase in the relative risk of developing major depression when people had a history of insomnia. Still another study, by Ohayon and Roth, (2003) found that insomnia more often precedes the onset of a first episode of depression (41% of the time) compared with the rate of insomnia following a first depressive episode (28.9% of the time). The same pattern holds true in regard to relapses (56.2% of the time preceding versus 21.6% following relapses). So strong is this temporal relationship that Ford and Kamerow (1989) suggested that an early diagnosis of insomnia may afford clinicians an opportunity to prevent depression’s onset if it is recognized and treated appropriately. Unfortunately, however, as is also true of diagnosing depression, the early diagnosis of insomnia is statistically unlikely. As in depression as well, the low likelihood of proper diagnosis is because only about one third of those suffering insomnia report this to their physicians, and only about 5% of those with insomnia seek treatment for it (Cochran, 2003). Thus, both depression and insomnia are underreported and underdiagnosed problems.

ASSESSMENT OF INSOMNIA AS AN INDICATOR OF THERAPEUTIC GOALS

The pattern of the insomnia is clinically revealing. Although insomnia associated with depression can affect sleep’s onset or continuity, which sleep pattern is most affected correlates highly with the primary diagnosis. Anxiety and depression are most often found to coexist as comorbid conditions. However, when the anxiety
is primary, the sleep disturbance is most often manifested as difficulty falling asleep, called *sleep-onset insomnia*. When the difficulty is staying asleep, as in early-morning awakening (called *terminal insomnia* for its disruption of the final, or terminal, phase of sleep), depression is most likely to predominate the clinical picture (Jindal & Thase, 2004).

Thus, the clinician who inquires about the quality of the client’s sleep can learn valuable information that can help in treatment planning. Although it has not been typical of psychotherapists to ask about the quality of their clients’ sleep, there is clearly ample reason to do so as a matter of course in developing a diagnosis and treatment plan.

There are a number of ways to gather relevant information about the client’s sleep patterns. These include the following:

1. Taking a brief sleep history involving questions about the insomnia’s onset, duration, and severity. Asking about any precipitating events, lifestyle changes, and dietary changes (e.g., caffeine or alcohol usage) would be helpful.
2. Assigning the person the task of keeping a sleep diary for at least one week in which the person records such variables as the time gone to bed, the length of time it took to fall asleep, the number of awakenings during the night and for how long each lasted, the time of final awakening in the morning, the level of fatigue noted during the day, naps taken, and any other factors one might wish to include (e.g., exercise schedule and dietary factors). The sleep diary may be an especially valuable tool to obtain a more objective picture of the person’s sleep patterns because studies have shown that purely subjective reports are often inaccurate (Roth & Roehrs, 2003).
3. The use of formal sleep-related testing instruments, such as the Pittsburgh Sleep Quality Index (Buysse, Reynolds, Monk, Berman, & Kupfer, 1989) or the Stanford Sleepiness Scale (Dement & Vaughan, 1999).

Some clinicians have encouraged clients reporting chronic insomnia to seek out polysomnography (PSG), an electrical study of the brain during sleep that is typically performed overnight. Other neuroimaging studies of the brain using positron-emission tomography (PET) imaging and functional magnet resonance imaging (MRI) have identified specific patterns associated with the sleep of depressed individuals, such as sleep that is shortened, shallow, and fragmented, and REM sleep is altered, based on subjective reports and empirically confirmed with PSG studies (Szuba, 2001).

With PSG, measures such as the amount of time (latency) to sleep onset, the number and duration of awakenings, and the overall sleep efficiency (i.e., a figure calculated by the amount of actual sleep divided by the amount of sleep time available) can be determined objectively. However, sleep integrity measures from PSG have some drawbacks: First, even normal sleepers may have some insomnia
the first time they sleep in a sleep lab (dubbed the first-night effect), whereas, paradoxically, poor sleepers sleep well the first night in the lab. And, second, insomnia typically varies from night to night, making one night's sample possibly nonrepresentative. For these reasons, the American Academy of Sleep Medicine has advised against the use of PSG for the routine evaluation of chronic insomnia associated with psychiatric disorders (Littner et al., 2003). Thus, for most clients treated by psychotherapists, the sleep profile will be obtained through taking the client’s history and perhaps assigning the keeping of a sleep diary.

**TREATMENT OPTIONS FOR DEPRESSION-RELATED INSOMNIA**

Interventions currently in use for treating depression-related insomnia fall into two general categories: medications (pharmacologic) and psychotherapy. These are not mutually exclusive treatments, and so-called combined treatments are common.

**Medications**

There are four main categories of pharmacologic intervention for depressed individuals with insomnia: single antidepressant medication (monotherapy) approaches, the use of two antidepressants, the use of a single antidepressant with either a hypnotic or antianxiety (anxiolytic) drug, or two antidepressants in combination with a hypnotic.

The use of selective serotonin reuptake inhibitors (SSRIs) is the most common monotherapy approach. In particular, Lexapro (escitalopram) and Paxil™ (paroxetine) are typically used when anxiety is comorbid with depression and affects sleep.

The use of two antidepressants has become more common and usually features a sedating tricyclic antidepressant (such as trazodone) in combination with a less sedating SSRI.

Hypnotics or anxiolytics alone may sometimes be used on a short-term basis; however, in the longer term, these have been associated with either worsening depression or a new depressive episode onset (Sussman, 1998).

Two antidepressants and a short-term (7 to 10 days) hypnotic in combination have been shown to be an effective combination, although the potential for a negative interaction between medications is increased.

Sleeping pills available as over-the-counter remedies are readily available to anyone who wants them. The potential for their abuse, therefore, is substantial.

**Psychotherapy**

Psychotherapeutic interventions for chronic insomnia associated with depression have focused on a number of key issues: improving sleep hygiene (i.e., the
behaviors and environmental conditions associated with one’s sleep habits), reducing anxiety about sleep, and correcting erroneous perceptions about sleep (e.g., “If I don’t get 8 hours of sleep, I’ll never be able to function”). In line with these goals, behavioral and cognitive-behavioral approaches have been the most common forms of psychotherapeutic intervention for managing insomnia, and additional approaches (e.g., interpersonal therapy) may simultaneously be employed in addressing the individual’s depression and/or anxiety.

The use of self-help techniques for sleep learned in the context of psychotherapeutic approaches compared with pharmacologic approaches offers several key advantages: Self-help will not lead to either addiction or dependence, it can be applied under all conditions, and it will not lead to potentially harmful interactions with other interventions. In fact, a highly publicized recent study (Jacobs, Pace-Schott, Stickgold, & Otto, 2004) comparing the use of cognitive-behavior therapy (CBT) with the popular sleeping pill Ambien™ (zolpidem tartrate) in the treatment of sleep-onset insomnia showed CBT so clearly superior in its multiple effects (reduced sleep-onset latency, increased sleep efficiency, and total sleep time) that the study’s authors concluded that CBT should be the first-line therapy approach for sleep-onset insomnia. Cognitive-behavior therapy also proved to be more cost effective and to provide more enduring results. Another study, by Morin, Colecchi, Stone, Sood, and Brink (1999), reached a similar conclusion that patients receiving CBT were more likely than medicated patients to show a sustained improvement.

**HYPNOSIS AND PSYCHOTHERAPY FOR INSOMNIA**

Although there have been no controlled studies specific to the use of hypnosis with chronic insomnia secondary to depression, there have been numerous applications of hypnosis described in the literature for addressing insomnia and depression independently.

The use of hypnosis in treating insomnia and sleep disturbances (e.g., night terror) has been described in numerous case studies and clinical reports, such as those of Anderson, Dalton, and Basker (1979); Bauer and McCanne (1980); Becker (1993); Borkovec and Fowles (1973); Evans (1976); Fry (1973); Graham, Wright, Toman, and Mark (1975); Koe (1989); Kohen, Mahowald, and Rosen (1992); and Stanton (1989). In general, each of these articles described the successful use of hypnosis for anxiety reduction, relaxation, and thought slowing and redirection. Stanton’s 1989 study is particularly relevant for its successful use of a hypnotic relaxation technique compared with a stimulus control and placebo conditions for reducing sleep-onset latency.

Hypnosis is not generally considered a therapy in its own right (American Psychological Association, 1999). Rather, hypnosis is considered a vehicle for delivering information and perspective and for teaching specific skills that can have their origin in any type of established therapy model (e.g., cognitive-behavioral
or psychodynamic). Thus, the most relevant research in hypnosis asks whether a specific approach employed in treatment is enhanced by the addition of hypnosis (Kirsch, Lynn, & Rhue, 1993). The general answer appears to be “yes” (Lynn, Kirsch, Barabasz, Cardeña, & Patterson, 2000; Schoenberger, 2000).

Hypnosis may be of greatest benefit in psychotherapy when it is used as a means of teaching skills that can empower the therapy client (Yapko, 2001, 2003). In regard to insomnia in particular, there are a number of specific skills that someone suffering insomnia can learn that will make a positive difference, for example, as those already mentioned (e.g., relaxation and good sleep hygiene). However, there is another specific skill not yet mentioned that is an amenable target for a well-crafted hypnotic intervention. That target is called rumination.

RUMINATION, DEPRESSION, AND SECONDARY INSOMNIA

Rumination is the cognitive process of spinning around the same thoughts over and over again. It is considered an enduring style of coping with ongoing problems and stressors, a coping style that can both lead to and exacerbate depression. One’s coping style is a significant factor in one’s overall mental health and is an especially important factor in depression. Coping can be defined as

a stabilizing factor that can help individuals maintain psychosocial adaptation during stressful periods; it encompasses cognitive and behavioral efforts to reduce or eliminate stressful conditions and associated emotional distress. Although coping responses may be classified in many ways, most approaches distinguish between strategies oriented toward confronting the problem and strategies oriented toward reducing tension by avoiding dealing with the problem directly. (Holahan, Moos, & Bonin, 1999, p. 42)

Rumination can be thought of as a pattern of avoidance that actually increases anxiety and agitation. Ruminative responses include repeatedly expressing to others how bad one feels, pondering to excess why one feels bad, and catastrophizing the negative effects of feeling bad (Nolen-Hoeksema, 1991). By ruminating, the person avoids having to take decisive and timely action, further compounding a personal sense of inadequacy. Rumination leads to more negative interpretations of life events, greater recall of negative autobiographical memories and events, impaired problem solving, and a reduced willingness to participate in pleasant activities (Spasojevic & Alloy, 2001). As Just and Alloy (1997) stated, correlational, field, longitudinal, and experimental studies all provide evidence that ruminative behavior not only is highly associated with depression, but also serves to increase both the severity and duration of episodes of depression. The common term analysis paralysis describes the hazard of ruminating at the expense of taking effective action.
It is especially significant that rumination not only features in the quality of one’s depression but also actually predicts depression. Susan Nolen-Hoeksema (2000, 2003) of Yale University has published enormously valuable research that establishes the link clearly: A ruminative coping style that precedes depressive symptoms predicts higher levels of depressive symptoms over time (after accounting for baseline levels), onset of new depressive disorders, greater chronicity of depressive disorders, and higher levels of anxiety symptoms.

Thus, rumination is an especially high-priority target at which to aim one’s interventions, hypnotic or otherwise. Rumination generates both somatic and cognitive arousal, both of which can exacerbate insomnia, but the evidence suggests cognitive arousal is the greater problem. As Harvey (2000) reported in her research on the relationship between cognitive arousal and insomnia, insomniacs were 10 times more likely to cite cognitive arousal as central to their sleep difficulties, compared with somatic arousal. Harvey went on to say that the need for minimal cognitive processing and a reduced effort to fall asleep are key treatment goals.

**HYPNOSIS, TARGETING RUMINATION, AND ENHANCING SLEEP**

Having asked literally hundreds of individuals who declare themselves “good sleepers” what they tend to think about when they go to sleep, their common and consistent answer is some variation of the reply “nothing.” That doesn’t mean that they literally think of nothing and have “empty minds.” Rather, it means that the content of what they think about is so simple and nonthreatening that it generates no significant somatic or cognitive arousal to interfere with sleep. Conversely, when I ask people who say they sleep poorly what they think about when going to sleep, they typically say some variation of “everything.” They think of worrisome problems, unresolved situations needing to be addressed, obligations to be met, tasks still needing to be done, and on and on. The levels of cognitive and somatic arousal are raised to the point of interfering with sleep.

The use of hypnosis to teach the ability to direct one’s own thoughts rather than merely react to them is a well-established dynamic and a principal reason for employing hypnosis in any context (Lynn, Kirsch, Neufeld, & Rhue, 1996; Yapko, 2003). Reducing the stressful wanderings of an agitated mind and also relaxing the body while simultaneously helping people create and follow a line of pleasant thoughts and images that can soothe and calm are valuable goals in the service of enhancing sleep.

In order to achieve these aims, there are a number of important components to include in one’s treatment plan. These include the following:

1. Teaching the client how to efficiently distinguish between useful analysis and useless ruminations. The distinction features variations in factors such as the amount of research, if any, to be done and the timing of a
decision to act (i.e., how much information to gather and how long to contemplate what to do), but the single most important distinguishing characteristic is the conversion from analysis to action.

2. Enhancing skills in compartmentalization in order to better separate bedtime from problem-solving time, with the well-defined goal in place of keeping them separate.

3. Establishing better coping skills that involve more direct and effective problem-solving strategies. The client who avoids making decisions and implementing them out of the fear of making the wrong one, such as perfectionistic individuals, who are also at higher risk for depression as a result of their perfectionism (Basco, 1999), will need additional help learning to make sensible and effective, albeit sometimes imperfect, problem-solving decisions.

4. Helping the client develop effective strategies for choosing among a range of alternatives. There is evidence that having more options, an oft-stated goal for clinicians, actually increases the anxiety and depression of those who don’t have a good strategy for choosing among many alternatives (Schwartz, 2004).

5. Addressing issues of sleep hygiene and attitudes toward sleep in order to make sure the person’s behavior and attitudes are consistent with good sleep.

6. Teaching “mind-clearing” or “mind-focusing” strategies, especially self-hypnosis strategies of one type or another, that help the person direct his or her thinking in utterly benign directions.

Each of the first five components listed above supports the potential value of the sixth, the actual hypnosis strategy one employs to help calm the person to sleep.

**HYPNOTIC APPROACHES**

Hypnosis can be used as a vehicle for teaching the client effective ways to make distinctions between useful analysis and useless ruminations, compartmentalize various aspects of experience, develop better coping skills, develop more effective decision-making strategies, and develop good behavioral and thought habits regarding sleep. Such hypnosis sessions are quite different in their structure from a session designed specifically for the purpose of enhancing the ability to fall and stay asleep.

The primary difference between a sleep session and a regular therapy session employing hypnosis is that hypnosis for sleep enhancement is designed to actually lead the client to fall asleep. In standard therapy sessions involving hypnosis, the opposite is true: The clinician takes active steps to prevent the client from falling asleep during the session. It has been well established that hypnosis isn’t a sleep state and that sleep learning is a myth. Thus, clinicians employing hypnosis
encourage the client to become focused and relaxed, yet maintain a sufficient degree of alertness to be capable of participating in the session by listening and actively adapting the clinician’s suggestions to his or her particular needs.

Another key difference between a hypnosis session for enhancing sleep and a standard therapy session is the role of the client during the process. In therapy, the client is defined as an active participant: actively involved in the search for relevance for the clinician’s suggestions, actively involved in absorbing and integrating the suggestions, and actively finding ways to apply them in the service of self-help. Relaxation may or may not be a part of the process. In fact, some suggestions a clinician offers during hypnosis might even be anxiety provoking or challenging to the client’s sense of comfort. After all, personal growth often means stepping outside one’s “comfort zone.” In the sleep session, however, cognitive and somatic arousal are to be minimized, and so challenges to the client’s beliefs (or expectations, role definition, or any other aspect a clinician might appropriately challenge) are precluded.

The content of the strategy (e.g., progressive relaxation, imagery from a favorite place, recollection of a happy memory, creation of fantasy stories, and counting sheep) is a secondary consideration. Thus, what specific hypnotic approach one uses is relatively unimportant. The primary consideration is that whatever the person focuses on needs to be something that reduces both somatic and cognitive arousal.

Approaches can be direct or indirect according to what the client finds easier to respond to. Likewise, they can be content or process oriented, again depending on what the client finds easier to relate to. Because sleep isn’t something that can be commanded, an authoritarian style is generally counterproductive. A permissive style is both gentler and more consistent with an attitude of allowing sleep to occur instead of trying to force it to occur.

The use of recorded hypnotic approaches (i.e., tape recordings or compact disc recordings) can be a useful means of helping the client to develop the skills to focus on calming suggestions. Generally, these should be considered a temporary help in the process so that the person is eventually able to fall and stay asleep independently using self-hypnosis. However, recordings pose no major or even minor hazards that warrant concern they will be abused in some way, so there seems to be no good reason to push clients to stop using the recordings for as long as they find them helpful.

A SAMPLE TRANSCRIPT OF A HYPNOSIS SESSION FOR ENHANCING SLEEP

Presession Discussion (“Framing the Session”)

Preceding the formal hypnosis session is a discussion of the session’s aim in order to establish the therapeutic alliance. One might say something such as the following:
There are many, many other things that I could say about sleep, but there is one especially prominent factor that influences your quality of sleep. It’s called rumination, and it’s the primary target of this hypnosis session. Rumination is the anxiety-provoking and frustrating tendency to spin around and around and around the same thoughts, the same feelings, the same concerns, over and over again. It is a redundant process of endlessly worrying about and analyzing your ongoing issues and problems. Trying to analyze and solve problems at the time you’re trying to sleep only agitates you and actually prevents good, restful sleep. Problem solving is best left to your waking hours. But it means establishing a clear limit, a boundary, such that, when you go to bed, you strive to clear your mind of the everyday stresses and concerns. Make that clearing of your mind a consistent target to aim for. Bedtime is not problem-solving time. Let me repeat that. Bedtime is not problem-solving time. From the time that you go to bed to the time that you wake up well rested in the morning, you can strive to have your mind clear of unnecessary clutter. To help accomplish that, strive to set aside sufficient problem-solving time and thinking time throughout the rest of the day. Create pockets in your day to have time to think and reflect and make good decisions upon which you can take sensible action. Then you don’t have to give up sleep time to ruminations about ongoing issues and concerns.

And so, this is the target we are aiming for in this session’s experiential process—being able to distance yourself greatly from the everyday concerns and issues so that you can have some quiet time in your mind to be able to sleep more comfortably and with greater rejuvenation as a result. Always remember, it is your ability to create a peaceful and pleasant atmosphere within yourself that makes sleep possible. Learning to manage worry and keep it out of your bed, learning to relax and focus on the positive, and building good sleep habits are all vital skills to master if you want to sleep well.

With that brief discussion behind us now, we can move on to the hypnosis session.

Hypnosis Session Transcript

I’d like to invite you to arrange yourself in a position that is comfortable. I’d encourage you to listen to the recording of this session while you are lying in bed so you can drift off to sleep and then sleep comfortably through the night. Unlike other kinds of sessions we’ve done involving hypnosis or relaxation processes, with this particular hypnosis session it is appropriate for you to listen to it while you’re in bed as you’re going to sleep. After all, the purpose of this particular session is to make your sleep easier, more satisfying, and more restful. …

So, with that in mind, I’d like you to let your eyes close … and notice the differences instantly as soon as you let your eyes close. … It means you are no longer focusing on things around you … it means that you have closed your eyes to the outside world … for now. … And in a way … you might think of that … simple action of closing your eyes … as starting to close out … the world out there. … Now, certainly you’ll hear … the sounds … the routine sounds … of your environment … and
because they are so routine ... whether it is a dog barking or crickets chirping ... or traffic ... it doesn’t matter what it is ... it’s routine ... and not worth noticing for more than the moment it takes to gently pass through your awareness ... it’s just there ... and it doesn’t require anything of you ... it’s merely an ongoing—but easy to ignore—background ... that simply keeps reminding you ... in a very indirect way ... that the outside world is going about its usual business ... nothing particularly important going on ... nothing in particular requiring your attention right now. ... And that frees your mind ... to be very present in this moment which precedes your sleep ... you get to let your mind ... grow ever quieter ... ever more comfortable ... and notice how good that feels. ... Now, you know and I know ... that people are ... constantly ... talking to themselves ... through their thoughts ... and so you might already have noticed ... that it is as if ... there is an ever-present voice in your head ... the voice of you talking to yourself ... that is entirely normal ... and, in fact, can be quite comforting. ... And while you might normally be talking to yourself about ... things that happened earlier today ... or things that may be happening tomorrow ... or important things happening in your life ... it’s really quite soothing to now recognize that you can ... slowly turn down ... the rate and volume of that voice ... until you find yourself ... thinking in a slow, quiet whisper ... that is barely audible. ... And how surprisingly and wonderfully quiet it can get ... inside your head. ... Now I mentioned earlier how people who sleep well tend to report that they think about nothing when they go to sleep ... and even though they will often say they think about nothing ... that answer isn’t really very accurate ... because their minds aren’t really empty ... in fact, they continue to think ... and to be aware of themselves as they fall asleep ... but when you ask them what they focus on ... they’ll tell you that what they focus on is so simple ... so easy ... that it might as well be nothing ... one person told me she thinks of a special place she could go in her mind that was a beautiful, safe, relaxing place she created in her imagination ... and one fellow told me his thoughts automatically drifted to wonderful images of vacation spots he loved visiting ... and another woman told me she focused on images of playing happily with her dog ... and another man told me he had learned to count sheep as a child and still did that each night ... but not for very long ... because it was monotonous and put him to sleep ... and what matters is that you have the same ability ... to focus your thoughts on whatever soothes you ... and relaxes you ... and makes you feel good ... like you’re about to enjoy a special treat ... and a good night’s sleep is a special treat ... that you can enjoy nightly ... and you have the freedom to direct your thoughts to where you want them to go ... you can think about the kind of nothing that is really something soothing ... and you can develop your very own images ... sounds ... fragrances ... and feelings ... that help you feel so comfortable drifting off to sleep ... but before you drift off now, there is something else I want to remind you of ... it’s about having freedom in your mind ... all the freedom you need right now ... there’s so much freedom in just relaxing and not having to think ... you can feel the freedom ... of being able to ... drift off ... to sleep ... slowly ... deliberately. ... And, of course, you already know ... it’s not something that ... you can make yourself do ... any more than you can make yourself a height of 4 foot 8. ... Rather, it’s something that you ... allow yourself to experience ... by guiding your thoughts ... in a useful direction. ... In this case ... the direction of drifting off ... into a wonderful ... peaceful sleep. ... And so, where might your mind be right now? ... No place.
ADDRESSING INSOMNIA

Nowhere. ... The middle ... of nowhere. ... A place where ... you don’t have to think ... where your body just rests comfortably ... where you can notice the rhythmic ... rise ... and fall ... of your chest ... as you breathe ... slowly in ... and slowly out. ... And then, little by little ... you may become aware ... that you really aren’t thinking about anything in particular ... and how your attention stays ever more focused on ... the wonderfully ... comfortable ... immediacy ... of the safety and warmth ... the deeply comfortable warmth ... of your bed. ... And so you can feel your body ... for some people, their body feels as if it’s incredibly heavy ... weighted down ... as you lie there ... almost as if you’re just melting into the bed ... and for others ... their body feels remarkably light, almost as if it’s floating weightlessly on a cloud. ... And then you can notice the subtle sensations ... associated with falling asleep. ... Which parts of your body ... seem to drift off ... first? ... Which parts are heaviest. ... as if it would take just massive effort to move them? ... And which parts are lightest ... and free. ... And with your breathing slowing ... and your mind ... growing ever quieter ... it can feel wonderful ... to be drifting off ... so easily ... and effortlessly. ... And it’s interesting ... that as you drift off ... you first find yourself ... in this ... in-between place ... of not yet being asleep ... and yet ... not really awake, either. ... And it’s in this in-between state ... that you discover ... how it feels to have your body ... so fully supported by the bed ... to have your mind ... drifting along ... not really lingering on ... anything in particular. ... And then to notice the ... feel of the fabric of ... your sheets ... is a simple yet wonderful and calming sensation ... and the feel of your blanket ... snuggling against your body ... your pillow ... just perfect. ... And each of these soothing experiences of ... body awareness ... can just highlight for you how it feels ... to be in the middle of the experience ... of drifting off ... into a deep ... peaceful sleep ... a deep ... peaceful sleep ... that allows you to sleep through the night ... surprisingly well ... by scattering your thoughts all over until there aren’t any ... and thereby leaving you perfectly at ease with ... the very idea of ... sleeping well ... with nothing on your mind ... body comfortable ... very much at peace ... and relaxed within yourself. ... And so you notice ... that your body ... and your mind ... are drifting ... drifting ... and no need to drift off to sleep just yet ... unless you really want to ... but you can allow yourself ... the luxury ... of being in this ... state of mind ... and body ... for a long restful time. ... And when you wake up after this deep, restful sleep ... many hours from now ... you’ll naturally feel rested ... and energized ... it’s a powerful experience ... of rediscovering ... quite naturally ... that you can sleep ... you can sleep ... deeply. ... And so you can ... just enjoy ... the comfort ... the sense of peacefulness ... that you can carry with you into your dreams ... and sleep ... sleep. ... So now ... you can drift off ... drift off ... and sleep well. Good night. ...

INDICATIONS AND CONTRAINDICATIONS

It bears repeating that insomnia can arise in association with many different medical and psychiatric disorders. The same is true for depression as well. Thus, it is an essential initial recommendation to make to the client that he or she receive a thorough medical examination in order to determine if there might be any medical basis for the sleep difficulties he or she is experiencing.
The focus of this chapter was narrowed to specifically focus on a very common coping style, rumination, which can be a harbinger of an impending depression, or can be a most troubling facet of an existing depression. Rumination is generally an agitating process and is directly responsible for much of the anxiety associated with depression. In turn, it helps generate secondary insomnia, and can reasonably be considered a likely causal or exacerbating factor in middle and terminal insomnia as well, although this has yet to be clearly established. The hypnotic intervention described above must be provided in conjunction with additional therapeutic interventions addressing the related issues specified (e.g., teaching the client effective ways to make distinctions between useful analysis and useless ruminations, compartmentalize various aspects of experience, develop better coping skills, develop more effective decision-making strategies, and develop good behavioral and thought habits regarding sleep) and therefore is indicated when the client has an identifiable pattern of rumination that negatively affects his or her ability to fall or stay asleep.

Although there is no specific contraindication to helping someone focus, relax, and strive to improve his or her sleep, there are two important factors to consider that suggest an optimal timing and structure for the hypnotic intervention described in this chapter. First, simply performing a hypnosis session in which the clinician suggests relaxation is not an adequate reply to an ongoing ruminative process. One can perform a lengthy and wonderfully relaxing hypnotic induction that shows the client through his or her own direct experience that he or she can reduce agitation and anxiety. (This may help build positive expectancy for treatment, a highly valuable outcome in itself.) But, as soon as the client opens his or her eyes, and the ruminations begin again, whatever relaxation was generated during the hypnosis session instantly dissipates. The depressed client may become disillusioned if he or she concludes that nothing can help for more than a few minutes. Thus, it is important to let the client understand that the hypnosis is a valuable tool for relaxing and reducing ruminations, but the rest of the larger treatment plan involves learning additional skills (e.g., compartmentalization skills) that will support the use of hypnosis in order to make a more enduring contribution to enhancing sleep. The client needs to be able to place the hypnosis in the context of the larger therapy.

A second important consideration concerns the emphasis on the depressed individual being an active participant in the therapy process. When a clinician focuses on the issue of rumination, and justifiably wants the client to be less ruminative and more active, the issue is one of how and when the client should be active in making and implementing decisions. If the client lacks a clear and effective strategy for making the key relevant discrimination (when is it useful analysis, and when is it useless rumination?), the client may absorb the erroneous message of “Take action!” before he or she has really learned to determine what exactly constitutes sensible and appropriate action. There is a growing body of evidence that depressed people in particular are at risk for making decisions and taking courses of action that serve to make their depression even worse. These are
known as stress generation patterns, and they highlight the hazards of encouraging clients with poor decision-making strategies, limited insight, and minimal foresight to be action oriented (Hammen, 1991, 1999; Harkness & Luther, 2001). Being active in resolving depression is critical to treatment success, but the actions taken must be productive ones.

THE BIGGER PICTURE

Every epidemiological survey, whether national or international, indicates depression is on the rise around the world (Yapko, 1997, 1999). In the United States, depression receives a great deal of attention for all its negative effects on health, productivity, and relationships. However, the lion’s share of research funding goes to exclusively biological interventions, a direct suggestion that medications or some other biological entity will alleviate depression. The evidence is irrefutable, however, that much of what spreads depression around the world, between and within cultures (including ours), are social factors. What people learn (and don’t learn) in their evolving patterns of thought, feeling, and behavior; how active and skillful they learn to be in problem solving and in building healthy relationships; how self-absorbed or selfless they are encouraged to be; and so many other such value-laden factors evident in one’s socialization can all serve to increase or decrease one’s vulnerability to depression.

The small but growing movement in the direction of a so-called positive psychology (Seligman, 2002; Seligman & Csikszentmihalyi, 2000) is an important step toward shifting the blame away from our biology (i.e., “It’s all in your genes”) and placing the responsibility on ourselves to create the personal and social conditions that empower people to lead more satisfying lives. Ultimately, it is up to each person to take the responsibility for his or her own quality of life, and to learn the relationship between the choices he or she makes and the consequences they yield.

Practitioners of hypnosis, those serious-minded clinicians who have already absorbed the implications of the truth that what you focus on defines your experience, are in an especially strategic position to make a significant difference. Appreciating the parallels between the benefits of positive, hypnotic “believed-in imaginings” (Sarbin, 1997) and the detriments of negative, depressive believed-in imaginings encourages the use of hypnosis in new and innovative ways. Hypnosis can be considered an original positive psychology in its foundational premises that people have more resources than they’re typically aware of and that conditions can be created through hypnotic procedures that bring these resources to the fore where they can be amplified and directed for personal and social benefits. The potential of hypnosis in this domain is only now starting to be considered. How exactly the role of hypnosis in treatment, and of equal or even greater importance in depression’s prevention, will evolve is not yet known. The prospects, though, can foster a deep sense of optimism.
EDITOR’S SUMMARY

- Difficulty sleeping, specifically insomnia, is the single most common symptom associated with depression.
- Insomnia may manifest as a difficulty in initially falling asleep or in staying asleep, or as experiencing a nonrestorative sleep.
- When anxiety and depression are comorbid conditions, the quality of the sleep disturbance can reveal which is primary and should be targeted in the first stages of intervention.
- Sleep problems aggravate depression in a number of ways, including feeling poor physically, having difficulty meeting job demands, and feeling too tired to socialize or seek out pleasurable activities.
- People with sleep disturbances are more likely to use alcohol as a remedy, a poor choice that can increase their risk for depression or exacerbate an existing depression.
- Insomnia often precedes depression’s onset temporally, serving as an “early warning signal” for possible intervention.
- Insomnia in depressed individuals can be directly related to the tendency to ruminate.
- Hypnosis to relax mentally and physically can reduce cognitive and somatic arousal and thereby enhance sleep.
- Hypnosis to reduce negative ruminations and increase a neutral and positive focus can be helpful in facilitating sleep.
- A transcript of a hypnosis session for enhancing sleep is provided to illustrate a general strategy for reducing rumination and encouraging restorative sleep.

REFERENCES

 ADDRESSING INSOMNIA


Section III
TREATING DEPRESSION WITH HYPNOSIS IN SPECIAL POPULATIONS
Disruptions in normal eating habits have a long and even celebrated history. The Egyptians endured long periods of fasting, often in “sleep temples.” The Romans had vomitories, places to purge themselves in order to accommodate their gluttonous feasting. Christ fasted for 40 days in the desert for a “spiritual cleansing” of sorts, and many early Christian martyrs engaged in fasting for similar reasons. Gandhi changed the political structure of his country by fasting, using his refusal of food as a means of reining in extremists and building a consensus.

Relatively few people engage in such extreme behaviors in regard to their eating habits. As with any behavior deemed extreme, eventually such behaviors came to be considered evidence of a psychological disorder, particularly when they either became life-threatening or interfered with the person’s ability to function. There are a number of eating disorders included in the DSM-IV-R (American Psychiatric Association [APA], 1999). Most common among these are anorexia nervosa and bulimia, two serious disorders featuring dangerous self-starvation in the former and repetitive patterns of binging and purging in the latter. The two disorders may merge in a disorder called bulimia nervosa that
features bingeing and purging behavior followed by periods of self-starvation
(Bulik, Sullivan, & Fear, 1997).

Epidemiological evidence shows that the incidence of both depression and
bulimia is on the rise (Kendler et al., 1991; Maser, Weise, & Gwirtsman, 1995).
Currently, approximately 20 to 23 million Americans are thought to suffer from
major depression, and these numbers are expected to continue to rise (Gardner,
2004; World Health Organization, 2002). Similarly, there had already been a
significant increase documented in the reported incidence of bulimia from 1988
to 2000 (Hay, 2005). Although these disorders can occur independently of each
other, there is a high incidence of comorbidity between eating disorders and major
depressive disorder (Kuehnel, 1998). The co-occurrence of depression and eating
disorders is not precisely known, but there have been estimates ranging from 36 to
68% of eating disordered patients also suffering comorbid depression (Maser et
al., 1995). The relationship between depression and eating disorders is a strong
one, and often the treatment of one will necessitate treating the other as well.

In this chapter, we will explore the relationship between depression,
suicidality, and eating disorders. We will describe a conceptual framework for
treating such patients, and we will especially emphasize the potential role
hypnosis can play in the treatment process. We will describe some of the ways
a hypnotic framework for understanding the mechanisms of eating disorders
can be helpful in formulating interventions, and we will provide an illustrative
case example.

HYPNOSIS AND TREATING COMORBID DEPRESSION
AND EATING DISORDERS: A RATIONALE

Working hypnotically with depressed patients who are also experiencing eating
disorders would, on first consideration, certainly seems to be appropriate and
potentially useful. After all, one could reasonably argue that hypnosis, depression,
and anorexia and/or bulimia all involve a common denominator of some form of
altered state. All require some degree of focus and an absorption in a frame of
mind that includes some awarenesses and excludes others. In fact, some hypnosis
experts have made the distinction between therapeutic hypnosis and symptomatic
hypnosis, suggesting that the direction of focus may differ between therapeutic
and symptomatic conditions, but not necessarily the quality of the focus (Araoz,
1985, Gilligan, 1987). As Yapko (2003) described, the so-called classical hypnotic
phenomena are the “building blocks” of experience, whether positive or negative.
Thus, it has seemed logical to us to consider how hypnosis has played a role in
the onset of these comorbid conditions and, more important, how we can sensibly
use hypnosis to help the comorbid patient overcome his or her difficulties.
The issue in treatment, as we see it, is how to eliminate the self-injurious patterns
by initiating a very different and positively focused altered state with a definitive
shift in the resulting behavior.
Arriving at this rationale for employing a hypnotic framework for problem conceptualization and treatment has been a circuitous path. After all, in our training as clinicians, we were encouraged to help people with creative applications of hypnosis, but we were also instructed not to challenge established protocols. This represented a “double bind” of sorts for us, in other words, seemingly a “no-win” situation in which a person must choose between equally unsatisfactory alternatives.

Patients come to us for treatment with any number of complex, psychological roadblocks that often result from double-binds they face. But, what if it is the therapist, rather than the patient, who is caught up in such a dilemma? How should a therapist proceed when hoping to employ a therapeutic strategy that is both encouraged and admonished by the scientific community of fellow researchers and clinicians? We have faced this dilemma many times, and later in this chapter we present one such episode involving a case requiring innovation in methodology. Julia (not her real name) was referred for treatment because she was severely depressed, threatening suicide, and suffering from a severe case of bulimia nervosa. She regularly engaged in bingeing and purging, a pattern that was interrupted every few months by a week or more of stringent fasting and drinking only water.

To work hypnotically with Julia, or not? The literature on the use of hypnosis with depressed individuals has ranged from warning therapists to “never” hypnotize a depressed individual, to the opposite position, which promotes hypnosis as an integral part of depression’s treatment. With suicidal patients in particular, hypnosis has traditionally been considered “forbidden.” We were told directly and unambiguously from an acknowledged authority in hypnosis, Dr. William Kroger (personal communications, December 1976 and January 1977), that we should “NEVER hypnotize someone who is suicidal.” (The issues associated with employing hypnosis in the treatment of depression will be described more fully in the next section.) On the other hand, for the treatment of eating disorders, hypnosis has generally been considered an effective and useful tool (Barabasz & Watkins, 2005; Lynn, Rhue, Kvaal, & Mare, 1993; Nash & Baker, 1993). Clearly, when someone is depressed and suicidal, and suffers a comorbid eating disorder, the confusing messages about what constitutes reasonable interventions can make treatment planning more difficult. We hope to provide clinical experience as well recent literature citations that can help the reader to resolve conflicting viewpoints and comfortably integrate hypnosis into the treatments of such patients.

HYPNOSIS IN THE TREATMENT OF DEPRESSION

Depression is a complex, multidimensional disorder that affects tens of millions of Americans, directly or indirectly (Kessler et al., 2003). Worldwide, it is considered one of the leading causes of human disability (World Health Organization,
2002). Inarguably, depression is a serious disorder that requires effective treatment. Can hypnosis be a viable component of effective treatment?

**Past Perspectives Delayed Evolving More Realistic Perspectives**

In the past, hypnosis was viewed as a contraindicated treatment for depression for a variety of reasons: Some thought that hypnosis with depressed patients might further erode their already inadequate defenses, thereby increasing the potential for suicide (Burrows, 1980). Some claimed that hypnosis was, at best, merely a method of symptom substitution and that the substituted symptoms may worsen depression (Crasilneck & Hall, 1985). Herbert and David Spiegel (1978) claimed hypnosis was likely to be harmful simply because it was unlikely to be effective with depressed clients. They were presumed to be unhypnotizable. The Spiegels suggested that clients suffering from depression cannot attend to input signals because they may be so narcissistically withdrawn and deficient of energy. André Weitzenhoffer, the co-creator of the *Stanford Hypnotic Susceptibility Scales*, also generally advised against the use of hypnosis with more severely depressed patients. He did, however, state that hypnosis may be useful when treating *milder depressive neurosis* (Weitzenhoffer, 2000), a diagnostic terminology no longer in use. Burrows (1980) and Watkins (1987) also concluded that hypnosis is not a suitable treatment for depression. Their psychoanalytic framework addresses the most destructive intrapsychic aspects of depression, such as anger and/or guilt. They believe that because the techniques of hypnosis move faster than regular psychotherapy into transference situations, hypnosis may be dangerous for a depressed patient with deeply repressed anger. They fear that such patients may become overreactive to the words or actions of the therapist as the new transference representation, thus resulting in the desire to punish the therapist for an imagined lack of care (Burrows, 1980). The anger, if turned inward as was presumed to be the case in the psychodynamics of depression, might then result in suicide. Finally, it was also believed that by employing hypnosis, there might be an overwhelming amplification of emotions that might lead to serious psychosomatic disorders or even death (Milechnin, 1967).

With direct threats of suicidality, ego fragmentation, emotional overload, and even death considered possible if hypnosis was employed with depressed patients, it is no wonder that this topic is so terribly underdeveloped in the literature (Yapko, 1992, 2001b). The older literature is full of anecdotal accounts of bad outcomes using hypnosis for depression, but meaningful controlled research is virtually absent.

In considering the underdeveloped role of hypnosis in the treatment of depression, it is useful to understand what researchers have found to be so dangerous about it, as described above. We agree with Yapko’s statement (1992), made in response to the fear-mongering of others:
It is my contention that virtually every hazard associated with hypnosis, not only in the treatment of depression, but in the treatment of any disorder, is a function not of hypnosis itself, but of the manner in which it is applied. (p. 20)

Over time, as depression was seen less as a psychodynamically motivated phenomenon and more as an outgrowth of multiple risk factors interacting with environmental conditions, views on the use of hypnosis for depression also changed. Many highly respected teachers and clinicians (such as those whose work is included in this text) have recently come to believe that hypnosis is a highly efficient therapeutic tool that can be used in addressing underlying dynamic issues, social and psychological risk factors, as well as the resultant symptoms of depression. Previous beliefs are continuously being dispelled as more insights about and cases of successful applications of hypnosis in treating depression accumulate.

**Hypnotic Approaches to Treatment**

It is important to note that hypnosis is not generally regarded as a therapy in itself, but as a valuable therapeutic tool to be used in conjunction with other established therapies (APA, Division of Psychological Hypnosis, 1999, pp. 4–5). Yapko (2001a) advocates not for hypnosis to resolve depression in a global sense, but rather for it to address specific patterns and risk factors known to exacerbate depression. Along these lines, several hypnotic approaches have been used successfully in the treatment of depression. Age regression and age progression have been employed in the treatment of psychotic and neurotic depression, embedded within hypnoanalytic methodology. This technique orients the patient to the future rather than the past in terms of a guided or directed fantasy of a future event (Sexton & Maddock, 1979). Because of the already existent ego suspension in the psychotic state and the reduced observing ego, age regression and age progression can be carried out without the necessity of formal hypnosis or trance induction, thus allowing for more expression of the experiencing ego (Sexton & Maddock, 1979).

Some have used cognitive therapy in conjunction with other behavioral techniques including hypnosis to allow for more flexibility and utility in counseling and psychotherapy (Gilliland & James, 1983). Hypnosis is a kind of social interaction in which various changes in experience and behavior are suggested, and it provides a context in which the effects of cognitive-behavioral interventions can be potentiated for some clients (Kirsch, 1993). For example, the hypnotic context permits the therapist to repeat statements over and over that would ordinarily seem strange outside of the hypnotic context (Kirsch, 1993). The innovative psychiatrist, Milton Erickson, described an approach to removing depressive symptoms in which he would restructure pessimistic and dysfunctional cognitions by the suggested generation of a physical symptom and then a post-hypnotic suggestion that it would subside (Haley, 1973). This was done with the
hope that symptom reduction would be generalized to the experience of depression (Alexander, 1982). A more straightforward approach involves the therapist suggesting that the patient visualize a more preferable way to live. While affirming the positive potentials, the therapist can also challenge the legitimacy of the patient’s negative self-concepts and offer encouragement that his or her pessimistic life views will be replaced with more positive ones (Deltito & Baer, 1986). Finally, anxiety is often found as a comorbid condition in depressed persons (see Chapter 4 in this volume, by Steve Lynn, Abigail Matthews, Steven Fraioli, Judith Rhue, and David Mellinger, for more on comorbid depression and anxiety), and hypnosis can be useful as a relaxation tool to help better manage anxiety. It has been found that exposure to relaxation techniques frequently decreases both anxiety and depression symptoms in these comorbid patients (Rachman, Hodgson, & Marks, 1971). The approaches above have been relatively weak applications of hypnosis yet have still generated meaningful results. However, there are even better reasons and more effective ways to use hypnosis.

Yapko (1993) identified several compelling reasons for using hypnosis in the treatment of depressed patients: (a) hypnosis makes active and experiential learning possible, (b) hypnosis brings about faster integration of germane learning, (c) hypnosis establishes therapeutic associations in a more concerted manner, (d) hypnosis disrupts one’s habitual experience of oneself that augments developing an unstable attributional style, and (e) hypnosis models flexibility by inspiring experiences beyond one’s usual constraints. Depression is highly treatable, and with the integration of hypnosis into the therapy process aimed at salient targets (i.e., risk factors and symptom patterns), there is a high chance of recovery as well as a reduced rate of relapses (Yapko, 1993, 2001b).

**Hypnosis and Suicidal Patients**

Suicidality has been a major factor contributing to the fear of using hypnosis for depression and other related disorders. As mentioned above, it was believed that hypnosis somehow strips the client of defenses, leading to an increased potential for suicide (Yapko, 1992). This line of thinking is similar to previous erroneous beliefs that a direct discussion of suicide would be heard by the depressed patient as a suggestion to carry it out. This myth has been dispelled by recent and substantial evidence that talking about suicide does not encourage suicidal behavior (Gould et al., 2005). It is now considered mandatory to discuss a client’s suicidal ideation for both risk assessment and therapeutic intervention.

How did some experts explain the basis for their concerns about hypnosis and an increased potential for suicide in depressed patients? Some suggested that this is due to unrealistic expectations for therapy on the depressed client’s part leading to grave disappointment, presumably a belief that therapy is doomed to fail and therefore suicide is necessary (Spiegel & Spiegel, 1978). Crasilneck and Hall (1985) believed that suicide is attempted when patients are lifted out of their depression and their energy is sufficient to exhibit suicidal behaviors, which may
occur if hypnosis is used. They apparently believed that the tendency to act out in a suicidal way is a function of their level of energy, which increases with improvement in therapy (Crasilneck & Hall, 1985).

In response to these contentions, it is now well understood that hypnosis does not strip away defenses, dissolve ego boundaries, or dissolve impulse control, nor does it create or amplify the hopelessness that is at the core of suicidal tendencies. Suicide is a reflection of a severe line of thinking about hopelessness about the future and is seen as a permanent solution to temporary problems (Clark, 1995). It may be true that suicide would likely increase if hypnosis was used to amplify the feelings of hopelessness, but hypnosis is best used to do the opposite, that is, to amplify a realistic and detailed sense of hopefulness. It is characteristic of a depressed client to have negative and unrealistic expectations, and hypnosis can be used to address this dysfunctional pattern (Yapko, 1988, 1992, 2001b). Lastly, the notion that hypnosis brings a client to an elevated state of energy enough to commit suicide is commonly held but without empirical evidence. Suicidality seems to have more to do with negative expectancy rather than a function of one’s energy. This illogical notion would suggest that a client is better off (i.e., less likely to kill him or herself) if he or she is in a depressed state rather than on a trajectory of improvement.

**HYPNOSIS WITH EATING DISORDERED PATIENTS**

*Hypnotizability and Eating Disorders*

Although the use of hypnosis with depressed and suicidal patients has been an issue of contention among researchers and clinicians, there appears to be a higher level of agreement regarding the use of hypnosis for the treatment of bulimia. A number of studies have suggested that bulimic patients may be more hypnotizable than those suffering from anorexia, evidenced by a greater capacity for dissociation (Griffiths & Channon-Little, 1995). Pettinati, Home, and Staats (1985) found that hospitalized bulimic patients were not only highly hypnotizable but also significantly more hypnotizable than patients with anorexia nervosa and normal age-matched controls. Research by Griffiths and Channon-Little (1993) found a higher level of hypnotizability in bulimics compared with individuals not suffering from this eating disorder. Sanders (1986) developed the Perceptual Alteration Scale (PAS) for the measurement of dissociation and found that there was a higher degree of dissociation in bingeing college students as compared with normal control groups. Clinical research suggests that hypnosis can be an effective adjunct in the treatment of eating disorders (Barabasz, 2000).

The concept of hypnotizability has been described in terms of a number of hypnotic phenomena displayed by normal populations, including absorption, total and self-altering attention, heightened responsiveness to involvement, heightened responsiveness to instructions, dissociation, imaginative involvement, “fantasy proneness,” and “daydreaming style” (Barabasz & Watkins, 2005). Higher levels
of hypnotizability may correspond to greater treatment responsiveness to hypnotic interventions.

One of the first researchers to report on the use of hypnosis in the treatment of individuals with eating disorders was Pierre Janet; he described dissociation as a factor in the etiology of eating disorders as early as 1907 (Vanderlinden & Vandereycken, 1988). A number of other studies have shown that binge eating and hypnotizability may both involve a dissociative process (Sanders, 1986; Torem, 1987; Vanderlinden, Norre, & Vandereycken, 1992). The bingeing and purging behaviors typical of patients with bulimia nervosa seem to resemble a dissociative experience (Beumont & Abraham, 1982), and their well-developed ability to dissociate helps explain, at least in part, their high hypnotizability (Pettinati et al., 1985). As we understood it, eating disordered patients have a tendency to dissociate when they engage in purging behaviors. And because they naturally are more prone to dissociate, they are more prone to being hypnotized because hypnosis necessitates dissociation to a certain degree.

In regard to the treatment of bulimia nervosa with hypnosis, many early studies had methodological flaws, such as measures of treatment outcome that were not adequately reported in order to evaluate the effectiveness. But one controlled comparative evaluation of a combined hypnotic and behavioral treatment was successful in showing that hypnotic techniques had a significant impact on treating individuals with bulimia nervosa and reducing accompanying psychopathology (Griffiths & Channon-Little, 1995). Kirsch, Montgomery, and Saperstein (1995) conducted a meta-analysis of studies comparing cognitive-behavioral therapy (CBT) with and without hypnosis in the treatment of several disorders, and though their meta-analysis was not specific to eating disorders, their results suggested that “hypnosis substantially enhanced treatment outcome, so that the average client receiving cognitive-behavioral hypnotherapy showed greater improvement than at least 70% of clients receiving hypnotic treatment” (p. 214). In this meta-analysis, six were weight-loss studies, and it was found that effects were pronounced for treatments of obesity such that those who experienced CBT plus hypnotherapy continued to lose weight after treatment ended, as opposed to those who did not have the additional hypnotherapy (Kirsch et al., 1995). How much relevance this has for other eating disorders, such as anorexia or bulimia, is unknown.

Designing Interventions Employing Hypnosis

It is important to note special considerations in using hypnosis as a treatment method for patients with eating/dieting disorders. Crasilneck and Hall (1985) stated,

While hypnotherapy is a useful treatment choice with bulimia or anorexia, in our experience these persons require careful and often extended hypnotherapy ... we seldom recommend direct symptom removal as the initial approach in bulimics because marked psychodynamic factors are often evident. (p. 214)
Many eating-disordered patients tend to be resistant to treatment, just as Coman and Evans (1995) emphasized. Eating disorders involve body image, self-image, social relationships, and other complex variables that complicate treatment. Thus, it is important to devise a varied approach to treatment to suit their individual needs (Coman & Evans, 1995). Furthermore, because bulimia nervosa often involves an issue of control, such as a fear of being controlled by others, it is important that patients develop a clear-cut understanding of hypnosis to eliminate ideas that it is something that could control them or serve as a magical solution to their problems (Hornyak, 1996). Thus, it is essential that the therapist address myths about hypnosis while establishing the therapeutic alliance before employing the method (Barabasz, 2000). Once this is done, various approaches can be used to identify and ameliorate the patient’s distorted cognitions and emotional conflicts that are precipitating and perpetuating the eating disorder. These may include ego state therapy, age regressions, age progression, and ideomotor signaling (Coman & Evans, 1995).

Nash and Baker (1993) described a number of different approaches to treating bulimia with hypnosis. These involve several steps that address struggles around self-pathology, control, and power conflicts, as well as difficulties with the adequate differentiation and integration of a cohesive sense of mature identity (Fromm & Nash, 1997). Erickson (cited in Nash & Baker, 1993, p. 386) conducted therapy in four phases with a 14-year-old anorexic girl using indirect suggestions and paradoxical strategies. The phases were as follows:

1. *Distracting frames of reference:* Lectures on oral hygiene and absurdly precise instructions for mouth care were presented.
2. *Depotentiating masochistic defenses:* The patient was instructed to rinse her mouth daily with cod liver oil. Punishment for failure was eating food. The patient, of course, failed.
3. *Therapeutic double-bind:* The patient was instructed to oversee her parents’ weight gain.
4. *Emotional catharsis:* The therapist provoked the patient by accusing her of being a liar and a coward.

In working with Julia, one of our patients whose case we will present in detail later in this chapter, we received some supervision from Milton Erickson about how to treat her. Erickson’s personal suggestions to us were quite similar to those somewhat unusual suggestions described by Nash and Baker (1993). There was a strong strategic component to the ways Erickson’s suggestions would be applied (Haley, 1973).

Nash and Baker (1993) described their hypnotherapeutic treatment approach to working with eating disordered patients in detail. Hypnosis was employed to help patients gain enhanced self-control related to diverse opportunities for improved security and mastery. Emphasis was placed on empowering clients to believe in their hypnotic ability, which was said to be representative of the bigger
issue of self-control. Structured and permissive techniques were used, and patients were reportedly most responsive to those that combined relaxation and fantasy. They strived to enhance the client’s sense of personal power, increase autonomous functioning, support the working alliance, and provide a generalized sense of ego support leading to increased mastery and positive expectations for behavioral success by using hypnosis early on. Then the focus was on body image distortions, and directed imagery and fantasy in hypnosis were used to confront these distortions. The correction of these falsehoods was associated with a more proper and mature sense of personal identity. The relationship between negative affect expression and distorted attitudes toward eating was explored. To further enhance the patients’ sense of self, rehearsal strategies in fantasy, age progression, and guided imagery were used to address concerns related to separation, individuation, integration, and adaptation. Hypnosis did not set out to correct specific defects in patients’ internal representational worlds. Rather, it was an opportunity to focus on some of the issues that interfere with psychotherapeutic work, including the defensive use of denial and dissociation that is central to distortions in body image and general self-concept (Nash & Baker, 1993).

REASONS TO HYPNOTIZE: A DIFFERENT VIEWPOINT

Given the divergent views discussed above about whether and how to use hypnosis in treatment, and being accustomed to using hypnosis with a wide variety of clinical cases (even those that others might be reluctant to so treat), we sought to find a frame—that is, a way to think about hypnotic intervention—that would justify its use in the case of Julia. A look at hypnotic intervention from a different point of view, a vantage point of resourcefulness and abilities (what some now term a positive psychology), reveals that even those patients who are depressed and suicidal, and who suffer from a comorbid eating disorder, enter therapy with latent “abilities” or “talents” that can be amplified hypnotically. Simply put, virtually everyone has at least some resources that can be used effectively in the course of treatment.

The patient’s capacity for hypnosis is a valuable resource, even if it is currently applied in a symptomatic way. Voit and Delaney (2004) insightfully described how clients often use hypnotic phenomena continuously and naturally, but in such a dysfunctional way that the hypnotic ability becomes the symptom itself. They wrote,

Our clients enter treatment exhibiting through their waking-state behavior many of the same hypnotic phenomena commonly exploited for trance induction. Symptoms develop when these “talents” have become habituated and problematic. As we begin to recognize the ways in which individuals express such talents through their actions, thoughts, and feelings, a new light is cast on the entire hypnotic progression. When clients are viewed in this way, their unique profiles of hypnotic phenomena suggest
In a sense, it is a goal of treatment to get the patient out of the dysfunctional trance state by using a different, ecological, healthful, comfortable trance state that will more effectively serve the patient’s needs.

Yapko (1992, pp. 91–97) also described how the same hypnotic phenomena can be used to generate either symptoms or solutions. In regard to depressed people in particular, he pointed out the hypnotic phenomena that depressed individuals use to construct their depressive experience:

1. **Age regression**, by primarily focusing on past painful events
2. **Age progression**, by projecting pain of the past as “always” following them into the future
3. **Amnesia**, manifested by inability to remember positive experiences and achievements
4. **Catalepsy**, shown by typical depressed behavior of low energy, lack of motivation, and psychomotor retardation
5. **Dissociation**, shown by continuous focus on negative and angry self-parts, functionally separate from positive aspects of self and experience
6. **Positive and negative hallucinations**, used by depressed persons to create and focus on perceived hurts and rejections and to ignore pleasant, positive events
7. **Sensory alteration**, shown in depression by decreased awareness of pleasurable activities and sensations
8. **Time distortion**, created when depressed individuals mentally extend the periods of past pain and project the idea of continuous pain and discomfort in the future and minimize the possibility of future success

Bulimic patients are no less hypnotically talented, especially when dually diagnosed with depression. Unfortunately, research and clinical material regarding the hypnotic abilities of patients with eating disorders is not as clear-cut, although hypnotic phenomena seem clearly evident in the problem:

1. **Dissociation** is possibly manifested by dissociating the bingeing and purging self-parts and separating “healthy” from eating disordered parts;
2. **Sensory alteration** is clear in bulimics when they experience a hypersensitivity to feelings of hunger and fullness;
3. **Negative and positive hallucinations** manifest in bulimic patients as an insistence on body shape that is too fat or lacking beauty and attractiveness
(i.e., when they see their emaciated body as too fat or when they don’t see the physical damage from their bingeing and purging);

(4) Age regression is used by eating-disordered patients, according to Fromm and Nash (1997), who state that in these disorders, “Many of the struggles center around self-pathology, control, and power conflicts, and difficulties with the adequate differentiation and integration of a cohesive sense of mature identity” (p. 152).

**THE CASE OF JULIA**

At about the same time that Hilde Bruch published a well-known book on eating disorders called *The Golden Cage* (1978), Julia appeared in our office very early one morning without an appointment. She announced that she was only willing to see Norma and that Phil must stay away as far as possible. She had been referred by her therapist, a student of ours who had taken several of our hypnosis classes, but was apprehensive about using hypnosis with her because Julia was so severely depressed.

Julia insisted that she wished to “look us over” before she made an appointment. After rejecting Phil as her ongoing therapist, she turned to Norma and said, “I’ll have to see you every day so that I don’t kill myself.” She was asked whether it would be all right for Phil to be informed and to participate as a consulting co-therapist. She agreed.

Norma answered, “Let’s start with two times a week and see how it goes.”

We made two appointments, and I (N.B.), as the treating therapist, called the therapist who had referred her to gather information about this very beautiful, slim, bright 20 year old.

I had just finished reading *The Golden Cage* and several articles about anorexia, now labeled “the affliction of the privileged,” and about bulimia, the very close relative of anorexia. Perhaps it was mere coincidence, but within a month we had three more cases involving eating disorders: two painfully thin, emaciated teenagers who were starving themselves, and one slim, well-proportioned college-age girl who ate and purged. Now there were four such patients in my caseload, and we were rapidly learning a lot about eating disorders and the unusually severe depressions that accompanied them.

Julia reported both anorexic and bulimic behaviors, earning the diagnosis of bulimia nervosa. Anorexic patients usually present with some pattern of starving themselves, eating as little as possible, whereas bulimics usually present with patterns of bingeing and purging and sometimes using laxatives to compensate for overeating. Julia would alternate by fasting, taking in no food at all for 8 or 9 days, and then eating and purging up to 24 times in one day, often for 6 or 7 straight weeks. Then she’d go on another fast, carrying on a continuous repetition of this cycle that had been going on for 7 years, from the time of her 13th birthday. Julia’s pattern was to eat and purge until her weight went up, then she would
fast, drinking only water until her weight came down. Then she would eat and purge until she gained 2 or 3 pounds, and then fast again.

When Julia came to therapy, she had been in the bulimic phase of her cycle for several months. She was eating and purging 24 times each day. She had little time for anything else, had recently withdrawn from college, and stopped working at her part-time job, so consumed was she with the “eat-and-purge” pattern. She was functioning at a very low level. She entertained suicidal thoughts most of the time, especially while eating.

Early on in the therapy, she began to bring poetry she was writing to our sessions. About her poetry, usually written after a therapy session, she wrote, “Perhaps you’ll find something in these that perhaps I can use to help myself quit counting the days till I die.” Her despair and sense of hopelessness were obvious.

Her very first poem spoke of dying, open wounds bleeding, a dream state, and a fear of awakening with no one to witness her, thus affirming her feeling of being all but dead. Another poem refers to abuse, rape, dissolution of her sanity and her self-esteem, betrayal by her family, and deep despair. We hypothesized from this, as well as her negative overreaction to Philip, that sexual abuse might well be part of her history, but a part she was not yet wanting to talk about directly. Indeed, a history of sexual abuse is a common underlying pattern in eating disorders and depression (Mallinckrodt, McCreary, & Robertson, 1995).

In the case of Julia, we chose to focus on her innate talents as a hypnotic subject rather than spending a great deal of time in seeking the “why” of her behavior. It was obviously more important to get an empowering behavioral change than to ferret out the cause of the behavior. Furthermore, the helplessness typical of depressed patients is a primary target for intervention, because encouraging a sense of personal efficacy is a primary ingredient of recovery (Sacco & Beck, 1995; Seligman, 1993).

One of Julia’s strengths was evident in her being a trained gymnast, one who had often competed and had won numerous medals. It is interesting to note that eating disorders are common among athletes, a factor we considered in Julia’s treatment (Garner, Rosen, & Barry, 1998). As a strength rather than a risk factor, though, her athleticism provided evidence of her high level of concentration and ability to focus. It demonstrated as well her discipline and her competitive spirit. Excellence on the beam was her specialty. We speculated about the phallic symbolism of this piece of apparatus. Whenever she spoke about her gymnastic activity, she said, “I’ve conquered the beam.” Early emphasis of our treatment planning was on the potential therapeutic value of hypnosis for Julia, given her apparent hypnotic abilities. Our assessment and interventions focused on Julia’s strengths, resourcefulness, and openly expressed deep desire to change. Our treatment philosophy was a positive psychology “Julia-centered” approach, and was not diagnosis or pathology centered. We steadfastly held to Yapko’s succinct and clear summary of the issue: “We treat people, not diagnostic categories” (2003, p. 177).
At this time in our lives, we were visiting Milton Erickson in Phoenix as often as we could in order to learn the intricacies of his hypnotic and strategic methods. On one such visit, we asked Dr. Erickson’s opinion about how to proceed with Julia’s treatment. We reported to him that Julia seemed a good hypnotic subject in that she responded well to relaxation suggestions and reported that she “felt good” during the session. But these gains were fleeting, for she would return to the bulimic behavior with desperation only an hour or two later. Consequently, she continued to sink into an even deeper depression.

Dr. Erickson’s suggestions, at first, seemed bizarre to us: “Have a contest with her. See who can vomit farther. Does she vomit equally well to the left? Is she better at it to the right? Can she vomit straight ahead?”

Both of us thought he was joking, because neither of us had ever asked for such obviously disturbed behavior from our patients. However, he most definitely was serious!

Eventually, we understood the deeper implication of his recommendations: Have her focus on the process itself, in other words, how she “did” bulimic behavior, rather than on her feelings about it, and then observe what happens as a result.

At our next session, I told Julia how I vomited and challenged her to observe her own patterns. She was then to report to me in exquisite detail. Julia’s predictable response was an outburst of rage! Finally—an appropriate proactive response rather than her usual passivity.

“You’re crazy!” she screamed.

“No,” said I. “You’re the crazy one.”

“If I’m so crazy, put me in the hospital.”

“I can’t; you’re not nearly crazy enough. However, I’ve had lots of experience with crazy people, so I’ll rehearse you until you can act crazy enough so they’ll take you.”

Now she was really angry—a new kind of experience and focal point for her. (Perhaps she was emerging from the old one?) It was a sign of her comfort with me (i.e., the therapeutic alliance) that she was willing to engage with me about her feelings rather than simply internalize a sense of being mistreated. This was a therapeutic gain I would strive to help her generalize.

**Key Phrases Had to Be Part of the Strategy**

Whenever Julia was in the fasting phase of her cycle and at that point was severely, morosely depressed, she engaged in a negative coping pattern called rumination. Rumination is the passive spinning around and around of negative, hurtful thoughts, and it has been associated with more symptoms that are also more severe symptoms (Nolen-Hoeksema, 2000). It seemed obvious that, in addition to her self-critical ruminations, her deprivation of nourishment contributed greatly to her experience of depression. First and foremost, in terms of therapeutic priorities, was the issue of survival. When Julia stated that she couldn’t swallow
a single bite and possibly never again would, we wanted to encourage her to experience a sense of appetite. I used indirect suggestions to remind her of nearby Capistrano, where the “swallows always return.” Indirect suggestions are generally most appropriate when one might anticipate or actually note some resistance to more direct methods (Zeig, 1980). Julia made it clear that no one could make her do anything she didn’t want to do. She seemed to have an internal warning system to resist any overt suggestions.

When she was in the “eat–purge” phase, one of the strategies we used was designed to encourage a reasonable response in the direction of the therapeutic goal. Instead of asking for a full 100% response to completely stop purging, a demand extremely unlikely for her to meet, we asked her to be only a “50 percenter”—i.e., eat and retain 50% “normally” and then eliminate the other 50% by purging. This is a softer “divide and conquer” strategy that tends to increase compliance on the part of the patient because it makes no demand for immediate and total change. At one juncture, she was urged to increase the undesirable 50%—that is, to double the volume of the purging by vomiting 48 times a day. This is a paradoxical intervention that has the effect of overloading a taxing behavior that is already very difficult to maintain (Haley, 1973). As expected, she was unable to comply with the demand and actually reduced the number of binges and purges by 75% immediately after that directive was included. Julia continued to fast stringently between the eat–purge episodes, however. At those times, she was listless, more hopeless and depressed, and barely able to function.

Session Transcript: Addressing Controllability

As is typical of depressed patients, Julia was steeped in a sense of helplessness (Abramson, Seligman, & Teasdale, 1978). We wanted to address this issue early on. The following is a partial transcript of one of Julia’s hypnotic sessions. It occurred in the 14th session and was offered as a means to address her fasting behavior and her associations to fasting as evidence of control. The reader can note the use of key phrases, which are highlighted and meant to catalyze the desired responses.

You know how to focus with pinpoint specificity when you’re on that balance beam. … You know where you are going to land even without looking down because you’re looking up or even straight ahead. … You’re thinking about the next move … not the past moves … and you can stay relaxed now … because you need that flexibility to respond automatically … and it’s a good thing that some things are dependably automatic … like the seasons. … Spring always follows winter … and you can depend on the swallows to come back … to Capistrano with precise automatic regularity. … The amazing thing about some things is their dependability. … When you release a breath … just before you make that move in your routine … you know that next breath will precisely, automatically, regularly come in all by itself. … And you are in charge of releasing that breath, no one can MAKE YOU do it, except
you. … You get to choose. … Choice is always an option, and you alone can choose to choose the exact moment and you already know the next breath comes in all by itself … just like at Capistrano … one swallow follows another … and they always return.

For the next 10 months, she reported no more fasting and fewer and fewer “eat-and-purge” episodes, from a high of 24 to lately only once or twice each day. Every few days, however, there would be an upsurge to 6 episodes, followed by an immediate downswing the next day. Her weight remained stable; there was no more fasting at all. Julia seemed reluctant to relinquish the eat–purge behavior completely and, despite her improvements, continued to entertain thoughts of suicide, albeit less frequently and far less vociferously. It appeared that the metaphor succeeded in reducing her sense of “obligation” to please everyone by focusing her on her innate dependability (disrupting a pattern of perfectionism common to both eating disorders and depression), and also helped encourage a stronger sense of an internal locus of control (“no one can MAKE YOU”). In addition, in a gentle counterexample to her unrealistic statement “I’ll probably never be able to swallow another bite,” she was reminded that “swallows always come back.” This suggestion had an obvious effect. She stopped the fasting behavior.

Yet, despite her gains, she was, in some ways, still stuck.

Many months and many sessions later (after about 45 sessions, now occurring at a frequency of once a week instead of two times per week, as at the beginning), she was an accomplished and very competent hypnosis participant. She would begin each session by reporting what had occurred since her last visit. After all, she had been instructed to notice what was different, especially what was changing in her own behavior. She really enjoyed “tracking for differences.” When she finished reporting, Julia would kick the recliner back, and say, “Okay. It’s your turn.”

When I would include any reference to her parents, especially to her father, she would cover her ears. She continued to exclude Phil from our sessions and usually ignored his greeting to her. Because of the poetic references to rape and abuse, our ongoing presupposition was that she had probably been molested by her father. Whenever I suggested a direct discussion about the possible reasons for the “eat-and-purge” behavior, she deftly changed the subject. She was now a bit less depressed and only occasionally would slip into a morose “dark and scary void,” which she further described as “very dangerous, on the brink of hell. If I talk about this any more today, I will go back to purging 24 times a day.”

Despite her blatant refusal to directly address her earlier family experiences, Julia continued to progress. Many of our sessions were devoted to helping her make decisions about her educational and career goals, because she now felt empowered enough to “rejoin the world.” She was no longer imprisoned by an all-consuming binge–purge cycle, yet the troublesome behavior still persisted, only to a lesser degree. Her therapy continued, and the focus remained on teaching
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her the social and coping skills known to reduce depression, such as reducing
avoidant behavior and increasing her social network (Yapko, 1997).

Julia was now almost 22 years old, was working part-time for a news service,
and was also back at college. Her parents continued to support her, but she insisted
on paying for her own therapy, which was now reduced to only once or twice a
month. There would be an occasional extra hour when she felt hopeless of ever
being rid of this “monstrous burden” that would throw her off balance and “into
the void.” Phil and I often consulted together between her sessions, and we both
agreed Julia needed a more overt sign of progress to challenge her sense of still
being “stuck” in terms of her eating disorder. We chose to remind her of her
proficiency on the balance beam, an area where she felt positively in control
and skillful as a metaphorical foundation for defining herself similarly in other
areas of her life. The challenge was how to help her generalize beyond the balance
beam.

How to structure this purposeful metaphor for encouraging flexibility, adapt-
ability, and a greater self-awareness of the need to cast off old, self-limiting beliefs
became a challenge for us. We decided I would tell her an instructive story about
a polar bear. This story was first told to us in a personal exchange with John
Grinder in December 1976. It has since been published (Bandler & Grinder,
1979). The story embodies the kind of perceptual and behavioral rigidity that we
hoped to target and disrupt.

The metaphor was told as follows:

You remember when you told me how you were able to make a transition from
holding onto the balance beam ... and then being able to release it ... and you felt
like you had wings and you were free to move ... on the balance beam, of course.
... Well, I wish you could have had a chat with a polar bear at the Denver Zoo. ...
Polar bears, like you, are probably in a state of transition, too. ... They are spending
more and more time in the water. ... People who track these trends tell us they are
even changing their body configuration ... making themselves wider at the top and
narrowing down at the bottom ... to adapt to more time in the water. ... Well ... the
Denver Zoo was given a gift of a beautiful 8-foot-tall polar bear. ... The bear was
delivered in a large cage probably as long as a balance beam—but wider. ... When
the cage arrived, the zoo had not yet completed the compound that would house
the bear. ... The compound would have lots of water and would be much like his
home terrain. ... So, they placed the cage and the bear in the center of the compound
while they worked on the grounds. ... During the process of the work going on, the
bear, stuck inside the cage ... began to pace. ... He would take four steps up ... swing
his arms over his head, and take four steps back. ... He continued this
monotonous behavior day after day after day. ... And isn’t it strange how an
intelligent being can keep doing the same thing over and over again ... and then
complain about being in a rut?... Now bears don’t normally pace—but what else
could he do in that small space? ... Maybe he was making changes in his behavior
while he was in this transition. ... He had yet to discover that choice is an option.
... When the compound was completed, with all of the surroundings similar to its
natural habitat, the task was to release the bear from the cage. ... Now the bear is
a beautiful animal, and also quite dangerous. ... The director of the zoo instructed his staff to sedate the bear, and when the bear was asleep ... they cut the bars from the base of the cage, lifted the top off with a crane, tipped the base, and rolled the bear onto the ground ... and waited for the tranquilizer to wear off. ... When the bear awoke, he stood up to his magnificent height ... looked around ... and even though his circumstances were now very different ... he took four steps ... threw up his paws ... turned around and took four steps back. ... He didn't realize HE NO LONGER HAD TO ... it was as if the bear did not know the bars were gone. ... He didn't know, YET, THAT HE NO LONGER HAD TO. Choice is an option now, but he didn't know it yet ... and I wonder how long it takes for a bear ... or anyone else ... to figure out they’re not in a cage anymore. ...

At the next session, Julia brought along a poem she’d written about the polar bear. In it, she mused about the constraint of being caged. She expressed rage (felt by the bear) for the first time in her writing. She included a bit of humor: “At the zoo they turned him loose between a tiger and a kangaroo.” Our metaphor had clearly gotten her thinking about constraints and freedoms, a positive step in starting to redefine herself.

Most of the hypnotic portion of our sessions evolved into “storytelling” with the hope of being helpful to Julia by encouraging her greater self-awareness and self-definition. We also hoped that by not forcing her to reveal sensitive information about her history, she’d feel more comfortable about and ready for eventually tapping into a regression process that might reveal something about the problem’s origins. (This was something she made clear through direct statements as well as indirect evasions. She would not deal with this until and only when she felt ready to deal with it.) Our belief is that people develop ways of coping that may not serve them very well, yet are meant to serve them. In other words, we have come to learn that what seems like destructive and even stupid behavior on the surface is actually a misguided but well-intended effort to cope. There is a positive, often protective intention behind every behavior. In Julia’s case, we had assumed all along that her issues with food represented a survival mechanism of some sort. In one revealing moment, she acknowledged that had she not been able to purge at will, she believed she would have died. The fasting, she said, was “a way of knowing I’m in control of me and no one could take that away. They couldn’t MAKE ME do anything.” Her emphasis was wonderfully firm. Now she was repeating this at least once during each session. I would add, “Nor can I.” Her response was a forlorn, somewhat sad smile.

Then, a remarkable breakthrough occurred. Phil created a story that matched much of her life metaphor. He and I decided that he must be the one to tell it, if Julia would allow him to do so. We felt she was ready to face up to her animosity toward him (and probably to all “fatherly” men). This “push” from us provided a pattern interruption and would create a very different setting during our session. Julia initially objected to his presence and participation, but finally agreed. The story she was told while in hypnosis follows:
A photographer and an assistant worked for a magazine that reported on natural phenomena around the world. As it happened one day, Yellowstone National Park reported that there was a new geyser that appeared among the other geysers at the park along with “Old Faithful,” the most famous geyser of them all. The magazine sent the photographer to the park to get a photograph of this geyser spewing to put into the next issue.

The photographer arrived at the park and set up his equipment and waited for the geyser to spew. However, unlike Old Faithful, there didn’t seem to be a consistency as to when the geyser spewed. Old Faithful spewed every hour on the hour 24 times each day. One could almost set his watch by when it spewed. This new geyser would spew many times one day and then sometimes only half that number another day and maybe only once on another day. Often it went for days, not spewing at all. Well, the photographer waited and waited and waited.

The assistant did very little except to stand around and wait as well.

The first day, the geyser didn’t spew while the photographer was there and the light that was necessary for the photograph diminished and he had to pack up all the gear and wait until the next day.

This time the photographer set up his equipment very early, hoping that when the geyser did spew, he would be ready. Unfortunately, the other geysers spewed, but the new one did not. The photographer was getting very upset because he had a deadline to meet for the magazine and he hadn’t been able to get a photograph of the new geyser. Again, he packed up the gear and returned the next day, repeating the same process.

After setting up his gear the third day and waiting and waiting he became very frustrated and angry that the geyser was not spewing at all. So, noticing again that the light was diminishing he walked over to the geyser and looked into the opening. At that moment, as he was looking into the geyser, it spewed once more and for what turned out to be the very last time for it no longer had to.

Julia went into deep hypnosis, deeper than ever before as Phil told her the metaphor. When he ended with “because it no longer had to,” she bolted out of the chair, screaming, “You and your goddamn stories!” And she left.

She was angry! But this anger was assertive rather than merely raging. Her demeanor and posture were most definitely different from her previous depressive ones where she sat with collapsed, slumping, rounded shoulders: the depressive crunch. Her ability to directly express anger to Phil, a man, rather than simply silently ignore him, seemed a progressive step. I had no doubts that she’d be calling to come in sooner than our next appointment scheduled for the following month.

She was back within a few days.

At that next meeting, she asked me to read a passage from a book she brought along. It described a scene from the writer’s childhood when the author’s father made her swallow his semen. When I looked up from the book, I saw that Julia was quietly crying.
In a childlike voice, in a seemingly dissociated state, she began to tell her story:

“She was so little, only 3 ½, and he forced it into her mouth and the hot sticky stuff stuck in her throat … and he made her do it almost every day and then he’d take her shopping or out for ice cream … daddies aren’t supposed to do that.”

“When did it stop?” I asked.

“After I vomited on him! It was my 13th birthday.”

Our presupposition had been accurate. She had been sexually abused by her father.

At the next meeting, Julia told us (Phil was invited by her to join us) that she had not purged, “not even once,” after Phil’s story. She actually hugged him on her way out! Her overgeneralization that “all men are bad” had apparently been disrupted, and she came to discover that there were, in fact, some caring and good men she could relate to in positive ways. Hypnosis had proven to be a valuable means of building a therapeutic alliance and encouraging a redefinition of her views of men and, ultimately, herself.

Julia continued with therapy for several more months, until she announced, “I’m ready to be on my own for a while, but I want to come see you now and then.” We agreed she could call or come in “as needed.”

She continued to write, and about a year later she brought in a handwritten volume of poetry dedicated to Norma. She had recently graduated from college and went to work as a freelance journalist.

Even though this had not been openly discussed during the therapy, Julia was processing our sessions in her poetry and working on resolving the abuse issues she had “metaphorically.” In several of her poems, she refers to challenging the mysteries of her past, to conquering fear and having the courage to stay alive. In another, she speaks of a little child entertaining a fantasy of being able to trust an adult and deciding to return to the womb and be born into a different world. In a later poem, she traveled into her past and realized she had been a victim of “suburban insanity” and was not responsible for any of it. Then, from the morbid, depressed horror, she emerges (like a bird—perhaps a swallow) to seek the heights, to soar and fly and to embrace her passion to be free.

We received a holiday card from her just a few years ago in which she wrote, “I went to the zoo the other day and the polar bears were running wild.” We look to such spontaneous expressions as clear evidence of the merits of hypnosis and the use of indirection, especially metaphor.

Julia is 48 now. She is married, has several children, and is slim and trim and still very beautiful. One of her later poems relates a far brighter outlook, a sense of optimism about herself. She writes of moving through the shadows free of fear, able to choose what touches her and what she will touch. She mentions inner light fueled by self-esteem and lasting power.

This case of a severely depressed, suicidal, eating disordered young woman who was a talented hypnotic subject provided us with several remarkable learning
experiences that we think are relevant to others doing therapy as well. The most important of these are as follows:

1. **Patience**: She would likely have abandoned therapy had we not been willing to proceed slowly.

2. **Trusting our presuppositions**: Though she refused to address the abuse by her father (it never even entered the discussions), she was dealing with it in her own way through her poetry.

3. **Taking extraordinary “metaphorical” risks**: The geyser story was a mirror image of her situation. Had she not been in a state of readiness for it, we might have lost rapport.

4. **Willingness to forego “insight” and focus on behavioral change**: She repressed and avoided any reference to the early abuse (from 3½ to 13). It was a hidden yet obvious ghost in our sessions.

One thing was very clear to us from the outset: We couldn’t use any traditional approach with Julia emphasizing uncovering and analyzing her past. Perhaps it was from her that we learned that the past is to be learned from and not lived in, for she simply refused to discuss the past! Her only interest was to stop the damaging behavior and to feel “alive” again. We focused on her strengths and resources and guided her through her transition.

**SUMMARY**

In treating depressed eating-disordered patients, we believe there are many meaningful targets for intervention: fear of loss of control, distorted body image, anxiety, rumination, excessive self-absorption, perfectionism, avoidance, social impairments, and many other cognitive, perceptual, behavioral, and emotional patterns that are common to both depression and eating disorders. Although it is arguable which symptom pattern should be targeted first, there is little room to argue that empowering our patients to live the kinds of lives they want for themselves is a critical component of any therapy.

Hypnosis as a means of empowering people has been overlooked for too long, but individuals such as Julia can serve as potent reminders to us of the remarkable changes that can be created when hypnosis is applied in the service of amplifying a person’s strengths.

**EDITOR’S SUMMARY**

- Eating disorders are a common comorbid condition associated with depression.
- Eating disorders involve sensory alterations and physical dissociations that can be viewed as unfortunate applications of hypnotic phenomena.
• Redirecting the “symptomatic hypnosis” is a viable goal of hypnotic treatment.
• Hypnosis for treating both eating disorders and depression has a strong theoretical underlying rationale but is underrepresented in the scientific literature. Why these topics have received too little consideration is reviewed and discussed.
• Eating disorders and depression share a number of common contributing factors, one of which is distortions about the issue of control. Addressing this issue in a nonthreatening (i.e., non-resistance-arousing) way necessitates having a variety of therapeutic approaches to treatment that may range from direct to indirect.
• Comorbid eating disorders and depression also share such common factors as anxiety, rumination, excessive self-absorption, perfectionism, and avoidant coping.
• Framing hypnosis as a vehicle for increasing self-control can be a valuable means of meeting the client’s need for a sense of enhanced personal control.
• A detailed case presentation involving a serious eating disorder and suicidal depression is provided.

REFERENCES


Depression in Children and Youth: Applications of Hypnosis to Help Young People Help Themselves

DANIEL P. KOHEN
AND KATHERINE MURRAY

OVERVIEW

Until relatively recently, depression in children and adolescents was considered so unlikely that there were no established diagnostic criteria in place in any formal classification system. Historically, children were thought to be unable to experience true depression, a disorder thought to be related to psychodynamics only associated with adult psychosocial development. Consequently, long-term studies about children’s depression and response to clinical interventions are virtually nonexistent. Treatments for children largely parallel established treatments for adults, with some modifications to make them more age appropriate.

Currently, depression in children and adolescents continues to be a highly controversial topic for a number of reasons: (a) recent government warnings about the use of antidepressants in young people possibly increasing their suicidal ideation and behavior (U.S. Food and Drug Administration, 2004), (b) questions about the efficacy of antidepressant medications in young people, (c) epidemiological evidence that depression is growing rapidly in prevalence in children and adolescents, and (d) the recognition that depression in children or adolescents serves as a major risk factor for adult depression as well as the onset of other
In the Diagnostic and Statistical Manual for Primary Care (DSM-PC), childhood depression is described in the following way:

Sadness, irritability, or a loss of interest in normally pleasurable activities is a common and normal response to disappointment, failure, or loss. Such mood changes only represent a problem if they persist more than a few days and if they represent intense distress or significantly impair the child’s ability to function or relate to others at home, school or play. … Children and adolescents may not present with sadness, but may report aches and pains, low energy, or moods such as apathy, irritability or even anxiety. (Wolraich, 1996, p. 153)

Depression is distinguished from bereavement, defined in the DSM-PC in the following way:

Bereavement is an intense grief response after a major loss (e.g. death of parent) and is usually a normal reaction involving mood and sleep or appetite changes. When bereavement symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness or suicidal ideation, major depressive disorder can be diagnosed. (p.153)

In the case of either depression or bereavement in which the symptoms may be similar, the child may require intervention.

The signs and symptoms most commonly associated with depression include sadness, apathy, loss of pleasure (anhedonia), agitation, sleep disturbance, appetite changes, decreased energy and fatigue, decreased concentration, low self-esteem, crying, social withdrawal, and irritability.

There is no one single characteristic that defines depression, nor is there one single cause. There are many risk factors, some biological, some social, and some psychological, that can influence the onset and course of depressive episodes. Risk factors for childhood depression include depressed parents, strong family
history of depression, early onset of a diagnosable anxiety disorder, alcoholism, family and marital discord, substance abuse, early childhood losses, poor coping skills, lack of social support, uncertainty about sexual orientation, and a history of previous depressive episodes (Wolraich, 1996).

Depression is 1.5 to 3 times more common among first-degree biological relatives of persons with major depressive disorder than in the general population.

Depression is thought to occur in approximately 2% of children and 4 to 8% of adolescents (American Academy of Child and Adolescent Psychiatry, 1998), and major depressive disorder (MDD) appears to be twice as prevalent in adolescent girls as in adolescent boys (Emslie, Weinberg, Rush, Adams, & Rintelmann, 1990). Thus, the prevalence of MDD in children and adolescents is estimated to range from 2 to 8% (Birmaher et al., 1996a, 1996b). Based on a figure of approximately 38 million Americans currently between the ages of 6 and 15 years, 2 to 8% represents between three quarters of a million and 3.04 million young people who may meet the formal criteria for the diagnosis of MDD.

We could not find any prevalence data for other forms of depressed mood/sadness in children and teenagers that we believe to be far more common than MDD. When we consider the additional diagnostic categories into which children with sadness and depressed mood problems fall (see below), we believe it is conservative to estimate that there are likely anywhere from 7 to 10 million children with significant symptoms of depression and depressed mood.

In one telling study, Garland et al. (2001) employed the Diagnostic Interview Schedule for Children (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000), which they administered to 1,618 randomly selected youth ages 6 to 18 years. These children and adolescents were active in at least one of these five public sectors of care: alcohol and drug services, child welfare, juvenile justice, mental health, and public school services for youths with serious emotional disturbances (in San Diego, California). Major depression was identified in 8.9%, 4.7%, 4.7%, 5.7%, and 7.9% of children in these groups, respectively, or overall in 5.1% of respondents. Not surprisingly, the less severe (but more chronic) diagnosis of dysthymia was identified in only 0.5% of respondents.

One might reasonably predict that the severity of dysthymia would preclude either an identification of an affected child or an involvement in services provided in any of these sectors, suggesting an underdiagnosis. Furthermore, missing from these kinds of data, further suggesting an underdiagnosis, are all those children with other forms of depression and depressed mood (discussed further below), as well as all categories of individuals who may have contact in other sectors (e.g., private or other community medical/mental health care) and those who have gone unidentified and untreated. Particularly when we understand the accelerating prevalence of problems that children encounter that may best be characterized diagnostically as an adjustment disorder with depressed mood, it is not unreasonable to consider that, as with the adult population, sadness and depression in children and youth are of large and still growing proportions.
ASSESSING CHILDREN'S DEPRESSION

Like most, if not all, of what we do in clinical health care, the clinical diagnosis of depression should begin with an understanding of what signs and symptoms (including parental concerns or “complaints”) should lead one to consider the possibility of depression as either a primary or secondary cause of the presenting concerns. For children and youth, this requires a recognition that while so-called classical signs of depression in adults may appear in children (making diagnosis easier), the “typical” vegetative signs of low energy, hypersomnia, and sad mood are less likely to be evident in children and more likely in adolescents (Wolraich, 1996). Instead, virtually any—especially “new”—behavioral or behavioral concern may be a sign or symptom of an as-yet-unidentified or undiagnosed depression. These will vary according to age.

In school-aged children ages 6 to 12, recurrent and/or persistent somatic complaints, such as chronic or recurrent headaches or recurrent abdominal pain, may be the first indication that the clinician should begin to consider and inquire about depressed mood and related feelings. Clinicians must trust their own clinical judgment and intuition when first noticing and then thinking about kids being sad. This means being confident, comfortable, and willing to make time to ask them directly to talk about sad feelings, as well as to consider the use of various formal screening tools and/or inventories to support or confirm one’s clinical perspectives. These include the Child Depression Inventory (CDI; Kovacs, 1985), the Beck Depression Inventory (BDI; Beck, Steer, & Brown, 1996), the Achenbach Child Behavioral Checklist—parent (CBCL) and the Achenbach Youth Self Report (YSR; Achenbach, 1991), and the Pediatric Symptom Checklist (Jellinek et al., 1988). We utilize these assessment instruments as adjuncts to clinical evaluation, specifically to facilitate the evolution of our therapeutic communication and alliance, and not solely as “diagnostic instruments.” They are regarded as clinically reliable only if they confirm the clinical suspicion or further inform the clinical impression of depression. They may be particularly helpful diagnostically if the child’s presentation, at first glance, doesn’t seem like depression, yet on deeper consideration makes a clinician think depression might be there, such as when the patient presents with anxiety or “hyperactivity” (e.g., impulsivity and inattention).

If the CDI or other inventories reflect a “normal” result, then the patient may indeed not be depressed, or the patient is depressed but coping well enough to not “look” depressed, or he or she has figured out how to deceptively appear to “look okay” on the inventory. In our opinion, therefore, one should never rely only on such inventories to arrive at a diagnosis of depression. If one clinically suspects significant depression but an inventory does not support the “official diagnosis,” one should nonetheless proceed to provide appropriate supportive and therapeutic intervention (Birmaher, Brent & Benson, 1998).

In an analogous way, changes in mood—for example, sad mood—must be understood and responded to with an appreciation of the child’s history and
environment, and especially from the perspectives of frequency and interference with ability to function. Thus, we are not invested in the “requirement” of a precise label of a diagnostic category of “depression” or “depressed mood,” particularly if numbers of symptoms don’t fit published categories or scores on inventories don’t add up to a diagnosis. If a child’s distress from persistent sad mood (i.e., beyond a few days) interferes with normal function (e.g., not going to school or participating in sports or clubs), then the child deserves assistance toward relief of suffering and may well appropriately benefit from our intervention. As such, the discussion that follows regarding approaching depression with hypnosis applies equally well to those others suffering from their sadness.

EMPLOYING HYPNOSIS IN CLINICAL INTERVENTIONS

Research to support the use of hypnosis and self-hypnosis in the treatment of depression is lacking in general, and relevant research in children and adolescents is practically absent. We searched both the Medline and PsychInfo databases for depression and hypnosis. Our search revealed studies primarily directed at the treatment of another illness with changes in mood reported only as a secondary outcome, if at all.

One such study was conducted in the United Kingdom and involved 200 subjects with irritable bowel syndrome (Gonsalkorale, Miller, Afzal, & Whorwell, 2003). Based on survey results one year following “gut-directed hypnotherapy,” the subjects reported an improvement in depression scores. Interestingly, this finding was not linked to their level of improvement in irritable bowel symptoms. This suggests that the role of hypnosis in the improvement of depression is not simply secondary to an improvement in symptoms of the targeted illness.

One study we found specifically related to children used hypnosis and acupuncture in the treatment of chronic pain (Zeltzer et al., 2002). Of the 23 children enrolled in the study, none met criteria for depression prior to treatment, and this remained unchanged at follow-up. Certainly, the dearth of research suggests a need for prospective trials of hypnosis and self-hypnosis in the treatment of depression, especially in children and adolescents.

Despite the lack of research on the clinical applications of hypnosis in treating depressed children, the literature of hypnosis in general and hypnotic theory in particular may provide some valuable insights regarding the development of depression. In a theoretical article, Kaffman (1981) discussed the presence of “monoideism” in depression and the hypnotic influence of repetitive negative thoughts. In keeping with the important naturalistic concept of “finding the hypnosis in the encounter” (Sugarman, 1997), the initial therapeutic goal may be to elevate awareness of these “unconscious scripts” (i.e., beliefs and attitudes), examine their inaccuracies, and offer alternative therapeutic suggestions. This is a key aspect of cognitive-behavioral therapy, empirically a well-supported means of intervention for depression (Brent et al., 1997; Reinecke, Ryan, & DuBois,
1998). How hypnosis may be integrated with cognitive-behavioral therapies for depression has been addressed at length by Yapko (1992, 2001).

From a hypnotic perspective, and in practical consideration of helping young people to manage sad feelings, it is probably not as important or necessary to discern the precise diagnostic category of their depression as it is to honor and assure the patients’ awareness of depressed feelings and/or awareness of the manifestations of their depression (e.g., anxiety, somatic complaints, or “acting out”). Addressing children’s understanding and formulation of the reasons they are feeling that way (i.e., their attributions about its meaning), discussing their expectations and motivations for “getting well again,” and, most importantly, assessing if they have the energy and other resources to do the emotional and hypnotic work necessary to feel better are all vital parts of the early phase of treatment. They all influence the clinical response to treatment in general and thus may serve as possible targets for the hypnotic intervention. They are particularly important in helping the clinician to decide whether, if, and when the patient might also be treated with medication to facilitate sufficient functionality to be able to work clinically. We believe the same kind of thinking is applicable whether the medication being considered is an antidepressant, anxiolytic, and/or analgesic.

**DEVELOPING SPECIFIC HYPNOTIC INTERVENTION STRATEGIES**

*Depression and Negative Hypnosis*

The development of successful hypnotic strategies is dependent upon nine things the clinician must focus on and do thoughtfully and consistently: (a) history, (b) history, (c) history, (d) rapport, (e) rapport, (f) rapport, (g) notice, (h) notice, and (i) notice (observation)! Beyond the obvious importance of a thorough history and the necessity of establishing positive rapport, these must be integrated from the beginning with the clinician’s careful observation skills in order to “find the hypnosis in the encounter” (Sugarman, 1997). An expansion of Erickson’s guiding principle to go with the child, that is, “meeting the child at her own level” (1958, p. 29) in providing hypnotic intervention, “finding the hypnosis in the encounter” derives from an understanding of the fluidity of imaginal states (natural hypnotic behaviors) in children and youth, and the ever-present developmental drive toward mastery. “Finding the hypnosis in the encounter” means considering that children, particularly those who are suffering, hurting, and sad, may already be in a hypnotic state, one with many of the same characteristics as an “induced” hypnotic state, that is, focused narrowly and intently (albeit negatively so) on their sadness, loss, pain, poor self-image, perception of the existential futility of their life, or whatever the source of their distress might be. Depression may make them internally absorbed and seemingly less attentive or inattentive to surrounding stimuli, but there is nonetheless a readiness to listen with the often desperate hope that the clinician will say or
do something to provide some relief. Though this hurtful focus is, to be sure, a negative state, a recognition of its quality as a spontaneous hypnotic state allows the clinician to indeed “find the hypnosis in the encounter” and to consider the possibility that “being hypnotic” (i.e., speaking hypnotically without the formality of an induction) may be preferable to—and indeed, even more productive than—more formal discussion of and teaching hypnotic self-induction. Either direct or indirect approaches, or a blend of both, may well be appropriate to the needs of a given child.

HYPNOSIS AND THE LANGUAGE OF FEELINGS

In the context of history taking and rapport development, it is essential to develop an appreciation for and knowledge of the child’s language of feelings and his or her ability to identify and talk about feelings. In the unfolding of their personal history, desired outcomes are named in order to be able to (later) utilize their own ideas and language in the formulation of hypnotic suggestions and strategies. This may be done through the use of simple dichotomies in younger children, in other words, identifying with words or pictures that represent the complementary type of emotion. For example, children who draw themselves as “sad” may draw a picture they define as representing “happy” in response to the sentence stem, “I want to be …” Or, in older children, various symptoms may be given numerical values, such as in severity scales of headaches (or abdominal pain) in which the child is asked to rate the pain numerically anywhere from zero to 12 with 12 as the worst imaginable headache and zero as no headache at all. There can be an implicit or explicit understanding that 12 corresponds to depressed, sad, worthless feelings and that zero, in turn, corresponds to feelings of contentment or happiness. When there is a mutual understanding of the child’s perception of these differences, these may then be easily and matter-of-fact presented during subsequent hypnotic work (formal or informal experiences). Because they are familiar, indeed the child’s own construct, and because there is motivation for getting well, the scalings are that much more easily understood and accepted internally. Consider, for example, a child of 5 or 6 (or older) who has drawn a sad face with dark colors to represent “when I’m really sad” and a happy, sunshiny, bright smiley face of “when I was happy a long time ago.” In hypnosis, the following suggestions may be offered:

In your inside thinking, look in a mirror … and see that very sad face, like you used to be feeling (yesterday, last week, for months) … let me know when it’s there … okay … see how you can start to feel that way now? … Now, use the remote in your mind, and watch what happens as that face starts to get smaller and smaller … ’til you can hardly see it … and LOOK! … now here comes that happy smiley face, right into the mirror … and it’s getting bigger and bigger … and watch how the smile comes onto YOUR face too … isn’t it cool how just by seeing it inside your mind this way … it can really change how you feel when you want to. … That’s right! Wow!
Analogously, agreement on a numerical scale of discomfort–comfort, sad–happy, hopeless–hopeful, or headache–no headache allows for such scales to be integrated into hypnotic suggestion during trancework. For example, in the midst of an imagery and relaxation process, one might simply suggest, “When you’re comfortable in your hypnosis and ready to use this state of mind to help yourself make changes that are important, please let me know.”

Following an affirmative response (verbal or nonverbal), one might say,

Now would be a good time to picture that ruler (scale, measure, etc.) somewhere in your mind’s eye. … I don’t know where it’ll be, but you’ll know … perhaps in your pocket … or on a table … or up in the sky … or floating on the water. … or in the sand … when you see it and notice what it is made of and what color it is, let me know … great! … What color are the numbers? … And just notice, what number is it on right now? … Perhaps that number will be lit up … or the number will be bigger or a different color. … I don’t know, but you’ll know … just notice what number it’s on right now for how your [depression, discomfort, headache, helplessness] is feeling … remembering that a “12” [for example] is the worst it was, and zero is the best. … NO depression, NO headache, or discomfort. …

Typically, children or youth will offer a response quickly, for example “The ruler is plastic, it’s green, and the numbers are black, and it’s on 6, pretty depressed today but not terrible. …” With an unlimited variety of options, one might ask, “Would it be okay to have the 6 go down?” (or “… go down to a 5?”). Patients typically and quickly say, “Yes,” or, “Of course!”

One might then proceed to offer a variety of choices, such as the following:

I’m not sure how you will DO that … one kid I knew—he was younger than you—would always just imagine he was on an elevator … and when he felt about an 8 depressed, he would reach over in his mind and push 7 … and watch the light go off at 8 and on at 7 … and then he’d push 6 and watch the light … go … off at 7 and on at 6 … and then he got so good at helping himself this way that he’d skip floors … and take an express elevator right down to 2 … and then to zero. … And in his mind he’d get off the elevator … and the depressed feeling would be gone because he wanted to feel better and be the boss of it.

Or, one might say,

I knew this other girl who didn’t like elevators so she had her scale on one of those water slides … and the 12 was at the top of the ladder and the zero was in the cool, refreshing water … and she’d notice where she was at the start, like pretty depressed at about 9 or 10 or whatever … and then she’d picture herself on the slide and she’d slide down 10-9-8-7-6-5-4-3-2-1-0 SPLASH! … Into the water just at the same time as a smile would come on her face both IN her hypnosis and OUT of her hypnosis. …
Or, instead of providing a content-oriented suggestion, one might offer a process suggestion such as the following:

Just notice some other way of lowering the ruler that your mind comes up with, and enjoy that for a while ... and let me know when it has gone down as much as you want for today ... [then silent waiting for the patient to do his or her own internal work].

HYPNOSIS AND EGO STRENGTHENING

Beyond its positive value in any hypnotic encounter, ego strengthening is a necessary and liberally applied ingredient in the provision of hypnosis and self-hypnosis strategies for children struggling with depression. Ego-strengthening suggestions are intended to (a) increase the patient’s ability to cope by developing both self-confidence and competence (e.g., in anything desired and also in self-hypnosis), (b) reinforce self-reliance, and (c) help develop a positive self-image (Hartland, 1965, 1971).

With specific reference to depression, the intent of ego strengthening is to foster a sense of self-efficacy to counter the prevailing feelings of worthlessness, helplessness, hopelessness, and negative self-attributions characterizing the depression. Brown and Fromm (1986) suggested that there are three kinds of ego-strengthening suggestions: “general ego-strengthening suggestions, specific suggestions intended to facilitate the discovery and enhancement of the patient’s inner coping strategies, and specific suggestions to foster the patient’s sense of self-efficacy” (pp. 194–195). Thus, any positive suggestions for enhancing one’s self-worth and personal effectiveness are and should be used to facilitate ego strengthening.

Ego-strengthening opportunities are easily derived from careful history taking in which the clinician can and should be sure to focus not only upon the presenting concern but also upon identifying specific strengths and positive attributes of the child or adolescent. For example, we always make a point of asking children and adolescents, “What do you do best?” or “What are you best at?” in school, at home, or at play. We make a point of writing these down and telling the child, “I don’t want to forget what you tell me; it’s really important.” We write these down to be recalled and used later in the development of hypnotic suggestions. Similarly, we ask questions such as “What are your parents, grandparents, or teachers most proud of you for?” and “What will be different when this problem (sadness, trouble sleeping, stomachaches, etc.) is gone?” This kind of inquiry not only asks a “legitimate” question about expectations, hopes, and desires, and thereby provides potential material for future-oriented imagery, but also purposely includes the embedded, implicit suggestion that the problem will indeed be gone.
HYPNOSIS AND FUTURE (GOAL) ORIENTATION

Agreeing upon the targeted outcome of (hypnotic) treatment is integral to developing the key ingredients of positive expectations and motivation for “getting better.” Use of “split-screen” techniques, for example, provides easy access for children familiar with TV and computers to use natural talents of imagery to begin to allow the possibility of change. They may be invited to picture themselves as they are right now in a video on one TV screen in their mind, and on the other screen (or a split screen) to picture how they want to be in a day, a week, a month, or a year. A variety of suggestions may then be offered to invite them to experiment with that imagery, such as “Perhaps you can make the unpleasant TV image get dimmer and dimmer until it gets completely dark … while you’re making the desirable image grow brighter and brighter.” Or, perhaps, one might offer suggestions to “make one screen smaller and the other one bigger.” Or one could suggest the patient possibly imagine having someone come in and take the negative-image TV away and leave only the positive-image future TV there; or have the patient imagine the week, month, or year on the bottom or side of the screen of the TV and with positive imagery offer hypnoprojective suggestions based in presuppositions about when the positive change will occur.

For an example of such an approach, one might say,

... just look at that picture and see what it is you are doing that you are having so much fun! And look at how it just keeps getting better and you are happier and happier ... and so confident ... and grown up. ... I'm not sure how old you are ... but you'll be able to tell by seeing on the side or the bottom where there is a calendar ... and I don't know if it will be in days, like Thursday or Friday or Saturday ... or months like [current month, e.g., July] then August ... or days, like August 5, then 6th, 7th ... just notice it ... BECAUSE the more you do, the more it can really be that way because you want it to. ...

The use of an “affect bridge technique” may be very helpful to the depressed child who has a clear memory of having felt happier or better before feeling as “crummy,” “crappy,” “sad,” and so on as he or she does now. That clear memory awareness will allow the child to hypnotically age regress to that time, reexperience and reenjoy the different components of that memory and “remember” them in any number of imaginative ways, and then come back to the here and now while “bringing that good feeling back with you.”

The use of future-oriented projections is embedded in another strategy called the Magic Mirror. In this approach, the child can look in a special mirror and see him or herself in the future, “a day, week, month(s), years into the future. ... Look how great you look ... tell me what you see. ...” In analogous fashion, positive suggestions may be offered for a variety of targeted outcomes, such as developing internal images and expectations for ease of falling asleep, improved attention and increased success in school work, enhanced sports performance, greater comfort in personal interactions, or any other such positive goals.
The aims of such approaches are to acknowledge, see, and give voice to the desired outcome, image, or experience. Such approaches help establish an association within the clients to positive and empowering personal resources they can use to help themselves in specific situations.

TWO CASE EXAMPLES OF HYPNOTIC INTERVENTIONS FOR CHILDHOOD DEPRESSION

Case examples can highlight fundamental principles and guidelines regarding child hypnosis and, more specifically, approaches for problems of depression. Although hypnosis techniques and strategies must always carefully match the individual, this “tailoring” is especially important with children whose needs must be identified and met by considering where they are in their developmental/maturational trajectory. After all, 5 year olds are not the same as 8 year olds, nor are they the same as 12 year olds or 16 year olds, neither behaviorally nor developmentally, or therefore, in response to hypnosis. With this in mind, two different cases are described below that illustrate developmental differences and considerations in formulating age-appropriate hypnotic interventions for depression.

The Case of R.

R. was 12 ½ years old when he was referred to the first author (D.K.) by his school social worker for help with “sloughing off” in school, “acting up” in school, feeling anxious, and reporting he was having trouble sleeping. It was assumed that these symptoms could be related to depression, especially in view of his mother’s recent diagnosis of colon cancer.

R. presented as a pretty typical preadolescent, with little in the way of the language of feelings and a reluctance/refusal to talk about emotionally difficult subjects, such as his mother’s illness and treatment. His dad also had difficulty expressing his feelings about Mom’s illness. He was brought by his dad to the second visit. He reported he had liked our first visit (during which we had empathically gathered data and developed rapport through joining with R. and giving voice to some of the difficult feelings he undoubtedly was experiencing regarding his mother’s illness. Thus, when he declined to respond to open-ended questions about how he felt when he first learned of Mom’s diagnosis of cancer, he listened carefully to an empathic response that might be characterized as universalizing, which at once acknowledged possibilities of feelings without insisting he say his own feelings aloud, such as “It must have been quite a shock and scary to hear. A lot of kids tell me that when they hear the word cancer they think about dying and they get all sorts of different sad and confused feelings.” (He nodded in response, but said nothing.) In the second visit, he further shared that he was “feeling better” and “relieved” that Mom had just returned home and was recuperating from abdominal surgery in which “they removed half of her...
liver and put in a pump to give chemotherapy directly to the area.” With typical developmentally appropriate bravado and denial, R. said he was “sure that she will not die from this” and that “the doctor has said so, too.” Without any comment on this, I asked him what he had thought about when he considered if she did die. He was able to say—directly, but with detachment—“I’d be very sad.”

In the YSR Inventory, R. openly reflected a kind of pervasive sadness and angst that, on at least one level, he acknowledged as a function of his mom’s cancer. He said, “I can’t get my mind off certain thoughts: Mom’s cancer and how she’s doing.” As we discussed this, he said it sometimes causes problems in school by distracting him from paying attention in class. He also said, “I have nightmares [about Mom].” More generally, he noted that he is “too fearful or anxious.” Other revealing statements included the following: “I store up things [feelings!] I don’t need”; “I am stubborn; I have a hot temper”; “I have trouble sleeping … I think about Mom”; “I am sad”; and “I worry a lot.”

He noted that when his Mom was “really sick,” he couldn’t and didn’t do much homework, and his grades fell. But R. said that he was doing better now that she was doing better. He also reflected the common angst of early adolescence with concerns about friends, being liked, and so on. As with many teenagers, especially those who may have already had some contact with mental health care (e.g., a school social worker in R.’s case), there may already be a familiarity with psychological jargon.

I asked him directly if he ever thought he could be or already was “depressed.” He said, “Not really, just sad sometimes.”

His score on the CDI, confirmed my clinical impression of depression as reflected in his relatively muted affect. With regard to his specific response to a suicidality item on the CDI, I asked about the fact that he checked off that he had thought about killing himself but wouldn’t do it. He reiterated that he didn’t think he would do it and had never planned it, but just felt so bad sometimes that he wondered, “So why am I here?” It seemed more a kind of quasi-existential question than a suicidal idea. Determining that he was not at risk for suicide was, of course, integral to being able to both brainstorm with him and plan suitable clinical interventions.

Not until the fourth visit was there any formal introduction of hypnosis. This came about when he told me that the social worker who referred him had told him that I would show him a “cool computer” (biofeedback). Accordingly, computerized biofeedback was introduced with training in electrodermal activity (EDA) and in electromyography (EMG). The purpose was to provide a metaphor for the relationship between mind and body so that he could “see” in front of him the changes in physical measures (galvanic skin response, or electrodermal activity) in response to a change in feeling. After explaining how biofeedback “works” and familiarizing him with EMG and EDA, he was then asked, “Just think about something that made you angry.” He was able to see the almost immediate and predictable response of abrupt, dramatic elevation in EDA. He was also able to see the gradual return to “normal” when he was told, “Okay, now
DEPRESSION IN CHILDREN AND YOUTH

forget about that … put that thought out of your mind.” So telling him offered
the implicit suggestion, expectation, and belief that one can indeed “put thoughts
out of your mind” that quickly, and the “proof” was in the concomitant demon-
strable change in physiology (“Computers don’t lie”; Culbert, Reaney, & Kohen,
1994).

Then the following hypnotic suggestions were offered to R. during biofeed-
back as he sat with his eyes closed:

Now discover just how very comfortable you can become as you close your eyes
… you can forget about the biofeedback for now and let your mind wander … to
something you enjoy very much … like how well you play soccer … great … notice
everything about it … how fast you run and how well you pass … and dribble …
and defend … and how from time to time you do a header as needed … using your
head the right way at the right time … like you are using your head the right way
for NOW, too. … And as you enjoy knowing that you use your head well these ways
… perhaps you’ll notice your parents on the sidelines watching and cheering for
you and your team … and what a good feeling it is to know you have your Mom
and Dad in your mind this way whenever you want … helping and cheering for
you … just as you cheer for and help them in other parts of your lives together. …

This hypnotic experience ended the computerized biofeedback session and
was followed by a review and printing out of recorded results with the intent that
they be used as an anchor (i.e., associational cue) at home to recall the ease with
which his mind and body could work together. This was reinforced with a so-
called waking suggestion: “This is something that you can take home and look
at later to remind you of what you are really capable of doing to help yourself
focus, be calm, and fall asleep easily when you want.”

The value of the hypnotic experience and the conversation about it afterward
involved multiple levels of meaning. Perhaps most importantly, it allowed for
furthering our rapport. Soccer, his favorite activity, was employed as a model for
believing in the value of focus, the reality of his personal effectiveness, while
conveying the importance of the value of practice to improve anything. Then, in
a more formalized training of relaxation and imagery, further direct mention was
made at multiple levels of meaning how the mind’s focus can help change the
body’s function. “Evidence” or “proof” of this, important particularly to a doubting
and sensitive, bright young adolescent, was then presented to him. The evidence
came from the beginning of the session when it was pointed out directly to him
that from simple eye closure and his focus on internal imagery, an alteration
of his breathing rate followed rather “abruptly” and “effortlessly.” As further
evidence, his muscle tension dissipated measurably, “all without your really
meaning to do so.” From this apparently objective truth, we were then able to
begin extrapolating that ability to other areas of concern through suggestions “to
use your focusing ability to fall asleep more easily by focusing or ‘emptying’ or
‘slowing’ your mind, and [offering a motivating suggestion] enjoy discovering
the value of good sleep toward providing more energy to be able to successfully
and effectively navigate the next day.” And, during hypnosis, R. was also told how this same focusing skill might be used in other beneficial ways:

And so, before you finish this experience … you can let your inner mind remind you of how cool it really is … that our expectations have an impact on outcomes … on how we sleep … on how we focus attention. … Sadness is normal … and as we let it decrease and drift away, it doesn’t have to be immobilizing. … Instead, we expect that as we focus and practice … we’ll be able to do well in school … and in soccer … and the other things we do. …

As he acknowledged early in our clinical relationship, R. had always been troubled by getting stuck in negative self-talk, for example “can’t get my mind off my Mom.” As such ruminations often do (Yapko, 1992), R.’s have had substantial negative effects in promoting both his anxiety and the symptoms of his depression, especially difficulty in concentration in school and on homework, and trouble falling asleep. Reduction of these symptoms with hypnosis have been integral to R.’s progress, improvement, and self-confidence that he can manage difficult, awful feelings.

Although a selective serotonin reuptake inhibitor (SSRI) medication (fluoxetine) had been prescribed, in a much more dramatic way, the relationship between R. and his mother has been the most important antidepressant. Medication has clearly been less important to relieving his depression than has being able to talk about his concerns about his mother and her health issues. His mother has been a good role model: Courageous, inspiring, and positive in her struggle with cancer, she is a “glass is half full” optimist but also a realist who, throughout her odyssey, has been forthright and honest with R. She has encouraged, even insisted upon, his continued positive efforts, not only in school but also in self-care. She gently pushed him to take charge of his depression rather than passively allowing it to take charge of him. The results: His insomnia has disappeared, and his school performance has improved. He is “up and down” along with his mother’s status, as anyone would be to some extent, but now he is able to notice it, discuss it, and more effectively manage it. A year later he asked again, “Show me again how to fall asleep with self-hypnosis.” I did … and he did.

Over time, R.’s depressed mood, anxiety, and school performance have remained a kind of bellwether of his mom’s cancer; thus, when she feels bad or is doing poorly, so he feels worse, down, and frightened. However, through his hypnotic work, he has come to recognize, acknowledge, and be able to talk about that connection in an accepting and positive way. And, as this awareness has grown, so is that his being a barometer of his mom’s status has decreased in intensity and duration sufficiently that it has much less of an impact on his ability to function. As such, his self-hypnosis has not only provided relief of symptoms but also impacted the associated dysfunctional patterns that had contributed substantially to maintaining his depression (Yapko, 1992). Much as a traditional cognitive-behavioral therapy approach might advocate in attempting to curtail
negative ruminations, R. now successfully applies self-hypnosis to reduce or eliminate obsessive thinking; to confront, discuss, and modulate rather than avoid difficult feelings; and to counter his helpless feelings through self-comforting.

The Case of J.

J. was 14 ½ years old when she was referred to the first author (D.K.) by her family physician and pediatric neurologist for help with chronic, daily headaches refractory to other interventions. J.’s history was obtained from her in an interview and from her completed Achenbach CBCL and YSR inventories, a headache questionnaire, a handwritten note from her mother, and later, her completed CDI.

J. began ninth grade in the fall of 1999, a few months before our first visit. Mother was present in the first session and described J., an average student, as “gregarious, wonderful with small children, thoughtful, and loving toward her family. She enjoys golf, fishing, rollerblading, plays piano and trumpet, enjoys cards, and is in the school science and drama clubs.”

J. told me at our first visit, “I have headaches.” Responding by “being hypnotic” (i.e., using naturally occurring hypnotic phenomena and talking hypnotically in the context of the “ordinary interview”), I invited J. to “take your mind back to the very first headache you ever had.” (Note: This interview is “seamless”; there is no formal delineation that indicates, “Now we’re taking a history … and now we’re doing something called hypnosis.” We believe suggestion is inevitable in clinical interaction, with or without the formality of a structured induction process.) This so-called waking suggestion and, functionally, invitation to regress is different from the question, “When was your very first headache?” It is posed as a matter-of-fact invitation with the implied expectation that she can and will “do” it, that is, regress.

J. paused for several minutes, stared off into the distance (in a spontaneous hypnotic state), then looked up and said, “It was a headache that didn’t go away, and it was January 1998.” She remembered telling her mother about it. She got no relief from over-the-counter analgesics, and the headache was so severe that the school nurse called Mom to take J. home from school. Mom reported, “You could see that she wasn’t feeling well … she was flushed, tired, and feeling hot.” This seemed different from a “regular headache” by being “stronger.” On an introduced scale of 0 to 12, with 0 indicating feeling fine and 12 indicating the worst imaginable headache, J. said that the new headache was a “7 or 8.” Before that, random headaches were perceived as a “3 or 4.”

After the headache recurred daily for a month, the family doctor prescribed acetaminophen with codeine that, J. said in thinking about it, now allowed the “7 to 8” to go down to a “2.” The doctor also prescribed amitryptaline as a “mild antidepressant that often helps.” However, because Mom noted that J. “is so sensitive to all drugs and got so sleepy,” they stopped both medications. Their family doctor referred them to a university pediatric neurologist. Depakote was
prescribed, but “it was no help and she just slept a lot,” so it was discontinued after only a couple of weeks.

A sleep-deprived EEG was done, and it was reported that J. showed a “possibility of having small seizures.” However, she never had a seizure either before or after the EEG. An MRI was normal. Carbamazepine (an anticonvulsant) was prescribed as a precaution, but complaints of substantial sleepiness led to its discontinuation.

A decision was then made to “keep her on nothing and see how she does.” After daily headaches for 13 months, the neurologist recommended a referral to the first author (D.K.) with the enthusiastic suggestion that “he will probably be able to help you.”

As noted, the history was obtained in a hypnotic fashion, that is, by doing it hypnotically, offering positive suggestions in context and embedded in multiple levels of meaning, all while learning about her headaches. When I asked the somewhat peculiar, perhaps even “stupid-sounding” question, “Do you need the headache for anything?” J. readily said, “No.” Similarly, when I asked, “Will you miss the headaches when they’re gone?” (these are embedded suggestions for establishing expectations that they will be gone), she replied, “No.” When I asked, “What will be different when they’re gone?” she said, (a) “I’d feel better,” and (b) “I’d be happy, relieved that they’re actually gone.” When asked what her main feeling was when she had a headache, she did not say “pain” or “bad,” but instead “mostly feeling sad and mad.”

Two kinds of headaches were described: (a) a “regular” tension or stress headache, which is “always” present and averages “7 to 8”; and (b) migraines every month or two, which are “7 to 8” and higher, last much longer, and are accompanied by nausea without vomiting, flushing, feeling hot, pallor, and dizziness; are bitemporal; and are associated with substantial fatigue. She initially reported no aura. J. reported three very specific dates she’d had migraines: (a) on her father’s birthday, (b) on the day her father died (having become abruptly ill 12 days earlier, and (c) while vacationing in Texas where they used to live. When I asked J., “Would you tell me about your Dad?” she quietly shook her head in refusal as tears welled up. She nodded when I asked, “Perhaps at another visit we can talk about him?” and she spoke very little for the rest of our initial visit.

J. reflected a reasonable range of affect, clearly contemplated before responding, and was able to laugh. In contrast, when the death of her father was mentioned about halfway through the session, she became teary, declined to discuss it further, and was much quieter thereafter. She gave an overall impression of being depressed, even though a range of affect was seen. Although the CDI did not confirm this clinical impression, I believed that the CDI accurately reflected her denial, her for-the-moment reasonable coping skills, and how she wished to be perceived at this initial contact.

The empowering idea of self-monitoring leading to self-regulation was introduced with a nice connection to the 0 to 12 scale described earlier, which she
agreed to use daily to keep track of her headaches. Positive expectations were suggested with the metaphoric directive to “leave your headaches here in my file cabinet.” I told her that I was 100% certain I could help her to help herself, providing that she didn’t need the headaches for anything. She seemed to resonate with this idea and agreed she had no need for the headaches.

My assessment of J. after this first 1-hour visit was as follows: chronic daily headache spanning 18 months involving a combination of tension and migraine headache presumably reflecting a somatic representation of depression, at least in part related to grief surrounding the death of her father 3 years earlier. There was a vague history of depressed mood that may have predated her father’s illness and death.

It was clear during the first visit that J. showed elements of spontaneous hypnotic regression in response to invitations to consider the origins and timing of prior headaches and migraines. It was also apparent that her relationship with her now deceased father was very significant in the onset and course of her headaches. I considered the likely possibility that the headaches were a somatic representation of her ongoing, unresolved grief. J. agreed with Mom’s perspective that stress played a big role; she defined stress as “pressure,” such as pressure to perform coming from school or a parent (mother).

The questionnaires revealed that her headaches occurred daily, she had no (conscious) idea what triggered them, and there was a history of migraine in her father (who died in 1996). Additional history noted that J. had daily headaches in the fourth grade, no medications helped her, and they disappeared abruptly. In February 1995, her grandfather (who lived in town) died. Later that year (October 1995), her other grandfather (who lived out of state) died, and in February 1996, her father died after being in the hospital only 12 days. In August 1997, Mom’s grandmother (J.’s great-grandmother) died. In describing some of this history, Mom wrote, “In August, 1997, my grandmother (J.’s great-grandmother) died. J. had been very close to her.” When school started (the fall of 1997), J. “fell apart,” saying she couldn’t cope. At that time the school reportedly “tested her for clinical depression,” but the “numbers weren’t high enough to warrant medication.” Although she met with the school counselor weekly, she didn’t really improve. After the Christmas holiday, J.’s grades were dropping, she was distraught, and within two weeks she had her first headache and was sent home from school. J. was 11 years old (Mom was 43 and retired from the U.S. Army) when Dad died. He was retired from the Air Force. J. has a sister 4 years younger than she.

Second Visit: First Private Visit. After J. reviewed her self-monitoring diary and reported, “I don’t have any headaches lower than a ‘6,’ but they are ‘up and down,’” in response I told her a story about a girl I had known once who had a problem with abdominal pain and created two self-monitoring scales, one for stomachaches and one for how she was dealing with them. She liked that story. Then I asked her if she knew what would be best to talk about. She nodded sadly
and began to talk about the many deaths in her life. She began, “Uncle Bobby died when I was 2 or 3 years old. He was 30 years old, my Dad’s brother … he died from diabetes.” She said, “I didn’t know what it was. …” (The *it* she referred to was death, not diabetes.) A few tears came, and she said she remembered feeling sad. I commented, “That’s very hard when someone’s only 3 … it must have been nice to have some grown-ups around to help.” She agreed. (This “waking hypnotic suggestion” set the stage for other grown-ups, including me, to be seen as “helpers,” and to see herself later as having become more “grown-up” and become her own helper.)

Asked who was next, she said her paternal grandfather died when she was 10 years old. She heard about it in a phone call from her great-aunt. She explained, “He was a smoker.” She added, “We didn’t go to the funeral because neither Mom or Dad could get time off to go.” With therapeutic intent, I asked her what she was thinking back then when she found out. She said, “Why now?” and cried more. She said that she had even discussed this in this way with her mom.

J.’s maternal grandfather died next. He had been sick, and Mom went out of town to see him. Although they had not seen one another for quite a while “because he was too sick for them to travel,” J. said they “would be in touch by phone and get Christmas presents and stuff.” She said that Mom was there when he died, and she felt surprised and sad when Mom called to say that Grampa had died. She said, “Mom went to the funeral and stayed there a few days.”

J. was then able to talk about her father’s death. As she did, she began to sob, spontaneously regressing to that obviously emotional time. She described how she found out he had died: Mom picked her and her sister up from school and told them, “I took Dad to the hospital; he’s sick.” J. described seeing Dad at the hospital and how he “looked very sick, pale, and was delirious.” Shortly after that glimpse of him, they saw him being rushed to the intensive care unit (ICU). J. and her sister had to wait in the waiting room but eventually got to see him in ICU “with all these tubes in him and he was unconscious and he couldn’t breathe on his own” (sobbing). Aware of her spontaneous trance and the obvious sadness in recalling the hurtful memory, I offered a reframing suggestion with the observation, “He must have been glad to see you,” and she shifted, smiling, however briefly. She went on to say, “In 12 days we had to take him off the ventilator … the doctors advised it, they said they didn’t think he’d regain consciousness.” When they did this, she was at school. Her mother and her teacher told her that they had turned off the ventilator and that he was going to die. He died the following day, just over 3 years prior to our first visit.

As I encouraged J. to talk about it further, she did so in a clear and spontaneous hypnotic state, regressed to the time of the funeral. She spoke of sitting in the front and reported that “the church is full of people.” Offering positive suggestions to help create an affect bridge and reframe the sadness of the memory, I observed that J.’s dad must have been a nice guy and had lots of friends. J. liked that comment a lot and acknowledged that she, too, had a very positive relationship with her father and they had enjoyed a lot of good times together.
With therapeutic intent, I introduced J. to a 0 to 100 Subjective Units of Distress Scale with 100 indicating one’s worst sadness and 0 indicating one’s best happiness. Using this framework to help her guide her own history and to revivify the experience in a modulated fashion, I asked her to give the ratings (now) at different times (then). The interaction went as follows:

DPK: What number was it at the time of his death?  
J.: Pretty close to 100, high 90s.  
DPK: What about a year later, like when you were 12 years old?  
J.: I was really sad, crying, 80s.  
DPK: How about when you were 13 years old?  
J.: Not as sad, but still sad, about 60 something …  
DPK: How about a few months ago, three years after he died? (She was 14 years old 4 months earlier,)  
J.: I couldn’t think of it that day ’cause I was taking an important test … but 40s and 50s I think. (This revealed her internal resources and ability to compartmentalize her feelings while also allowing herself to become aware of how her perceptions and coping have evolved over time.)  
DPK: Now today?  
J: 30s.  

I asked about her thoughts at the moment and she said, “I wish he could see me now.” J. verified that she has pictures of her and her dad together, and that although she of course feels sadness now, it is different from the way it was then.  

As this first private visit came to an end, I asked J. if she thought that being sad and missing her dad had anything to do with her headaches, and she said, “Yes,” very definitively. I told her in clearly hypnotic-like language and demeanor that sometimes people are very surprised that after they have let difficult feelings out, just as she did today, those feelings don’t have to bother or disturb them in the same way, and that they may not have to “come out sideways,” such as through headaches or stomachaches. She liked this idea, reflecting her new understanding that she could begin to be empowered to “be the boss of the headaches” instead of the headaches being the boss of her. And, at the same time, of course, she could be the “boss” of her grief response, too.  

I remember musing to myself afterward that she had been in a spontaneous trance throughout what had evolved into a grief counseling/therapy visit. It occurred to me that by paying even more careful attention to her naturalistic trance and joining with her, I was “being hypnotic,” and that becoming more consciously aware of that after the fact would (and did) allow me to be even better at facilitating her informal and formal trance work in future sessions.  

At the third visit, J. was asked to inform the resident who was joining us for the visit why she had come over to see me. She said, “I have headaches. I’ve had them almost a year, and I can’t get rid of ’em …” She accepted my addition of “…. YET!”
J. then quite spontaneously brought up that we had “talked about death” most of our previous visit. She became sad as she discussed this, and tearful, turning her head away to look out the window. I observed aloud, ostensibly for the resident’s benefit, that a lot of people J. cared about had died and that it was hard to manage. I reminded her, and then J. recalled, that I had talked about the fact that it was good and right to cry because “when we let out feelings that are inside, like through crying or talking about them, then those feelings can’t come out ‘sideways’ or some other way to bother us … like …” I paused and waited for her to finish my sentence, and she stated matter-of-factly, “headaches.”

A more formal introduction to clinical hypnosis was given to J. first through her viewing a videotape called *Children and Hypnosis* (WCCO Television News, 1991) featuring our treatment program. The tape happens to include a young teenage boy talking about how he had used self-hypnosis to help him with headaches. Next, we had a discussion and an opportunity to demystify hypnosis. Both J. and her mother viewed the video. When I asked J. specifically about hypnosis and the process of hypnotizing, she said she had seen it on TV where they “showed a guy with a watch and he makes you fall asleep and tells you that you are feeling sleepy and then tells you to ‘wake up!’ and do or say strange things.”

I used this opportunity to talk about what hypnosis is and is not, emphasizing that all hypnosis is self-hypnosis and that there is no such thing as someone “hypnotizing” someone else. I told her that clinicians (like me) are essentially coaches, teachers, and helpers. I also told her that hypnosis involves imagination and relaxation, and is used by athletes, performers, musicians, actors, and anyone who wants to do something well in order to focus, concentrate, and do their best.

Mom then spontaneously talked about the natural hypnotic state she achieves while playing the organ in church, and I talked about how musicians hear the music in their minds. Because she plays both trumpet and piano, J. was at once able to relate to her mom’s modeling of positive personal experience with self-hypnosis as a musician. She was able to resonate easily with this description of the value of different states of mind. She learned a self-hypnosis technique I taught her readily.

During hypnosis, J. was invited to “see the color of headache.” With a look of surprise on her face, she said, “Red!” She was asked the “color of no headache,” and she answered, “White.”

**DPK:** See that ruler in your mind that measures headache. … What does it look like?

**J.:** It’s blue plastic.

**DPK:** And the numbers?

**J.:** They’re black.

**DPK:** Just notice what number your head is on right now ... it might be noticed by a light around it or by an arrow, or whatever.

**J.:** It’s on 6.
DPK: Would it be okay for it go lower?
J.: Yes.

DPK: I don’t know how you’ll do that … one kid I knew … whenever he’d have a headache … he’d imagine he was on an elevator … like on the 7th floor if he had a “7” headache … and he’d picture himself pushing the button for 6 and watching the light go off at 7 and on at 6 … and then he’d push 5 and watch it go off at 6 and on at 5 … and then 3 … until he got to 0 and got off the elevator without a headache.

… This young woman I knew … she was 18 … loved to ride horses … and whenever she had a headache … she’d imagine she was riding her horse on the beach … and there’d be a big 0 to 12 ruler written in the sand … and if she had a 9 headache … she’d ride the horse along the ruler, beginning at 9 … and its hooves would kind of erase the 9 … then the 8 … then the 7 … all the way down to 0 … I’m not sure how you’ll lower yours, but I’m sure you’ll discover that surprisingly soon. …

At the end, J. was encouraged to “just practice this at home at night and in the morning. … Do it by imagining something fun, do your hypnosis for a few minutes and practice lowering it down, and record on your calendar when you have practiced.” She was very agreeable to the idea of regular practice.

At her next visit, J. reported that “hypnosis is relaxing and daydreaming. I thought about walking in the woods; that’s how I relaxed. And my headaches got better; now I don’t have any above ‘7’ any more!” Her calendar of self-monitoring showed that J. was indeed remarkably improved! Her average headache rating had been 9.1 at the last visit, and in the ensuing 2 weeks improved by 33% to an average of 6.0. On her scale of paying attention to it, her previous average rating was 6.18, and this too decreased by 33% to an average self-rating of 4.1.

J. practiced self-hypnosis 20 to 30 minutes nightly. She imagined walking through leaves, climbing trees, and going up in deer stands, and “sometimes I run with Magic (her dog). Sometimes I just watch a headache get smaller and smaller … it just goes away.”

At the third hypnosis session, additional therapeutic suggestions given to J. included “paying attention to tension and how tension goes away and the way that you do that,” and ego-strengthening suggestions focused upon “being proud of what you have done for yourself and for giving yourself this gift of your own imagination and being the boss of how you feel.” (This was intended to help generalize the metaphor of empowerment from headaches to “how you feel” more generically.) An audiotape was given to J. for her to use as needed.

By the follow-up visit 4 weeks later, J. glowingly reported that she had no headaches in the preceding four weeks! Ten weeks later J. remained well, happily telling me and the visiting resident that “I came here ’cause I had headaches for a long, long, long time, like every day, and I learned self-hypnosis and I got better and now I have no headaches ever.”
At her eighth visit 10 weeks later, J. reported that she had remained headache free for what was now 4 ½ months. Asked why she thought she had no more headaches, she said quite matter-of-factly, “Because of self-hypnosis. … I do it before I get a headache. … I know when I’m gonna get one because I can feel it in the back of my eyes.” We had never previously and explicitly discussed “auras,” so we did today. Her aura is described as a sensation in the back of her eyes, and she says, “I just feel it.” There is no apparent smell, taste, or other feeling or “difference” associated with this sensation.

She says that the sense that she “might” get a headache still happens once a week, usually in the afternoon, but stated, “I just do my self-hypnosis and it goes away!”

Because her headaches have disappeared, she is no longer practicing self-hypnosis as regularly but still does it once or twice a week. Perhaps most tellingly, she said she has not felt much sadness at all in the past 4 months. My sense of J.’s healing is that resolution of her depression took place unconsciously while she managed the manifestations, that is, her headaches, both unconsciously through self-hypnosis and with cognitive management strategies including self-monitoring, “traditional talk-therapy.”

Though we never discussed it per se, she learned clearly and quickly that avoidance (of talking about the depth of her grief over the death of so many relatives and especially her father) was a maladaptive coping strategy that drove her symptomatology (to daily and severe headaches). Being able to shift the way in which she coped and continues to cope with losses in her life allowed her to become not only headache free but also free of suffering from both prolonged bereavement and depression.

INDICATIONS AND CONTRAINDICATIONS

In applying hypnotic strategies for children and youth, whether for depression or for any other problem, techniques must be applied according to the individual’s level of developmental maturation and capacity to understand as well as to the specific behavioral characteristics and manifestations of their individual problems (“diagnoses”). For R., at 12 years old, it would have been inappropriate to talk about pretending, for example, because that is what younger children do and reflects the way they understand hypnotic phenomena and behavior. Instead, it was natural to invite him to use his imagination to construct a game of soccer in which he was being very successful, and in the context of that successful imagery discover how his mind could help his body to “automatically” relax. In his case, this allowed for two goals (extending the soccer metaphor!) to be met: (a) easing the problem of falling asleep and (b) easing the “getting stuck” feeling of dwelling on his mother’s illness, then feeling so sad and preoccupied as to prevent experiencing pleasure, interfere with his homework, cause him to get behind in school, and so on.
In J.’s case, learning imagery was a key to discovering that relaxation of the mind could be manifested in relaxation of the body and, in turn, the elimination of headaches. Because of her level of maturation at 14 years old, one could present the metaphor of being able to focus her mind on happy activities without dwelling on the sadness of the death of her father and other relatives, and having it “come out sideways” as headaches. Her greater maturity also allowed for us to speak openly, that is, “out of hypnosis,” about the value of positive memory and ways to recall deceased relatives without having to be immobilized by the sadness of their deaths.

**INDICATIONS FOR THE SELECTED STRATEGY**

Decisions regarding indications for a particular strategy depend entirely upon having an understanding of normal child development, taking a careful history, developing rapport, and trusting one’s intuition to listen carefully to children and, as noted, “go with the patient.”

Really listening means being able to give back to children in and out of hypnosis their own beliefs, ideas, goals, and positive expectations, reframed to fit with who they are, where they are developmentally, and what the goals of treatment are. This is accomplished not only through careful listening but also by making and taking careful notes (written, as needed, or audio- or videotaped), including sometimes using the precise wording and phraseology they used in a new context or a new way in order to maximize the transforming effect. Thus, I often ask children, “I hope it’s okay with you that I take some notes … I want to remember exactly what you tell me—they’re really important things.” This is true and drives rapport positively. Later I will use the precise language of the child or teen in the formulation of suggestions and strategies.

Both in formal hypnosis and in offering reframings of possible ways of thinking about and talking about things, I tell patients why I do this when I say, Because … how we talk is how we think, and how we think is how we feel deep inside, so one very important way to change how we feel is to start by paying attention to the words we use, and beginning to make changes that way. …

Contraindications to hypnosis with children are only relative … and largely only when relatives are interfering! Effective use of hypnosis is also hindered when it is the parent who is motivated to make a change in the child and not the child or teen who wants to or needs to, or recognizes the need to make a change in him or herself. In rare circumstances when rapport does not seem to be evolving, the clinician must allow him or herself to be aware of this and be willing in the best interest of the patient to consider referring him or her to a colleague.
SUMMARY AND CONCLUSIONS

Making the diagnosis of depression in children and adolescents is an essential beginning to getting help for them, that is, to help them identify and utilize more effectively the antidepressant qualities and abilities within themselves. Toward that end, it’s imperative to allow our young patients to let us know what it is that they need. If we will only listen, and watch, and wait, they will often lead us—and themselves—in a meaningful direction. And, when we follow properly, we can in turn lead them—teach them—to lead themselves back to health.

As reflected in the cases discussed above, we believe all problems can be broken down into three components: (a) the problem itself, for example, the depression, the new acting-out behavior, the increased anxiety, the increasingly frequent headaches, or whatever the presenting problem(s) might be; (b) the youth’s reaction and adjustment to the symptom(s), and his or her style of coping with it (them); and (c) the family’s reaction and adjustment to, and style of coping with, the problem(s). To attend to one or the other of these without appreciating and attending to all of them is to do a disservice to the youngster and to miss the opportunities for added clarity and paths to healing. All must be done in the context of the uniqueness and specificity of the youth’s family, culture, environment, personality, and perhaps most importantly, strengths. As noted, this is accomplished through careful, ongoing focus upon history, rapport, and noticing (careful observation).

We must notice, attend to, and help young people utilize their verbal and nonverbal “reactivity” or responsivity. In the midst of the urgency of identifying symptoms, making diagnoses, and formulating treatment plans, we must remember to identify and focus upon strengths: What do you do best? We know that perceptions affect mood. Is it hypnotic to “simply” ask that kind of question? Of course, because it is inherently suggestive of a specific focus and is even more meaningful when one can ask such questions seemingly spontaneously and therefore integrate them seamlessly into the context of an interview, a formal session, or an informal conversation.

We tend to allow this kind of suggestive questioning to “happen” and unfold in the context of an initial visit. Strength-based questions do not get “asked” in any formalized or structured fashion. On the contrary, they are asked at what intuitively seems the “right” time. These tend to be times when there is a lull in the (first) conversation with a new young patient. It may be a second or third conversation with an adolescent, especially if he or she has become “therapy wise” and therapy aversive, or is very angry or very depressed. Rapport in such instances is a paramount concern; it may take a few encounters to build enough rapport to get to a place where teens are willing to acknowledge or divulge something as personal as what they think they do best.

In contrast, a younger child, for example, ages 6 to 12, may much more easily share a strength in a spontaneous fashion. Thus, lulls in conversation
occur either when there is genuine uncertainty by the child about what to say next, or when talking about “the problem” has gotten too difficult, too painful, or too “close” to something important and hard to share. “Honoring” that reluctance or uncertainty may eventually prove to be a path toward increasingly positive rapport. Thus, asking a child, “So, what do you do best?” may serve both as a relief (that you changed the subject or that you stopped pursuing that “hard-to-talk-about stuff,” at least for now) as well as important evidence that you are indeed interested in him or her as a person, and not only as someone with headaches or anxiety (or whatever). This, of course, drives the rapport in a positive direction.

So, is it hypnotic? From yet another perspective it is, to the extent that it represents a disruption of the “No” set that most people (parents for sure!) bring to the clinical encounter. Yes, it is hypnotic to the degree that it can “fit” into that nice and important category of ego strengthening fundamental to all good hypnotic work and therapeutic communication.

As reflected in the case examples, we teach skills to manage moods and cope with problems and bad times. We teach people what to do with anger, disappointment, frustration, and emotional pain. We validate and reinforce young people’s own choices of what “works”—at least to the degree that it “helps” even temporarily (but not necessarily to the degree that what is working may also be hurting.) Thus, “checking out” by listening to music, for example, is fine to the degree that the adolescent is aware of the purpose and nature of his or her checking out, for example, to allow modulation of mood, but not to the extent that it interferes with, disrupts, or even prevents more potentially self-empowering behaviors, such as meeting the responsibilities associated with school, job, or family.

Children and youth have many more positive attributes and abilities than they consciously realize, and more than most adults give them credit for having. Working hypnotically allows us to help them develop not only awareness of their many strengths but also confidence and faith in, and development of, the variety of other coping strategies, life skills, and problem solving available to them as they navigate the challenges of their ongoing development. Self-hypnosis training facilitates the maturation, evolution, and expression of positive coping and developmental attributes. They find their expression in positive outcomes that are based on (our and their) positive expectations and motivation for change.

**EDITOR’S SUMMARY**

- Depression in children was historically considered so unlikely that no such category was included in diagnostic classification systems until the most recent *DSM-IV*. As a result, the scientific literature on children’s depression is underdeveloped.
Children and adolescents are the fastest growing demographic group of depression sufferers according to recent epidemiological surveys. Signs and symptoms of childhood depression appear to parallel those of adults, but any troublesome behavior, especially if recent in onset, may be an indicator. Diagnosis can be made through a combination of clinical interviewing and the use of standardized assessment instruments such as the Child Depression Inventory (CDI). Having a depressed parent is a strong risk factor for a child’s developing depression, primarily because of ineffective patterns (e.g., negative attributional style and avoidant coping) modeled through the parent’s behavior. The use of hypnosis to treat depression in children has received very little consideration in the scientific literature thus far despite its merits in clinical practice. Addressing children’s understanding of their feelings, expectations, and motivations, and identifying their resources to mobilize in therapy, are all important considerations in developing a treatment plan. Meeting the child at his or her frame of reference is considered vital to the treatment process. Hypnotic strategies are provided for helping children better describe their feelings, enhance ego strength, and develop a goal orientation. Two detailed case examples of hypnotic interventions are also provided.

REFERENCES


INTRODUCTION

At one time, hypnosis was considered contraindicated for the treatment of depression. As recently as 15 years ago, a well-respected text on hypnotic suggestion cautioned practitioners to be careful in using this approach with depressed individuals because “the severity of depression may be exacerbated through uncovering of emotion-laden material” (Hammond, 1990, p. 330). Thanks to more refined current investigations, however, we have learned that hypnotic intervention can address root cause variables as well as specific symptoms (Yapko, 1996, 2001, 2003).

Yapko (2001) has presented a clear rationale for using hypnosis with depressed individuals. He pointed out that hypnosis can be used to amplify positive resources to promote more adaptive and functional patterns of experience, as well as to address problem areas that most influence the client’s subjective experience of depression. These include physiological, cognitive, affective, behavioral, relational, symbolic, and historical dimensions (Yapko, 1988).

Both direct and indirect strategies of hypnotic suggestion have been studied (Johnson, 2001; Yapko, 1993). Indirect approaches effectively utilize the individual patient’s experience and belief systems in order to provide solutions for
Depressive patterns of behavior. As Johnson (2001) pointed out, the past literature on treatment of depression has been limited in suggesting that depression is a unitary or one-dimensional condition and that all depressed patients must go through the same restorative process. More formal and direct clinical techniques of hypnosis have also been applied to achieve therapeutic gains with this syndrome. This chapter examines how direct and indirect hypnotic suggestions can be used specifically to treat symptoms of depression and chronic pain that often coexist as two of the sequelae of posttraumatic stress disorder (PTSD).

DEPRESSION, PAIN, AND PTSD

Recent advances in psychoneuroimmunology (PNI) research have indicated a strong connection between emotional and physical pain (Dillard, 2002; Melzack & Wall, 1973). For example, antidepressants that increase levels of serotonin and norepinephrine in the limbic system can also decrease chronic pain for many individuals. Pain and emotions share common nerve pathways from the periphery of the body to the spinal cord, where they are sorted for intensity and forwarded to the brain. Positron emission tomography (PET) scans of chronic pain patients that record blood flow in the brain show simultaneous activation of two areas of the brain: the sensory-motor cortex, where sensation is registered, and the limbic system, the center of emotions (Dillard, 2002).

A common phenomenon that tends to elicit the dual conditions of emotional and physical pain is trauma, and the ensuing posttraumatic stress condition. Patients diagnosed with PTSD, for example, tend to have a high comorbidity incidence of depression. The National Comorbidity Survey (Kessler et al., 1994; Wittchen & Kendler, 1994) showed that 48% of men and 49% of women with a lifetime history of PTSD also had a lifetime history of major depression. Other research has indicated that PTSD and major depression each increase the risk of developing the other condition after exposure to traumatic events (Breslau, Davis, Andreski, Federman, & Anthony, 1998).

Allen (2001) noted several important connections between trauma and depression. First, many clients with a significant trauma history seek treatment because they are feeling depressed and suicidal; therefore, treatment of depression may be a common entry point for posttraumatic patients. Second, the current stressors that precipitate a severe depressive episode may be the “last straw” in a developmental sequence of stressors that originated in childhood trauma and neglect. Third, clients who feel emotionally hopeless usually report symptoms of physical depletion and/or other somatic symptoms such as pain. Allen concluded that depression is, like PTSD, a disorder of cumulative stress. Other experts (Davidson & van der Kolk, 1996) have indicated that when depression occurs along with PTSD, this syndrome may be both psychologically and biologically distinct from major depression occurring without PTSD. There are also indications that depression
DEPRESSION, PTSD, AND CHRONIC PAIN

occurring with PTSD may be more resistant to standard antidepressants and other forms of treatment.

There is also evidence to link PTSD and chronic pain. In fact, many experts believe that trauma is one of the bridges between the multiple mechanisms of pain (Scaer, 2001). A large percentage of chronic pain is the result of physical trauma such as muscular, tissue, joint, or nerve injury. Unresolved shock resulting from many types of trauma that have been held in the body is also a major contributor to pain (Levine, 1997). This can include reactions to medical diagnoses of a life-threatening illness such as cancer and AIDS, accidents and injuries to the body, and responses to intrusive medical procedures, including surgery. In the case of surgery, for example, it is widely accepted that many patients report depression as an aftermath of various types of surgery; it is less well documented that depressed patients may experience more tissue damage and longer recovery time than nondepressed patients (Barabasz & Watkins, 2005). In addition to these posttraumatic factors, somatoform dissociation, conversion, and other defenses related to unresolved emotional pain from trauma may also contribute to chronic pain conditions (Nijenhuis, 2004).

Comorbidity of childhood abuse and chronic pain has been especially well documented. For example, studies show similar biological markers in PTSD and fibromyalgia (Scaer, 2001). These include a suppressed release of adrenocorticotropic hormone (ACTH), which lowers cortisol levels if traumatic stress becomes chronic. Chronic fatigue syndrome (CFS) has many of the same symptoms as fibromyalgia, including similar hormonal markers and electroencephalogram (EEG) patterns during episodes, except for soft tissue pain. Central nervous system arousal sensitivity levels are consistent for fibromyalgia, chronic fatigue, and PTSD (Scaer, 2001).

Aborted neuromuscular fight-or-flight responses and extended immobility or freezing responses related to unresolved posttraumatic stress can cause sustained rigidity in the body, eventually resulting in chronic discomfort and pain (Levine, 1997). Excessive dysregulation of the sympathetic and parasympathetic nervous systems, a by-product of chronic posttraumatic stress, can also lead to profound instability of mood. Such effects can be found in people suffering chronic pain, bipolar disorder, major depression, anxiety, and other mood disorders, thus illustrating yet another linkage between the syndromes of chronic pain, major depression, and PTSD.

Women who have been sexually abused or assaulted have significantly more physical symptoms than women without this history. Heim and his colleagues (Heim, Ehlert, Hanker, & Hellhammer, 1998) found a high prevalence of physical and sexual abuse, as well as diagnoses of PTSD, in clients with chronic pelvic pain. Scaer (2001) pointed out that the combined factors of childhood sexual, physical, and emotional abuse are powerful predictors of chronic pelvic, abdominal, lower back, orofacial, and myofascial pain. Pain symptoms associated in general with childhood abuse in women include back pain, frequent or severe
headaches, pain in the pelvic or genital area, abdominal or stomach pain, breast
pain, chest pain, face pain, and frequent or serious bruises (McCauley et al., 1997).
These and other links between depression, pain, and PTSD clearly indicate
the need for comprehensive assessment and treatment. Barber (1996) pointed out
that, because depression is so frequently present in pain patients, it is essential
to evaluate to what extent the patient’s pain has resulted in depression. Conversely,
Barber continued, it is equally important to identify to what extent depression
occurring prior to the chronic pain problem may be functioning to exacerbate
the pain.

**ASSESSMENT STRATEGIES**

How do professionals screen effectively for PTSD, chronic pain, and depression?
Because of the common link between chronic pain and depression, experts who
specialize in chronic pain commonly recommend the use of a formal instrument
to rate chronic pain experience and obtain pain history information along with
an evaluation of depression by a formal scale such as the Beck Depression
Inventory II (Beck, Steer, & Brown, 1996; Eimer & Freeman, 1998).

Others routinely evaluate their clients for major depression and other mood
disorders through clinical interviews alone. When this type of informal assess-
ment is conducted, it is helpful to examine such factors as coping style. Chaves
(1993), for example, reported his research on the spontaneous coping strategies
used by patients during dental procedures. He identified two groups: spontaneous
copers who engaged in a mental focus that reduced pain, and spontaneous cata-
strophizers whose mental strategies amplified pain. Similar coping styles have
been reported for depressed patients (Peterson, Prout, & Schwarz, 1991).

I often inform my clients about the research that groups these three disorders
together. Many of them protest immediately that they do not feel depressed. I
usually comment at this point in the interaction that the effects of depression may
sometimes take the form of chemical reactions in the brain related to past trauma.
Then I may probe further about some of the traumatic events they have already
shared with me or uncover possibilities they have not considered to be “trauma,”
such as long-forgotten falls, illnesses, hospitalizations of a family member, or
sudden losses.

For example, one woman I treated for pain management following a complex
car accident could easily see that earlier physical trauma sustained when she had
fallen off a horse was linked to her current injuries. Yet, she failed to understand
that earlier traumatic experiences in her family life had “set the stage” for some
of her traumatic responses and the related chronic pain and depression.

In cases like these, I educate individuals with whom I work that trauma is a
layered experience and that layers closest to the surface are usually related to
current events, whereas the ones underneath consist of partially resolved or
dissociated traumatic reactions lost to consciousness. I set the expectancy that
we both stay open and curious about what may unfold in therapy. Sometimes clues appear in the form of dreams or interpersonal reactions, further somatic symptoms, or even misplaced memory fragments stirred in response to family interactions and to milestone events such as weddings, births, and funerals (Terr, 1998). These puzzle pieces can be examined periodically and fit with additional information to provide further links, rather than causation, between past trauma and symptom patterns related to emotional and physical pain. Changes in the client’s ongoing descriptions of pain, for example, can help determine both the extent of the individual’s suffering and his or her readiness for treatment (Barber, 1996).

Ongoing evaluation is important for both therapist and client. Even if little additional information becomes available, it’s possible to speculate about the types of scenarios that might provide a general organizing framework around the various pieces of therapeutic data. For example, Sue (not her real name) is a 48-year-old woman who presented initially with symptoms of chronic pelvic pain and panic disorder. We explored the nature of her pain that had resulted originally from endometriosis, a problem shared by her sister and mother. Sue had undergone an initial surgery to repair the endometriosis and then had five subsequent surgeries to remove scar tissue. Although she received several months of comfort following the first secondary surgery, any relief resulting from subsequent surgeries was short-lived, with her level of pain increasing more quickly and significantly above the intensity that had preceded the latest surgery.

I asked Sue about depression and trauma, which I do routinely with chronic pain patients. Sue told me that she had been treated for depression at the time of her divorce, more than 20 years earlier, when she had become a single mother raising a 3-year-old daughter. She had felt very hopeless and despairing then and was grateful for the help of the medication, but did not understand why her current doctor at the pain clinic had prescribed antidepressants along with her pain medication. I explained that the earlier episode of depression may have resolved as her life situation resolved, in meeting and marrying her current husband of 16 years. I speculated that the sudden traumatic loss of her grandparents, to whom she was deeply connected, when she was 7 years old, an event that she had shared with me when I took her family history, may have influenced her depressive response to her later loss through divorce. The traumatizing effects of four surgeries that had proven to be increasingly ineffective in helping her manage her pain, I explained, may have reactivated and even increased the earlier imbalance in her limbic system. “And,” I concluded, “even if you had not been depressed before now, the chronic pain condition itself may have triggered depressive responses.”

Sue remained largely unconvinced of this connection. Yet, when she persuaded her doctor to lower her antidepressant dosage, she immediately began to feel depressed. I was then able to help her understand better the childhood early loss/divorce/surgery trauma linkage. She began to realize that her limbic system may have been depleted of neurotransmitters such as serotonin that help to balance
emotional well-being, whether from earlier losses or just from the downward spiral of surgeries, and that she needed to replenish these important chemicals through medication and also through activities that stimulate brain chemicals such as endorphins that could further rebalance any depressive reaction. When we began to work with hypnosis shortly after this discussion to reduce her pain experience and her reliance on pain medication, we continued to reevaluate PTSD–depression–pain connections and to factor this information into our various intervention plans.

As Barber (1996) pointed out, because depression is so frequently present for pain patients, it is important to determine the extent to which the patient’s suffering from pain may have contributed to the depressive condition. Conversely, he continued, it is also useful to evaluate which aspects of a preexisting depression may have exacerbated the pain condition. It is precisely because of this strong correlation that antidepressant medications are routinely prescribed as part of pain treatment, not necessarily because the diagnosis of depression is suspected, but because they usually act to reduce pain.

**UTILIZING HYPNOSIS WITH DEPRESSED PATIENTS**

As stated earlier, hypnosis has not been addressed extensively in the literature on the treatment of depression. One of the problems in the treatment of depression in general has been the fact that, because of unremitting despair and hopelessness, a significant number of patients drop out of therapy before the resolution of symptoms can take place (Johnson, 2001). Gafner (2005) commented, “To turn around chronic depression, I believe you have to practice the equivalent of the full-court press in basketball, or the ‘full code’ in medicine” (p. 170). Thus, because of the nature of depression itself (i.e., the apathy and numbing fueled by hopelessness and helplessness) and the complexities of its interactions with chronic pain and trauma, therapists must be prepared to utilize all the tools within their psychotherapy toolbox. The good news is that not only can both formal and indirect hypnotic suggestion facilitate rapport and alliance with the therapist for the depressed patient, but its various uses can also alleviate depressive symptoms and reverse its too-often chronic course (Gafner & Benson, 2003).

Yapko (1993) identified several reasons for including hypnosis in psychotherapy with depressive patients: (a) hypnosis amplifies aspects of personal experience and may make it easier to recognize how the patient’s patterns of perception, thinking, interpersonal relating, and so on are contributing to depressive states; (b) hypnotic suggestion is an effective method of achieving pattern interruption; (c) hypnosis stimulates experiential learning; (d) hypnosis helps organize and contextualize desired responses; (e) it encourages and models flexibility in self-relations; and (f) it helps create focus.
Most of the hypnotic methods in treating depression have been focused within a brief therapy model, which emphasizes shortening the course of treatment and abbreviating the length of time before significant results are experienced by the patient. Solution-focused therapy, for example, has focused on identifying and changing specific patterns the individual uses to organize and respond to his or her perceptions of life (Johnson, 2001).

Because a variety of multidisciplinary and cross-cultural studies have clarified that there is no single cause of depression, it may be expedient to view depression as a result of various self-organizing patterns that can both trigger and maintain the experience of depression, and be used as targets for intervention (Yapko, 2001). For example, if a patient suffers from a limiting temporal orientation that is organized around efforts to get through each day, it may be essential to use hypnosis to help that patient develop a more flexible, positive orientation toward the future (Yapko, 1988, 2001). Other depressive factors to be addressed with hypnosis might include low frustration tolerance, rumination, inability to compartmentalize, and a diffuse style of focusing attention.

Solution-Focused Therapy

In solution-focused therapy, various questions are asked to address the symptoms and the nature of depression. The exception questions explore times when depression was less intense, was different, or was coped with successfully from the client’s point of view. Outcome questions address the client’s perception of what will be different when the depression has been successfully treated. The coping questions inquire about what the client has done to manage the depression and other difficulties on a day-to-day basis. The turning points in the therapy usually occur from collaborative efforts to achieve desired outcomes (Johnson, 2001). As the client learns it is possible to both set and reach goals, his or her sense of hopelessness and helplessness diminishes.

Ericksonian Approaches

Within the Ericksonian, or indirect, hypnotic model of treating depression, there are several strategies that have demonstrated efficacy. One is the use of directives. Yapko (1988) pointed out that directives are effective for a number of reasons: (a) they allow change to occur relatively quickly, (b) they facilitate the integration of therapeutic learning, (c) they utilize client resources for coping and change, and (d) they encourage an equal participation and collaboration by both therapist and client in the therapy process, in contrast to nondirective or insight-oriented approaches. Examples are using metaphors to build expectancy and positive motivation, assigning tasks to facilitate flexibility and the ability to let go, issuing directives for shifting behaviors related to erroneous perceptions of overcontrol or undercontrol, prescribing depression and patterns of depression in contexts likely to disrupt them, and issuing paradoxical directives aimed at perfectionism.
and reversing self-negation, such as directing the patient to perform tasks imperfectly and to invalidate intentionally his or her own feelings (Yapko, 1988).

Another major Ericksonian approach to depression involves the principle of utilization (Erickson & Rossi, 1979). One of the basic tenets is that, regardless of the technique being used, it is very important to utilize the client’s language, style, and perceived needs (Gafner, 2005; Yapko, 2003). The main advantage of utilizing the client’s language is that this approach allows the therapist to intervene in the problem as the client experiences it rather than as the therapist perceives it. This will solidify the client’s trust in the therapist; this is particularly important for the depressed patient, who typically struggles with hopelessness and despair. Yapko (2003) added that the Ericksonian approach is focused on utilizing an interactive relationship between therapist and client where various aspects of the client’s situation are fed back to him or her verbally and nonverbally as a basis for rapport. It is also important to utilize, in general, the surroundings where hypnotic treatment takes place, including the background sounds, comfortable furniture, and familiar setting within the hypnotic intervention.

Like the use of directives, Erickson’s utilization approach can be employed to identify, accept, and make use of each patient’s unique patterns by interrupting them, applying them more effectively, and mobilizing undeveloped or underdeveloped individual resources (Lankton & Lankton, 1983; Yapko, 1993). These important goals may be facilitated by the use of hypnotic suggestion to build an enduring sense of positive expectancy and an unstable attributional style (Yapko, 1993, 2001). Outcomes may be achieved throughout hypnotic work, including the tasks of constructing the therapy contract, setting the groundwork for hypnosis, creating an induction, activating positive resources related to past success, rehearsing new behaviors, and integrating important therapeutic understandings and generalizing them to many different settings.

In addition, many other Ericksonian strategies that can be used effectively with clinical symptoms and difficulties can also be used effectively with depression in particular. Some of these include suggestions for positive age regression, embedded commands, seeding, tailoring, paradox, confusion, pacing and leading, and truisms (Phillips & Frederick, 1995; Yapko, 1993).

**Formal Clinical Hypnosis**

Although Ericksonian strategies are often implemented in informal, naturalistic, or conversational contexts, they also can be used in more formal hypnotic inductions. Formal, structured hypnotic inductions are more traditional and directive than indirect or Ericksonian approaches, and generally feature more standardized rituals to create an experience that can be labeled hypnosis. There may be several advantages of formal inductions with depressive (or any) patients, including providing a bridge between the normal waking state and the experience of hypnosis, engaging the conscious mind while simultaneously dissociating it from unconscious functions, and facilitating a consistent response
set, or pattern of response to the practitioner, that can be reinforced over time (Yapko, 2003).

For depressed patients, creating a sense of personal empowerment is an important theme; thus, constructing a ritual that consistently stimulates a state of curiosity, expansiveness, and resourcefulness while encouraging a healthy disengagement from conscious, persistent negative thoughts (ruminations) and behaviors suggests obvious benefits for this population.

HYPNOSIS WITH CHRONIC PAIN AND PTSD PATIENTS

Hypnosis has been used much more commonly with both chronic pain and PTSD patients than with depressed individuals. In fact, one of the most frequently applied and effective uses of hypnotic suggestions is to create analgesia and anesthesia for all kinds of painful conditions. In a recent analysis of the benefits of hypnotically induced analgesia, researchers found that hypnosis provided significant pain relief for about 75% of their population (Montgomery, DuHamel, & Redd, 2000). There is also evidence to suggest that when hypnotic suggestion is added to patient-controlled standard medications, hypnosis provides greater pain relief than medication alone without unwanted side effects, such as addiction (Lang et al., 2000). In addition, hypnosis appears to be empowering to the patient and encourages a proactive role in managing pain (Chaves, 1989). Thus, hypnosis used in the service of pain management can also have the effect of reducing depression arising from pain-related feelings of hopelessness and helplessness.

HYPNOTIC TECHNIQUES FOR MANAGING CHRONIC PAIN

Several types of hypnotic suggestion have been cited as particularly helpful in managing physical pain. These include suggestions for escape or distraction, analgesia and/or anesthesia, sensory transformation, decreased perception of pain intensity, displacement to another part of the body, substitution of another sensation, alteration of the meaning of the pain, dissociation from awareness of the pain, time condensation, enhancement of competing sensations of comfort, and amnesia to forget pain (Syrjala & Roth-Roemer, 1996). These types of suggestions can be applied by trained dentists, physicians, nurses, and anesthetists, as well as by psychotherapists, to help patients prepare for invasive procedures, as an adjunct to anesthesia during surgery, to improve recovery from surgery, to assist in emergency medical situations, for palliative care, and for ongoing management of chronic pain conditions.

Earlier in this chapter, emotional and physical pain were linked in terms of neurobiology and trauma responses in the body. It is important to make the point here that there is an overlap in treating depression and chronic pain: hypnotic
treatments of chronic emotional (e.g., depression) and physical pain syndromes must consider and address the psychological factors affecting the prognosis of the patient. Many patients who suffer from chronic physical pain resist emotion-targeted interventions, fearing that they will be viewed as either malingering or faking their symptoms (Barber, 1996). Hypnotic communication can be helpful in these cases by providing the reassurance that regardless of the source of the physical pain or emotional suffering, reducing both of these aspects of the pain experience is the role of the professional.

HYPNOSIS FOR TRAUMA AND PTSD SYMPTOMS

Applications of hypnosis and imagery in the treatment of trauma-related conditions have been widely reported in the professional literature for more than 150 years. In the mid-1800s, James Esdaile used hypnotic analgesia to help patients through surgical procedures without the aid of anesthesia. In the late 1800s, Freud and his contemporary, Pierre Janet, each documented extensive hypnotic work with women suffering from what were then called “hysterical” conditions, more currently believed to be dissociative responses to emotional, sexual, and physical abuse and trauma (Phillips & Frederick, 1995). During both world wars in the last century, hypnosis was used successfully to help soldiers overcome the effects of combat trauma reactions (Kardiner & Spiegel, 1947).

The relatively recent recognition of posttraumatic stress disorder as a formal diagnostic category has triggered renewed interest in the use of hypnosis with extreme stress conditions such as PTSD, complex PTSD, and the dissociative disorders. Because of strong evidence that many people dissociate during a wide variety of traumatic events, hypnosis, as a state of therapeutically induced dissociation, is believed to be useful in accessing, working through, and transforming the elements of trauma-induced dissociation (Spiegel, 1993, 1996). The elevated hypnotizability associated with posttraumatic stress conditions also contributes to the belief that hypnotic psychotherapy is especially valuable as a tool to enhance controlled access to and resolution of traumatic experience and its linked unconscious associations.

In the last decade, partially in response to the repressed memory controversy, emphasis has shifted from applications of hypnosis to excavate and resolve traumatic memories to a focus on ego strengthening and improvement of current life quality (Frederick & McNeal, 1997; Phillips, 2001a, 2001b). This involves using hypnosis to activate inner strength and other empowering resources, to evoke memories of successful mastery of past events, to provide renurturing and transformative experiences, and to integrate personality functioning.

There are many hypnotic techniques that are useful to achieve these goals. These include, but by no means are limited to, suggestions for relaxation and regulation of anxiety, creation of feelings of internal safety and security, feelings
of ego strength and well-being, dissociated recall of past traumatic events using such techniques as the split screen or other remote viewing techniques (see Schwartz, 2002, for a detailed description of these methods), restructuring and reorganization of the traumatic experience, and ego-state therapy methods to reintegrate dissociated or conflicted aspects of the self.

STRATEGIC HYPNOTIC TECHNIQUES WITH POSTTRAUMATIC PAIN AND DEPRESSION

Strategic psychotherapy is structured on the premise that treatment is most effective when it targets specific outcomes and the steps required to achieve them (Haley, 1973). Techniques are then carefully selected to achieve these outcomes in the most efficient and effective ways. The general hypnotic approaches mentioned above can be combined in many different ways, depending on the needs, responses, and results desired by each individual client.

Recently, I have begun to specialize in posttraumatic emotional and physical pain conditions. Because of the complexity that exists when individuals suffer from a combination of emotional and physical distress related to unresolved past trauma, a strategic approach is particularly important. The following case example illustrates this approach.

A CASE EXAMPLE: SUE

Sue (introduced earlier in this chapter) is a 48-year-old woman who was referred by her couples’ therapist for hypnosis to manage chronic pelvic pain. She had been diagnosed with a benign ovarian cyst in 1990, and had surgery at that time to remove the cyst along with endometrial tissue. Prior to the surgery, Sue had suffered intense shooting pain. She felt immediate relief from the laser procedure; however, the pain slowly increased again, and in 1991, she had laser surgery to remove more endometrial tissue. In 1992, she had the same symptoms and this time had a partial hysterectomy. Following this third surgery, she was placed on birth control pills to help reduce her pain. In 1998, she started reporting bladder symptoms. After exploratory surgery, her ovaries were removed. She was on hormone replacement therapy (HRT) for a year and did well. However, a year later, in 1999, she had the same bladder symptoms, which included burning pain, pressure, and pain with bending and moving. Again, she had laser surgery to burn off the endometrial tissue on her bladder flap. After that surgery, she was taken off all hormones.

In 2004, after 5 years of good health, the pain returned. An ultrasound and other tests found that endometrial scar tissue had increased and was impinging on internal organs. Sue then consulted with a gynecologist who specialized in endometriosis. He did not recommend surgery because of how much scar tissue was present. His prescription was to put Sue on progesterone and to suggest that
she do daily exercise, yoga, and meditation. Because the pain levels precluded her from working at her job as a floral and interior designer, where she stood during most of the workday, he also recommended she go on disability, which began in May 2004.

During our first interview, I determined that Sue had a strong family history of endometriosis. Her younger sister had five surgeries, including one for an ovarian cyst. Her mother had a hysterectomy because of this condition, as had her mother’s sister. One of Sue’s troublesome unanswered questions about which she often ruminated was why she was the only family member to have developed a chronic pain condition. She felt discouraged and frustrated that the pelvic pain kept returning. She also manifested several other symptoms of depression, including sadness, lost vitality, and excessive sleeping during the day. Sue also reported that she had experienced anxiety for most of her life, which she related to having grown up in an alcoholic family as the second oldest of five children. She described her role in the family as that of “peacemaker,” commenting that she had “stuffed” her feelings for many years while trying to keep the peace with her family. Her second marriage of 20 years is a happy one, though she has not been able to be sexual for the last 7 months without using heavy pain medication. She also has been adjusting to an “empty nest” since her only child, a daughter, had left home about six months before our first appointment.

When I asked her what previous interventions she had found to be helpful, Sue related that Neurontin® and Vicodin (pain medications) seemed to help lower her pain levels, and that Paxil™ and Serzone® (antidepressant medications) had also been prescribed for depression, although she did not feel depressed. She believed these medications might have contributed to her recent weight gain, which she felt bad about. Her pain management doctor had prescribed Ambien™, alternating with melatonin, for managing her insomnia. She also regularly used moist heat, which seemed to help her pain in the afternoon and evening. I agreed with her that she did seem to be on quite a lot of medication and explained that part of our plan would be to reevaluate her medications as she improved and very gradually taper off most or all of them.

Hypnotic Treatment Plan

In consultation with Sue, several treatment goals were identified for which hypnosis would be used. These included the following:

1. Enhance physical comfort in her body; promote self-regulation of pain and anxiety; increase her ability to express negative emotions directly.
2. General ego strengthening, reduce anxiety and pain, and increase her self-confidence related to managing challenges in the present and future.
3. Improve boundaries in her interactions with husband and daughter.
4. Reduce dependency on medications; increase reliance on effective self-care and decision-making strategies.
5. Increase her sense of balance in carrying out daily activities and in maintaining internal well-being.

Sue was seen for a total of 25 ninety-minute sessions between early October 2004 and the end of May 2005. Hypnosis was used formally in 14 of these sessions and conversationally in the remainder. As of the end of May, she had decided to taper to two sessions per month and will terminate after several monthly maintenance sessions.

Hypnotic Treatment Sessions

After completing an intensive history and assessment in the first session, the next three sessions were devoted to a discussion about and use of formal hypnosis to create positive expectancy and initial success by reducing anxiety and pain levels. During the first hypnotic session, the focus was on utilizing a favorite place at the beach she had consistently associated with feelings of comfort and well-being during her many visits there as a child. She was able to create vivid imagery very easily in response to general suggestions from me. Initially, she envisioned her pelvic pain as a black space in her abdomen about 6 inches wide, which began to shift into a smaller gray space as she imagined wading into warm ocean water.

As Sue was encouraged to gradually walk out into the water, suggestions were given that her body could respond to the warmth of the water and the gentle soothing action of the waves, that she could adjust the height and movement of the water by varying her pace of wading, and that she could use each inhalation of her breath to help a comfortable warmth rise internally in her body. The last step was to put on a special flotation vest that could allow her to float at a water level that was completely comfortable for her so that she could rest fully in the warmth of the sun. During the hypnosis session, Sue’s self-reported pain level dropped from a 7 SUD (subjective units of distress) to a 2; she was given an audiotape of the induction and asked to play the tape at least once per day. She was also asked to make a chart of her pain to assess the intensity level three times per day (0 to 10 SUD), along with activity levels, emotional responses, and any positive or stressful life events.

At the beginning of the second hypnotic session, Sue reported that she’d had a very good week; she had enjoyed sexual intercourse without medication and had called her doctor to get permission to decrease her use of both Vicodin and Neurontin®. After cautioning her about the importance of decreasing the medications slowly so that her body would have time to integrate the changes she was making, we discussed various pain and anxiety triggers that had surfaced in her charts and agreed that anxiety seemed to precede each time her pelvic pain had suddenly increased to its highest levels. For the next four sessions (3 through 6), we used
formal hypnosis to focus on this anxiety, employing a “somatic bridge” strategy (Phillips, 1993; Watkins, 1990) to identify any past traumatic experiences that might be related to the triggers and to promote self- regulatory strategies to reduce the sensations in her body related to anxiety. The following is a partial transcript from session 3, the second hypnosis session:

Therapist: Sue, now that you are relaxed comfortably in your special place at the beach … floating in the water … I’d like you to find the anxiety that you felt during the conversation with your daughter … and when you do … let me know how that feels now in your body.

Sue: There is huge pressure in my chest and a sharp, burning pressure in my pelvis like I have to empty my bladder. My heart is pounding, and the more I try to relax, the worse it gets, like someone has hit me.

Therapist: For the next few minutes, it’s important to let go of the effort of doing anything, even to relax. … Instead, I’d like you to just be with those feelings … those sensations in your body … and just let yourself drift with them as you are drifting in the water … perhaps back to a time and place when these same feelings were very strong.

Sue: I get a sense that I want to scream and cry. … I don’t recall ever being hit. I don’t know what’s hitting me … oh, sadness is hitting me. My chest is tightening up more and there’s an empty feeling. … I think this is how I felt a lot as a kid only I could never feel it then.

Therapist: What would help right now with those feelings?

Sue: I think I need to swim … it’s taking a while to get synchronized but now I am doing the crawl stroke. That feels good. The tension is leaving my body and now I’m floating again. …

Therapist: Good. And can you imagine what it will be like if these feelings hit you again in the days ahead?

Sue: Yes. … I’ll probably forget that my body can move through them, but then I’ll play this tape or think about the beach and then my body can let go of the tension. That’s what I hope will happen.

In this brief excerpt, embedded suggestion was used to make distinctions between past, present, and future to help Sue stay focused in the present time, when she can make effective choices to change how she feels (i.e., by floating or swimming the crawl), and oriented toward the future when she feels hope that she can exercise those choices again. Hypnotic suggestion to create a somatic bridge (Phillips, 1993; Watkins, 1990) helped Sue to build resources in the present and future. This future-oriented approach stands in contrast to more common uses of hypnosis for age regression to past traumatic events, where the client can feel overwhelmed and become destabilized, especially in the early stages of therapy. The focus with Sue instead is on ego strengthening and building confidence that she can make good choices that can keep her solidly anchored in the
present and with hope for the future, in contrast to the hopelessness and helplessness of depression and trauma.

The next two hypnotic sessions were spent similarly in exploring feelings of anger related to interactions with her husband and daughter, which Sue learned from further bridging experiences were connected to her reactions when her parents fought bitterly. “I was determined not to be angry like them,” she said. “I would even hit myself on the legs to express my anger so that it did not come out in other ways.” Sue was given further suggestions that she no longer needed to allow her feelings to hurt her. Instead, she could make different choices by letting strong emotions move through and out of her body during the swimming imagery when listening daily to the audiotapes, and also during her regular daily walks. Sue could choose to allow her feelings to surface at a time where she could immediately release them through her body, empowering her and increasing her sense of mastery over her emotional and physical feelings.

The fifth hypnotic session focused directly on pain sensations in her pelvis, which appeared to be related to past feelings of sadness about the physical and emotional affection she missed in childhood, and to her grief that she would not have more children because of her hysterectomy, which had intensified when her daughter left home. During this meeting, we used ego-state therapy to work with a part of her that contained the grief and despaired that things would never get better. Through a series of renurturing suggestions (Murray-Jobsis, 1990), this part of her was able to move toward trusting that it was now safe to feel good because, unlike the past, good feelings would not be taken away from her through the actions or neglect of her parents. By the end of this and the next (sixth) meeting, Sue’s pain levels had stabilized to a SUD range of 2 to 4, she began to have whole days that were virtually pain free, and she increased both her physical activity levels and her hours of work at her new part-time job in sales for a wholistic health company.

During the next several meetings (7 through 10), hypnosis was used indirectly and conversationally to help Sue move through a series of setbacks that threatened her newfound feelings of comfort and well-being. These included an ankle sprain that occurred just as she began to move toward increased levels of activity and setbacks with her daughter who declined an invitation to a holiday dinner and announced her decision to move out of the area to live with her biological father.

Throughout this interval, we reframed Sue’s pelvic pain symptoms as being connected to the emotional pain she felt and continued to explore ways that Sue could express and release these feelings safely and productively. From this perspective, Sue began to see that some of the biggest contributors to her current episodes of increased pelvic pain were current reactions that triggered unresolved emotional pain from childhood. She began to examine weekly triggers in this light and to resolve many of these situations on her own. Her husband’s comment at this point in treatment was that she had “improved 600%.” He saw her taking better care of herself and keeping her pain and distress levels low, so that there was more enjoyment in their times together.
After completing this work, we returned to formal hypnosis during meetings 11 and 12 in order to address pain in her hip and leg that had begun to be a problem while she was recovering from her sprained ankle. During this time, we used hypnotic somatic bridging to discover that this pain appeared to be linked to a serious car accident that occurred when her daughter was 3 years old and Sue was a young mother going through a divorce. To “rework” this experience, we used hypnotic suggestion and ideomotor signaling for age regression, probing for details of the accident, and using several methods for reworking them, including “somatic experiencing” techniques (Levine, 1997) to help her release shock and constriction that appeared to be held in her body from that event.

We also created reparative imagery, such as a foam pillow that covered her steering wheel to cushion the impact to the front of her body. We then examined triggers that had evoked these somatic reactions and discovered that these included the limp from her current ankle injury, which evoked reminders of limping for a short time following her accident, and bending to work in her garden, which evoked the sensation of her abdomen being restricted by the seat belt.

Sue began to notice that physical activity that required her to bend or lift had the potential to trigger postaccident responses of soreness in her abdomen. It also seemed to stimulate the endometrial scar tissue in that body region. She found that she could make decisions for physical movement based on the possibility of triggering these somatic reactions and could keep herself in a relative place of safety with her SUD levels at 2 to 3. Rather than bending to turn the soil in her garden, for example, Sue bought a small lightweight stool on rollers that could move her around the patio more easily. She also learned to ask her husband to help her with any projects requiring lifting or bending.

Sessions 14 and 15 involved using metaphors and other conversational suggestion to help her deepen her commitment to self-care instead of feeling frustrated and anxious whenever pelvic pain increased, or whenever she worried about whether she would be successful at her new job or was reminded of the weight gain related to the medications she took. One particularly effective metaphor involved imagining her pain as an uncomfortable infant, who needed the kind of powerful attunement that only a good mother could provide. Sue reported afterward that she found herself tuning into her pain differently, identifying with both the mother role in caring for the vulnerable part of herself as well as experiencing herself as the baby beginning to thrive with the right kind of attention. We also began to utilize her interest in mindfulness meditation, and recorded an exercise where she used the concepts of “beginner’s mind” and “compassionate observer” along with breathing and hypnotic suggestion (Noelle Poncelet, personal communication, May, 1997) to learn to let go of distressing thoughts or feelings.

At the beginning of the 16th session, Sue reported that lately she had been feeling depressed with lower energy and feelings of despair that intensified in the late afternoon. We used ideomotor signals and age regression to explore this state of depression as well as accompanying feelings of anxiety. Sue identified a
familiar feeling of coming home from elementary school, not wanting to enter her house, and feeling helpless and fearful that she did not know how to guide herself through the long afternoon and evening that lay ahead. Again, renurturing imagery was used with “adult Sue” as the internal mother who could reassure the depressed, lonely part of her that it was okay for her to feel low energy in the afternoons without feeling depressed, and that she could help her “child Sue” decide what activity might help change the way she feels. The next session was spent integrating her discoveries during the week, which included adding more structure to her afternoon with a balance of rest, meditation, and leaving home to have coffee with friends in order to break the pattern of feeling trapped and helpless to change her circumstances.

Our 18th meeting began with Sue’s report of a visit with her family of origin, including her mother and two brothers. She felt very depressed afterward, and her pelvic pain increased to a 5 to 6 SUD. Once she was able to express her feelings of grief about her brothers, one of whom is very obese and the other who has had shock treatments for depression and is unable to work, and disappointment in her mother, who is still drinking and focused on getting her children to “party” with her, Sue was surprised to notice how quickly her pelvic pain decreased. We added a self-hypnosis exercise with breathing and self-suggestions related to changing her views of herself.

The next four sessions (19 through 22) featured formal hypnosis to help her cope with some of the physical discomfort she was suffering that appeared to be related to further decreases of Neurontin® and Vicodin. These included soreness in her lower back, a skin rash that was very irritating to her, and a bloating sensation that heightened her awareness of being overweight. The basic technique used was the “brain’s control room” (modified from Price, 1990), which is presented in the case excerpt below:

Therapist: Sue, I’d like you to imagine that you can shrink yourself to a size of about an inch or so high. Let me know when you’ve accomplished this.

Sue: [Signals yes with her finger.]

Therapist: Fine. Now I’m going to invite this miniature self to take a special journey through your body. Your miniature self has all of the wisdom and resources contained in your full-bodied self … yet can move easily inside your body. … So, on the next breath in, this miniature self can move with your breath into the diaphragm and lungs very easily and can travel through your air pathways wherever you’d like her to go to focus on any area that is of concern to you. … Do you know where you’d like her to go?

Sue: Yes. I want her to go to my lower back and hip.

Therapist: Okay. On the next breath out, she can begin to move down into your lower body. … Each time you exhale, you’ll find that she gets closer to your lower back and hip. … When she arrives there, let me know.
Sue: [Signals yes with her finger.]
Therapist: Good. … This miniature self can begin to let you know what needs attention there … as if she were connected to a high-power microscope and can send those pictures directly to you. … [Pause.] Can you tell me anything about what you’re finding?
Sue: Yes. That area looks like what I’ve seen in a medical book. There’s a really tight muscle, and that area looks inflamed and red.
Therapist: Ask the miniature self what is needed there.
Sue: She says that it needs to be cooler.
Therapist: Okay. … I would like you to imagine an internal ice pack which is made of gel so it can be moved easily … and can fit the contours of your muscles and tissues. … She can help put it in place. … Let me know when you feel it positioned just right.
Sue: Okay.
Therapist: Do you notice any changes yet?
Sue: Hmmm. … That area looks less red and not so tight … looser.
Therapist: Good … and you can feel that difference?
Sue: Yes, it feels better.
Therapist: Is there any other place she needs to go?
Sue: She’s going to the pelvis area, to the scar tissue, and she’s putting an ice pack there, too.
Therapist: Very good. She’s really taking charge of what you need. Anything else?
Sue: No. Those places are better.
Therapist: And while we are continuing with another focus … these areas will continue to benefit for as long as the cooling is needed. … Now I’d like to invite that miniature self to begin moving through the airways again. … With the next breath in, you can feel her moving up toward the diaphragm and lungs, then through the upper chest … through the trachea into the throat … into the sinuses … and then up into the forehead area … and now into the brain. … Let’s ask her to look around and find the control room in the brain. … It may look something like a room with a lot of computers and machinery with dials and screens. … Do you see anything like that?
Sue: [Pause.] Yes I think so. … Now I have it.
Therapist: Good. … Let’s have her look around, and she will find something that looks like the drip system in your garden … with tubes that can move anywhere in your body to dispense what is needed there.
Sue: Yes. I have that.
Therapist: So … let’s ask the miniature self to use her microscopic vision and send the tubing into whatever areas in your body would benefit from a muscle relaxant … delivered automatically on a timer system just like the water in your garden.
Sue: [Pause.] She’s sent this into the pelvis, my lower back, down my left side. …
Therapist: Is it turned on?
Sue: Yes, now it is.
Therapist: Take a few moments … and let me know when you feel the effects.
Sue: Yes, that feels good.

We continued to develop this imagery during the next three sessions, adding an internal IV of the “brain’s pain medication” that would be turned on by a timer an hour before she was due to take her lower dose of regular medication. We also added “the brain’s sleep medication,” turned on about a half hour before she is ready to go to sleep; “the brain’s topical analgesic” that can be sent to her external skin surface; and “the brain’s antidepressant” to rebalance the nervous system. Sue listened to the tapes regularly to reinforce all of these resources.

In the final two sessions, the focus was on helping her to increase her part-time job hours, increase her confidence in financial success, and balance the activities in her day. During this period, she has continued to step down her Neurontin® and Vicodin medications and her pain levels have stayed between 1 and 4 SUD, averaging 2 to 3 SUD. She is now working 20 hours per week, and her sales numbers are beginning to increase. We are beginning to focus on helping her lose weight as she prepares to stop all the medication, except for a low dose of antidepressant, and as she prepares to transition to a monthly maintenance schedule of sessions and termination.

EVALUATION AND DISCUSSION OF HYPNOTIC TREATMENT

Sue’s case illustrates some important principles of hypnotic treatment for post-traumatic distress conditions (Levine, 2005), which often include chronic pain and depression. First, it is essential to use hypnosis in the early stages of therapy so that both the focus and outcome are ego strengthening (Phillips, 2001a, 2001b; Phillips & Frederick, 1995; Schwartz, 2002). Experts are virtually unanimous in advocating a staged approach to treatment of trauma with initial emphasis on strengthening, stabilization, safety, and education (Phillips, 2000, 2001a, 2001b; Schwartz, 2002; van der Kolk, 2003). During this phase, work with symptoms is solely for the purpose of teaching the client self-regulation strategies to manage them effectively, rather than to uncover information about their origin.

This was accomplished fairly rapidly with Sue through a utilization approach, especially the utilization of a place of consistent comfort (i.e., her special place at the beach) from her childhood. There she had previously learned in vivo to regulate fears about “going deeper” into the ocean by amplifying accompanying feelings of mastery, confidence, joy, and play. The hallmark of the utilization
approach is the fact that it does not require the client to make an initial change, especially at a time of vulnerability. Instead, the therapist accepts fully and utilizes aspects of the client’s experience as valuable assets (Phillips, 1993; Yapko, 2003). This is particularly important with individuals who have a significant trauma history, as Sue did.

With some depressed clients, these kinds of resource-activation associations may need to be made more explicitly, especially when their cognitive styles are more concrete and less conceptual. Because Sue seemed to resonate with the symbolic aspects of the imagery from the beginning, however, her positive responses allowed us to build on the basic skills she had already mastered in learning to swim in the ocean by adding an opportunity to learn pain regulation. Additional embedded temporal suggestions helped separate current experience from past trauma and oriented her toward a positive future.

Because I tend to use an interactive model of hypnosis (Gilligan, 1987; Phillips, 2000; Phillips & Frederick, 1995; Yapko, 2003) rather than one that places the client in a more passive receptive mode with hypnotic suggestion, I am able to monitor the effects of various suggestions at both verbal and nonverbal levels. The client’s feedback allows me to shift my approach immediately. Thus, if Sue had needed more explicit or direct suggestions that emphasized the many resources she could access that were contained in her beach imagery, I could provide them. In my experience, this treatment model tends to empower the client as well as provide an opportunity for the healing of various kinds of attachment trauma. Because Sue’s mother was emotionally neglectful, it was very important that she experience me as “being present” with her, continually inviting her to share her experience with me, acknowledging its importance, and being immediately responsive to her as is generally the case when there is secure attachment (Main, 1995).

During later stages of work, after Sue had already increased her confidence in being able to regulate her pelvic pain and anxiety, hypnotic age regression was employed in a more traditional, direct manner through somatic (Phillips, 1995) and affect bridging (Watkins, 1990), ego-state therapy (Watkins & Watkins, 1997), and the use of ideomotor signaling (Rossi & Cheek, 1988). These techniques were employed first to uncover earlier sources of her anxiety and depression in the form of childhood experiences and reactions to a serious car accident as an adult. Then, Sue was encouraged to rework (i.e., develop new meanings or understandings about and responses to) those experiences by incorporating corrective strategies that would expand her current functioning, such as the brain’s control room and other similar techniques.

Ericksonian strategies were interwoven throughout Sue’s therapy. Such approaches included metaphors to help her learn a more compassionate level of self-acceptance in nurturing her emotional self, and utilization of interests in mindfulness meditation, physical exercise, and spirituality. These tools were used to implement several principles of working indirectly with pain patients: (a) a deep trance state is not necessary; (b) structure activities that modify the experience
of pain as the patient carries them out; (c) it is the patient’s resources that make pain control possible; (d) pain is a process, not a static entity in itself; and (e) frequent reinforcement is often needed to strengthen new associations, reactions, and behaviors (Zeig & Geary, 2001).

The main therapeutic directive given to Sue was to teach her the importance of proactively making self-beneficial choices, rather than allowing situations to happen to her as if she were a helpless victim. This was particularly effective in forging better relationships with her husband and her newly emancipated daughter. Conversational suggestions were also used extensively during sessions devoted to helping her integrate her experiences from formal hypnosis, reinforcing relevant themes, and reframing them in a variety of slightly different ways. These also served to expand her understanding and her applications of key learnings in the homework assignments given to her to carry out after each session.

Sue’s case further illustrates the clinical finding that emotional pain and physical pain are often intertwined as they interact with and potentiate each other. Epidemiological research has identified a large percentage of people with puzzling and seemingly intractable chronic emotional and physical pain conditions who have also reported severe physical, emotional, and sexual trauma and neglect (Naperstek, 2004). Understanding the role of trauma in these syndromes is essential in bringing more permanent, direct relief to those who struggle with pain that is too often treated primarily with pharmacology agents that often generate debilitating dependency and side effects (Scaer, 2001). Eventually, we may develop the kind of refined research that can help us determine whether individuals who suffer from pain conditions have also experienced substantial dissociation during past trauma, including intrusive medical procedures, and to what extent the related “neuromuscular freeze” response and constant activation of alarm states have released chemicals that generate pain in the myofascial tissue, as well as immune suppression and limbic system imbalance (Naparstek, 2004; Scaer, 2001).

It is clear from the results presented in Sue’s case that a more complete resolution of her physical pain was obtained only after her acceptance of the role of unresolved emotional pain, including past anxiety and grief, and after developing the ability to regulate and express this pain directly in empowering ways that connected her more deeply and positively with herself and others. Hypnosis may be one of the more valuable tools that can assist in such a complex process, providing flexibility and fluidity where there has been constriction and rigidity, focus and integration where there has been either fragmentation or flooding from overwhelming negative sensation, and the opportunity for restorative, healing relationships that build on creative strengths rather than pathology and pain.
EDITOR’S SUMMARY

- Recent advances in psychoneuroimmunology have indicated a strong connection between emotional and physical pain; these advances are described in this chapter.
- Trauma and the ensuing posttraumatic stress condition are common bases for emotional and physical pain, as well as depression. Sexual abuse in particular is associated with pain, PTSD, and depression.
- Feeling helpless and hopeless precipitates depression and exacerbates pain and distress.
- The patient’s coping style, whether it is a “spontaneous coper” or a “spontaneous catastrophizer” approach, directly affects his or her vulnerability to somatic and emotional symptom onset.
- Hypnosis can be valuable in helping patients develop effective coping and management skills to reduce pain and suffering.
- Intervention strategies involving the use of directives and the principle of utilization are identified as effective approaches for the activation of client resources.
- Hypnosis for pain relief has received strong empirical support in the scientific literature; a variety of effective strategies is reviewed.
- Hypnosis for PTSD has been applied successfully to enhance ego strength, provide nurturance, improve current life conditions, and integrate key learnings during therapy.
- A complex case of PTSD, pain, and depression treated with hypnosis is presented in detail.

REFERENCES


The Utilization Approach to Treating Depression in Individuals with Autistic Spectrum Disorders

DIANE YAPKO

OVERVIEW

Depression knows no borders. It can affect anyone regardless of age, race, socioeconomic background, level of education, or gender. Depression has many possible contributing factors, including some that are biologically based (such as genetic predispositions, diseases, side effects of medications, and biochemical anomalies), some that are environmentally based (such as social factors and situational stressors), and some that are psychologically based (such as temperament and style of coping). Given the range of factors that can trigger depression in anyone, it is not surprising that depression also affects individuals with autistic spectrum disorders (ASD), a complex neurobiological pervasive developmental disorder. Depression may even affect this clinical population to an even greater degree than occurs in the general population (Kim, Szatmari, Bryson, Streiner, & Wilson, 2000).

DEPRESSION AND AUTISTIC SPECTRUM DISORDERS: UNCHARTED TERRITORY

In just the past decade, two distinct areas of research and clinical work have begun to cross paths: depression and ASD. Speculations have been made in the research about common genetic, neurological, and psychological factors found
in both conditions. For example, anomalies in the amygdala and cingulate have been reported in studies that address the neurological correlates of depression as well as in other studies that looked at the brains of ASD patients (Howard, Cowell, & Boucher, 2000; Pezawas, Meyer-Lindenberg, Drabant et al., 2005). Other research describes similar neurotransmitter deficits, particularly serotonin, in individuals with ASD and those with depression (Anderson, 2002; DeLong, 1999; Maes & Meltzer, 1995). However, the neurochemistry associated with depression and ASD is currently not well understood. Genetically, to date neither disorder has been, or is expected to be, attributed either to only one gene or to genetics alone.

The psychology of depression has been well elaborated in the literature, identifying risk factors and effective treatment strategies (Beck, 1976, 1997; O’Connor, 2001; Seligman, 1989, 1990; M. Yapko, 1997). Many of these same psychological patterns are also evident in ASD individuals and suggest a strong relevance in their treatment. For example, a pervasive sense of helplessness, often found in depressed individuals, is also often found in ASD individuals (Barnhill & Smith-Myles, 2001; Smith-Myles & Simpson, 2002). Although we know a great deal about potentially effective treatment strategies for each of these populations separately, there is little practical information currently available suggesting ways to identify and treat depression as a comorbid condition in the ASD population. This chapter addresses these issues by identifying appropriate targets for therapeutic intervention. Readers will be introduced to how hypnosis may enhance the treatment process in working with ASD individuals in general and, more specifically, how the utilization approach to hypnosis may be an especially valuable framework for treating the cognitive, behavioral, and social factors associated with depression in the ASD population.

DEPRESSION

In the past 20 years, there has been enormous growth in the amount of information we have amassed about depression. Contributions from such diverse fields as genetics, biology, epidemiology, family studies, sociology, and psychology have each provided us with insights about depression’s multiple causes and the merits of multidimensional treatments. The well-established biopsychosocial model of depression reflects a combination of factors and highlights that depression is not attributable to only one causal factor (Dubovsky, 1997; O’Connor, 1997; Whybrow, 1997). Symptoms of depression can be physical (e.g., sleep disturbance, decreased energy, reduced or excessive appetite, and diminished libido), psychological (e.g., hopelessness, helplessness, and poor concentration) and/or social (e.g., social isolation and irritability). Just as the causes and symptoms of depression can vary widely, so too can the treatments. Currently, the preferred treatments usually include a combination of antidepressant medications and psychotherapy (Keller et al., 2000). The selective serotonin reuptake inhibitors (SSRIs) are the
most widely prescribed antidepressants, and cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT) are considered to be the most efficacious in the treatment of depression (O’Connor, 2001; M. Yapko, 2001b).

Hypnosis was first introduced as a viable option for treating depression by clinical psychologist Michael Yapko in his groundbreaking book, *Hypnosis and the Treatment of Depressions* (1992). In that book, Yapko dispelled many of the common myths historically associated with using hypnosis with depressed clients. The archaic and damaging view of hypnosis routinely taught to generations of clinicians portrayed hypnosis as a means of stripping away patients’ psychological defenses and leaving them vulnerable to psychotic thoughts and/or suicidal behaviors. Despite no evidence for these dire warnings, this view left an enduring fear that hypnosis would harm rather than help individuals suffering depression. Yapko provided a modern framework and a sound, clinically based rationale for using hypnosis with depression sufferers. He has consistently and convincingly maintained that there are cognitive, behavioral, and interpersonal patterns of depression that are appropriate targets for well-considered hypnotic and strategic interventions (M. Yapko, 1985, 1988, 1992, 1993, 2001a, 2001b). Since that time, additional research has supported Yapko’s assertion that hypnosis could enhance cognitive-behavioral approaches to treatment (Kirsch, Montgomery, & Sapirstein, 1995; Schoenberger, 2000).

**AUTISTIC SPECTRUM DISORDERS**

Whereas information about depression continues to grow almost exponentially in the literature, a plethora of information is also emerging about the identification and treatment of autistic spectrum disorders (ASD). Autism and Asperger’s syndrome (AS) were first identified around the same time in the 1940s, although the literature on the traditional, or classical, forms of autism recognized by psychiatrist Leo Kanner received the majority of attention for the next several decades. It was not until the 1980s that AS became better known when psychiatrist Dr. Lorna Wing introduced the term *Asperger’s syndrome* in recognition of Hans Asperger, the Viennese pediatrician who, in 1944, described four boys who were socially awkward with pedantic speech patterns and unusual interests (Asperger, 1944; Wing, 1981). It took another decade before the diagnostic label *Asperger’s syndrome* was included in the 10th edition of the *International Classification of Diseases (ICD-10)*; World Health Organization, 1993) and the 4th edition of the *Diagnostic and Statistical Manual (DSM-IV)*; American Psychiatric Association [APA], 1994). In the time since, the amount of information available on AS has increased dramatically (D. Yapko, 2003).

Epidemiologically, in the past decade the number of children diagnosed with an ASD has markedly increased. Thought to affect 2 to 5 per 10,000 children according to 1994’s *DSM-IV*, more current studies from the Centers for Disease Control and the National Institutes of Health suggest a much higher prevalence
of 2 to 6 per 1,000 (Centers for Disease Control and Prevention, 2005). This increase makes it likely that clinicians will eventually encounter and perhaps even treat individuals with a diagnosis on the autism spectrum and/or treat their families. Thus, the need for clinicians to better understand this unique population’s characteristics and needs, and to have the clinical tools for working with them effectively, is increasing as well.

**Diagnosing Asperger’s Syndrome**

Diagnostically, AS is one of the five pervasive developmental disorders (PDDs) listed in the *DSM-IV* (APA, 1994). These have also been referred to as the *autistic spectrum disorders* or, sometimes, *autism spectrum disorders* (ASD). These five conditions include autism or autistic disorder, AS, Rett’s syndrome, childhood disintegrative disorder, and pervasive developmental disorder–not otherwise specified (PDD-NOS).

Asperger’s syndrome is the diagnosis given to individuals who have a cluster of symptoms that affect qualitative impairment in social interaction (restricted, repetitive, and stereotyped patterns of behavior, interest, and activities) and who have no clinically significant delay in language, cognitive development, or adaptive self-help skills (APA, 1994). There is some controversy about the diagnostic boundaries distinguishing between several of the PDDs, such as high-functioning autism, AS, and PDD-NOS, as well as other conditions outside the *DSM-IV* PDD category, such as semantic–pragmatic disorder and nonverbal learning disabilities (NLD; Bishop, 1989, 2000; Klin & Volkmar, 2000; Rapin & Allen, 1983; Rourke, 1989; Szatmari, 2000). For the general purposes of this chapter, however, the relatively subtle differences between these diagnostic labels should be considered primarily a philosophical one because it is ultimately the behaviors, abilities, strengths, and weaknesses of an individual patient that are addressed in therapy, not the person’s diagnostic label. Thus, my focus here is on the issues, particularly the unique attributes of the higher functioning individuals on the ASD spectrum, that represent both targets for treatment as well as personal resources to employ in the therapy. Although I will use the term *Asperger’s syndrome* (or AS) in this chapter, the ideas and methods presented here are likely to also be relevant for individuals who present with similar patterns and issues, even if the diagnosis of AS has not been formally made.

Thus, the defining characteristics of AS are an individual with normal intelligence who suffers core deficits in pragmatic communication and social interaction, and has restricted interests. These can be manifested in a variety of ways and in varying degrees; each individual with AS is unique. A brief description of some of these primary areas of impairment is provided below.

**Social Reciprocity Deficits.** A key deficit area is in the skills associated with social reciprocity. Individuals with AS have difficulty relating to others with the typical “give and take” associated with normal social interaction. Instead, they...
often have a rigid, odd, and self-directed monologue quality to their language. Frequently, they talk about their favorite topics almost endlessly without any regard for whether the person to whom they are speaking even shares any of their interest. Their speech may sound strange, with unusual vocal patterns or inflections, sometimes to the point of even sounding as though they have a foreign accent.

“Mindblindness”. Individuals with AS typically have great difficulty appreciating the perspectives of others, an egocentricity often referred to in the literature as deficits in “Theory of Mind” or “Mindblindness” (Baron-Cohen, 1995). They have poor understanding and use of nonverbal language and social cues, such as facial expressions, gestures, and tone of voice. For example, understanding the indirect nature of sarcasm or insincerity is often difficult for individuals with AS. Unfortunately, this often leads to their becoming the target of mean-spirited jokes and being taken advantage of by others.

Concrete and Rigid Cognitive Style. Difficulties in understanding and using figurative or metaphorical language, including humor, also make up a common problem area. The cognitive style of individuals with AS is typically rigid and concrete, so they do not easily understand either abstract language or concepts. Their ability to focus or pay attention ranges from being highly focused in areas of personal interest to being inattentive and sometimes even unresponsive to others in their environment because of how internally absorbed they can become. Their concentration can be good for areas of interest to them but can also be quite poor, especially when information is linguistically complex and heavily loaded through auditory channels. Typically, their frustration tolerance is often very low for areas not of interest to them, which can make the delivery of therapeutic interventions especially challenging to clinicians trying to engage them.

ASD AND DEPRESSION

The clinical and research literature consistently reports the presence of depression and anxiety as emotional characteristics commonly found in individuals with Asperger’s (Bradley, Summers, Wood, & Bryson, 2004; Ghaziuddin, 2005; Ghaziuddin, Ghaziuddin & Greden, 2002; Lainhart & Folstein, 1994). Whether these are comorbid conditions (i.e., distinct disorders that coexist simultaneously with AS), are part of the AS condition, or are secondary conditions that result from AS is unclear at this time. According to a study by Kim and his colleagues (2000), there is a significantly elevated risk for depression and anxiety problems in children ages 9 to 14 with Asperger’s and high-functioning autism compared with the general population. Recently, attention has started to be given to this important topic, but there is still far too little information available about the diagnosis and treatment of depression in individuals with Asperger’s.
Cognitive Behavioral Therapy, AS, and Depression

Cognitive-behavioral therapy and psychopharmacology are generally regarded as the most appropriate treatments of depression in individuals on the autistic spectrum. These approaches are also considered the treatments of choice for the general population of depression sufferers (Bauminger, 2002; Ghaziuddin, 2005; Thase et al., 1997). Psychologist Tony Attwood (2004) described the need to modify traditional CBT in order to accommodate the unique linguistic, social, and cognitive profiles of individuals with AS. He suggested taking “visual support strategies” that are commonly used in working with ASD individuals and injecting them into the CBT. Some of the modifications Attwood suggested include (a) the use of an “emotion thermometer” in which the pictorial representation of a thermometer is used as a visual support for describing gradations of mood and assuring a similar interpretation of those words used to describe feelings, (b) a picture dictionary of feelings and associated language and personal experiences elicited from the client to maximize word-retrieval skills, and (c) the use of social stories and comic strip conversations. These are tools specifically developed by educator Carol Gray for the ASD population that can help the individual with AS better understand social cues. They can particularly help with recognizing the perspectives and thoughts of others while facilitating the development of appropriate responses for the person with AS through scripts contained in the story or comic strip (Gray, 1998).

Martin Seligman’s cognitively based learned helplessness and attributional-style models of depression (Seligman, 1974, 1989, 1990) have recently been studied in adolescents with AS (Barnhill & Smith-Myles, 2001). There is evidence that the more AS adolescents experienced depressive symptoms, the more likely they were to explain negative events with internal, stable, and global attributions. This finding is consistent with the general population of depression sufferers, who also typically blame themselves when there is a negative event (internal attribution) and who also believe it is an unchangeable outcome (stable attribution) that affects all similar situations or contexts (global attribution) (Seligman, 1989, 1990; M. Yapko, 1992, 1997, 2001b).

Employing Hypnosis in Treating Comorbid Depression in AS Individuals

Hypnosis has been found to be effective in treating depressed individuals with internal, stable, and global attributions (M. Yapko, 1992, 1993, 1997, 2001b). In a special issue of the International Journal of Clinical and Experimental Hypnosis (April 2000), Lynn, Kirsch, Barabasz, Cardeña, and Patterson reviewed the empirical evidence for the efficacy of hypnosis and concluded, “As a whole, the clinical research to date generally substantiates the claim that hypnotic procedures can ameliorate some psychological and medical conditions” (p. 239).

There is substantial clinical support for the use of hypnosis in treating depression, as the expert authors of the chapters in this volume will attest. However,
there is not yet any controlled research to document this. There is sufficient
evidence to infer a realistic basis for using hypnosis with depression sufferers,
and this inference is extended to include targeting the depression of AS individ-
uals. Admittedly, this is speculative, and this chapter is the first in my awareness
to enter into this currently uncharted territory.

The language used in the treatment literature on autism and AS is quite
different from that used by psychotherapists who employ hypnotic and strategic
interventions. However, language aside, there are many parallels in terms of goals
and methods that lend support to using hypnosis and strategic intervention strat-
egies with AS individuals in treating their depressive symptoms. In the remainder
of this chapter, I will describe some of these parallels.

**NATURAL INTERVENTION AND UTILIZATION AS A
TREATMENT MODEL**

Much of the original work with autistic children was based upon applied behavior
analysis principles and the work of UCLA psychology professor emeritus Ivar
Lovaas (1987). Lovaas supported the use of highly structured, behaviorally based
interventions for reinforcing the discrete behaviors necessary to move a child
forward in his or her skill acquisition. In the past 20 years, however, research has
demonstrated that using more natural intervention techniques is also highly effec-
tive for developing language and reducing behavioral problems (Koegel et al.,
1989; Schreibman, Stahmer, & Pierce, 1996; Wetherby & Prizant, 2000; Woods
& Wetherby, 2003). These “naturalistic” programs include principles such as (a)
following a child’s lead in activities; (b) allowing the child, rather than the
therapist, to choose stimulus items; (c) frequently shifting activities and/or stimuli
that interest the child; and (d) utilizing reinforcements that are natural to the
behaviors and environment rather than arbitrary tokens or food reinforcers.

In the hypnosis literature, when one similarly incorporates a client’s frame
of reference, that is, his or her interests, values, history, expectations, and
responses to ongoing environmental stimuli, into the intervention, this is com-
monly referred to as **utilization** (Duncan, Miller, & Coleman, 2001; Erickson,
1958; Erickson, Rossi, & Rossi, 1976). The utilization approach to hypnosis, also
commonly referred to as **Ericksonian hypnosis**, emphasizes adapting one’s
approach to the unique qualities of the person rather than adhering to a rigid or
standardized structure. Standardized approaches assume that the person will adapt
him or herself to the approach or technique employed, rather than striving to fit
the technique to the unique attributes of the person (M. Yapko, 2003). Individuals
with AS typically perceive, process, and respond to stimuli in idiosyncratic ways
that are quite different from those of the general population, which is one of the
many reasons why “fitting in” with others tends to be so difficult for them.
Therefore, any strategy or technique that flexibly takes into consideration the
unique interests, processing style, and language of the person with AS is more
likely to be useful. However, this assumption would need to be tested in order to confirm or deny its accuracy.

Temple Grandin, an autistic author and international speaker, has addressed this same conceptual framework. As one example, she described how she utilized her own obsessive interest with being squeezed into developing the “squeeze machine” for AS individuals, a means of applying deep touch pressure for calming. Grandin suggested that the negative fixations and compulsions that individuals with ASD typically have can be turned into productive activities (2004).

**Pragmatic Language, Social Skills, and Discrimination Strategies in Treatment**

The term pragmatic language was introduced into the speech–language pathology literature almost 30 years ago to describe the appropriate social use of language in specific contexts (Bloom & Lahey, 1978). Pragmatic language includes both the verbal and nonverbal aspects of communication that are part of a specific social context. Verbal skills such as turn taking, the appropriate use of formal or informal language, and indicating the function of the communication (e.g., requesting, directing, or commenting) are components of pragmatics. Nonverbal pragmatic skills include the use of facial expressions, gestures, body language, and vocal inflection. Pragmatic language is a critical area of both research and clinical work for individuals with ASD, given the pervasiveness of their social deficits. The same domain is often referred to as social skills training in the psychological and autism literature.

A concept that parallels the emphasis on pragmatics is the idea of facilitating effective discrimination strategies. A discrimination strategy allows one to recognize and respond with a sense of deliberateness to the unique attributes of a specific context rather than just responding reflexively, a skill Michael Yapko (2001b) strongly encouraged in the treatment of depressed individuals. In other words, individuals are encouraged to recognize which contexts call for which effective behaviors and skills (i.e., knowing what to do, when to do it, and with whom).

In the lives of AS individuals, this is an especially critical issue because it is their lack of discrimination skills that creates many of the social difficulties they suffer. They typically have one rigid way of behaving and communicating, regardless of the context they are in at the time. Predictably, this leads to frequent episodes of social rejection that may contribute further to depressed mood. For example, the formal, polite language and respectful speaking style that are appropriate and appreciated when a child with AS is speaking to an adult are ridiculed and used to ostracize the child from peers if he or she approaches them in the same way. Unless he or she adjusts by using the same kind of informal and slang language used by the peer group, the AS child invites potentially devastating criticism and rejection.
Other examples of discrimination strategies might include skillfully knowing when to express feelings and when not to, knowing whom to express them to and whom not to, and knowing when and when not to initiate a conversation. Clinicians need to be able to provide very direct and concrete criteria to AS individuals to help in this regard. Michael Yapko has said that the same is generally true for depressed individuals (2001a, 2001b).

People who overcome adversity are typically able to put negative experiences into a separate category, essentially kept apart from everything else in their life that is good or satisfying. This is a skill called compartmentalization, and it is directly related to effective discrimination strategies. Individuals with AS typically don’t compartmentalize as a general strategy, simply because they don’t differentiate well between contexts. Their behaviors tend to be consistent between situations and people, suggesting that their ability to compartmentalize is underdeveloped. This is strongly associated with the global thinking style of depression sufferers who similarly believe that the negative events in one’s life affect everything (Seligman, 1989, 1990).

Discrimination skills alone will not resolve the skill deficits that individuals with AS experience. Thus, therapy needs to continually encourage social skill acquisition as well as discrimination strategies for context specificity that facilitates generalization of newly learned skills outside the therapeutic environment.

**Complementarity in Therapy and Encouraging Flexibility**

Effective therapy has been defined as being complementary in structure to the client’s symptoms (Haley, 1973). In other words, clinicians can identify the structural components of the client’s symptom patterns and strive to provide experiences that counterbalance them. To illustrate this point with depressed clients, Michael Yapko (1992, 2001b) identified depression as being a past-oriented phenomenon that responds well to more present- and future-oriented interventions. Therapy thus amplifies skills that clients already have while also either providing clients with additional skills they are missing or teaching them how to more effectively use the skills they already have.

This principle of complementarity may offer further support to the hypothesis that the utilization approach to hypnosis is well suited for working with individuals with AS. Flexibility, which is modeled by the clinician and taught as a skill to the client, is an essential counterbalance to the rigidity typically seen in this population.

In AS individuals who suffer depression, as in depressed individuals in general, there are many predictable, rigid, self-organizing patterns that are appropriate targets for hypnotic intervention. Some of these include cognitive and perceptual rigidities, difficulties managing ambiguity, control issues, attentional impairments, a past temporal orientation, poor ability to compartmentalize, and perseverations or ruminative thoughts (Beck, 1976, 1997; Burns, 1999; Nolen-Hoeksema, 2000; O’Connor, 1997, 2001).
Rigidity is a core feature of individuals with AS, affecting how they think (cognition), perceive the stimuli in their world (perception), feel, and behave. The autism literature frequently refers to executive function deficits when addressing issues pertaining to cognitive flexibility and central coherence deficits when referring to the difficulties of bringing together diverse bits of information to form a meaningful whole (Frith, 2003; Hill, 2004; Ozonoff & Griffin, 2000). The concreteness of the cognitive style associated with individuals on the autism spectrum makes recognizing and tolerating ambiguity an ongoing challenge in their lives. Therapy often focuses on teaching AS clients how to see “gray,” not just “black and white.” Similarly, one of the rigidities typical of depression sufferers is that they interpret ambiguous situations (i.e., situations with no single, clear meaning) in one rigid, typically negative way that hurts them (M. Yapko, 2001a). As a simple example, if a depressed person leaves a phone message on a friend’s answering machine and the call is not promptly returned, he or she is likely to automatically attribute this to not being liked by the friend anymore, a painful sign of rejection. The depressed person is unlikely to generate alternative explanations (such as the person has yet to return home to receive the message, or it was not yet given to him or her by a family member who may have picked up the message first). This same pattern of negatively interpreting ambiguous events is often seen in individuals with AS. For example, when asked, “Who did you play with at school today?” the answer is typically, “No one.” When questioned as to why that was the case, the answer might typically be, “Because the kids don’t like me.” Although this may not be entirely incorrect, it may not be entirely correct, either. The cognitive rigidity is evident in the individual with AS generating only one negative attribution and going no further in his or her thinking: He or she isn’t able to generate any other reasons (e.g., he or she doesn’t know how to play the game and therefore wasn’t included, he or she isn’t a good soccer player and so wasn’t wanted on the team, or he or she wasn’t present when teams were chosen). Perceptually, individuals with AS are so rigid that they can only see situations from their own limited and even depressing perspective. Therefore, therapy needs to model the importance of generating multiple perspectives and provide AS individuals with specific strategies for developing flexibility in perceiving information and seeing possibilities beyond their own rigid, reflexive, and self-limited ways.

Clarifying Controllability

Individuals with AS, like others who experience depression, generally do not accurately assess the degree of control they have in specific situations to influence desired outcomes. They may incorrectly assume they have some control where they actually have little or none, or they may perceive they have little or no control when they do, in fact, have some. For example, it is common that individuals with AS adhere rigidly to rules and unrealistically expect others to do exactly the same. They may overestimate their control in situations where they intrusively
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and inappropriately attempt to enforce rules upon others when it is not their responsibility to do so. For example, in the classroom, it is generally the teacher’s responsibility to manage the behavior of the students, but the AS individual may step in and attempt to take over that responsibility, generating ill will in the process. Similarly, at home, it is primarily the parents’ responsibility to manage the siblings’ behaviors, but the AS individual may create family tension by trying to enforce rules that are not his or hers to enforce.

In contrast, AS individuals may not think they have control over certain situations when, in fact, they may have some. This parallels the helplessness seen in depression sufferers (Seligman, 1974). For example, individuals with AS often report episodes of being bullied or ridiculed that some research has suggested is one of the possible causes of depression in these individuals (Attwood, 1998). In such situations, individuals with AS typically underestimate their control, often retreating into social avoidance (a consequence of overgeneralization) or blaming others for circumstances they believe to be beyond their control. There are times, however much we may sympathize with their plight, when their own behavior may have been the impetus for getting bullied. In other words, sometimes the child gets bullied with no provocation, but sometimes the child with AS who is bullied may have been engaging in a behavior that prompted the ridicule in the first place. By always talking about their particular restricted topic of interest, for example, by engaging in socially inappropriate behaviors such as picking one’s nose, or by acting as “the enforcer,” the child may unintentionally give some intolerant kids fuel for teasing him or her. In no way does this justify bullying, of course, but it does highlight how issues of control may be misunderstood and serve as a potential target of therapy. This parallels the vitally important concept of “stress generation” in the depression literature, referring to ways in which depressed people actively, though unintentionally, contribute to their depression worsening (Hammen, 1991). The AS child needs to learn that his or her behavior affects others, and that behavior can be changed to elicit more positive feedback from others. He or she is not helpless, despite too often believing him or herself to be. Hypnotic suggestions to empower the child to better distinguish what is controllable from what is not controllable are important to the larger aims of therapy, as is empowering the child to recognize his or her capacity for positive influence in a variety of situations.

Attention and Focus

A basic premise in hypnosis is that what you focus on, you amplify in your awareness (M. Yapko, 2003). Hypnosis as a process involves deliberately shifting someone’s focal points in order to introduce and absorb him or her in new possibilities that can enhance his or her experience. It has been shown that someone can manifest hypnotic phenomena even when in an active and alert state (Bányai, Zseni, & Tury, 1993; Cardeña, Alarcón, Capafons, & Bayot, 1998). Hypnosis can take place without the ritual of a formal induction or without the necessity of eye
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closure or incantations to relax. Therefore, it might reasonably be said that when individuals with AS (and depression, too) are exclusively focused on their own areas of interest, so absorbed that they essentially dissociate from external, ongoing experience, they are in a state that may either be hypnosis or at least share some common characteristics with hypnosis. This has been a primary rationale for why I incorporate hypnosis into my clinical practice and treatment of AS individuals. Therapy employing hypnotic and strategic interventions first acknowledges and then utilizes the AS individual’s ability to focus on one area to the exclusion of another, and reframes it as a skill to be accessed in other contexts with a more socially appropriate direction.

AS, Depression, and the Past Orientation

A past orientation means that the person uses the past as a reference point for making new decisions, projects past failures into future contexts, and tends to hash and rehash past episodes. This is generally true with most depression sufferers (M. Yapko, 1985, 1992, 2001b). It has been my experience that individuals with AS will describe in great detail past episodes of failure and/or injustice they have experienced, even though the examples may be in the distant past and irrelevant to the current contexts that are causing them difficulty. They may retell one particular negative incident over and over again and react as emotionally to it as if it is still happening in the present. One of the salient attributes of the AS population for clinicians to be aware of is that although their language patterns on the surface may appear to be unaffected, they may have difficulties in sequencing narratives and describing personal experiences. Whether this is due to their focus on the details rather than the whole (central coherence deficit theories) or their difficulties in planning and organizing (executive function deficit theories), or perhaps some other factors, is not known. Such individuals will thus explain a negative experience as being current when, in fact, it is something that may have happened in the past, possibly even in the distant past. I have had numerous experiences of children with AS relating a story about bullying or teasing at school as if it is currently happening when additional questioning or parental input revealed that the experience actually happened many years ago. Not only do AS individuals focus on rehashing the past to make themselves unhappy in the present, like other depression sufferers, but they also use this past orientation as a predictor of the future. Their stable attributional style (i.e., enduring belief that conditions will not change) contributes powerfully to viewing the negative events in their past as indicators of what the future holds for them (Seligman, 1989, 1990). Hypnosis to build positive expectancy that things can change for the better is an especially important application in addressing the depression associated with AS (Kirsch, 1990; Torem, 1992; M. Yapko, 1992, 2001b). Without a sense that things can improve, there is no motivation for the AS individual to do the often difficult work associated with being in therapy.
**Perseveration and Rumination**

The frequent retelling of the same story over and over again, the constant rehashing of pointless information, or even the repeating of a single word or behavior over and over again is diagnostically referred to in the autism literature as *perseveration* or *repetitive behaviors* (APA, 1994). This is a common symptom in individuals with AS, probably most often seen in a perseverative monologue on their favorite topic. This style of perseverating or repeating something over and over again may be related to a coping style associated with depression called *rumination*. Rumination is the repetitive loop of thinking the same distressing thoughts over and over again with no useful outcome. Rumination has been shown to be a primary predictor of depression’s onset, as well influencing the quality and severity of depressive symptoms (Just & Alloy, 1997; Nolen-Hoeksema, 1991, 2000, 2003). Just as clinicians want their depressed clients to convert ruminative thoughts into constructive courses of action as a means of empowerment, when AS individuals are perseverating, clinicians will want them to do the same. Hypnosis can be used to suggest new “cues” for self-recognizing perseveration and for recognizing opportunities to take effective action. Learning to read situations more insightfully in order to better know what an effective action might be reinforces the value of the discrimination strategies described earlier.

**Where to Begin? Another Look at Assessment Issues**

With so many different potential targets in treating individuals with AS, it can be difficult to know where to begin. Sequencing multiple therapeutic goals is an important consideration in order to address the issues that are most distressing to the individual or are most negatively affecting his or her life. Depression as a primary diagnosis allows more of a singular treatment focus than occurs in AS individuals, where depression is just one of many important issues that may be present in so pervasive a condition.

Determining whether the AS individual is depressed and, if so, when to target the depressive symptoms in treatment are matters of clinical judgment, informed by self-reports from the client as well as reports from the parents and/or spouse of the AS individual. Contact with others who know the person is valuable because AS individuals may not be able to accurately report on their own mood. Asperger’s syndrome individuals frequently have difficulty with recognizing, responding to, and expressing their emotions. This is not to say that they do not have the emotions; rather, it means there is often difficulty in labeling the emotion, identifying the cues that suggest emotion (e.g., voice, posture, facial expression, and change in behavior), and regulating the expression of that emotion. But those who know the individual well are often aware when the individual is struggling with his or her feelings. In a study by Butzer and Konstantareas (2003), parents rated their children with AS as being significantly more depressed than did the children themselves. It’s possible, of course, that parents were engaging in some
degree of projection, but given the difficulties that AS individuals typically have in managing their feelings, it is reasonable to hypothesize that much of their depression is underrecognized and therefore undertreated as well.

Ghaziuddin (2005) reported that there are several special features of depression in people with PDDs. These typically include an increase in existing behaviors typical for the AS individual, such as an increase in social withdrawal, an increase in ritualistic behaviors, or a change in the quality of the fixations or perseverative topics that they discuss. The topics may turn to ones with a darker, more negative focus, increasing the likelihood of negative emotions being associated with them (Ghaziuddin, 2005).

In diagnosing depression in individuals with AS, consideration must be given to the historical nature of a symptom, specifically whether it is a new one or has been there all along and, if so, whether there is a change in its quality. Because newly troublesome symptoms may reflect an increase in previously existing symptomatology, it may be difficult for some individuals with AS to see the problem(s) in themselves. Likewise, this may be a reason why affective disorders tend to be underdiagnosed in this population: Clinicians may incorrectly attribute the increased symptoms to the AS diagnosis rather than to a comorbid affective disorder (Samet, 2005).

One other diagnostic issue deserves mention. Sleep disturbances are a common feature and even a predictor of depression in the general population (Thase & Howland, 1995). It is, therefore, no surprise to see an overlap: sleep problems are quite common in the ASD population (Tani et al., 2004). Further research in this area is needed in order to know whether treating the sleep disturbance in individuals with AS can help improve their level of depression as it does in the general population of depression sufferers.

**INCORPORATING HYPNOSIS INTO THE TREATMENT PROCESS**

Hypnosis has been defined in various ways over the years, leading to many different theoretical models describing its mechanisms of action (Barabasz & Watkins, 2005; Hilgard, 1991; Weitzenhoffer, 2000). In addition to the utilization approach of the late psychiatrist Milton Erickson (Erickson, Rossi, & Rossi, 1976; Gilligan, 1987; Lankton & Lankton, 1983), the social influence model described by Michael Yapko (2003), in which meaningful ideas are suggested in an interpersonal context that can motivate the client to accept and utilize the ideas, is a primary framework guiding my work with AS individuals. Clinical experience with AS children over the past 20 years has provided many clinical opportunities to apply a social influence model of hypnosis involving a utilization approach. Although I will typically collaborate with psychologists or psychiatrists when psychologically oriented conditions such as depression, anxiety, or obsessive-compulsive behaviors become a primary area of concern in treatment, I have had
unavoidable opportunities to target some depressive symptoms, particularly when working on social skills training. A sample transcript from a hypnosis session for enhancing social skills is provided below in order to illustrate how salient suggestions might be worded in working with an individual diagnosed with AS.

_Hypnosis and Enhancing Social Skills: A Case Example_

In the following case example, a 9-year-old boy who will be called John (not his real name) was diagnosed with ASD at the age of 3. He resides with his biological parents and an older brother who has no developmental or neurological issues. There is no family history of any similar problems in extended family members. John has had formal psychoeducational assessments documenting his intelligence and academic abilities, and these reveal he is in the average to above average range. John’s parents initially consulted with me when he was in preschool, primarily to address pragmatic language issues. Treatment occurred weekly for approximately a year and eventually changed to a monthly consultation model when his progress required a less intensive level of service. Additionally, services were being provided by the school district, which was the context (with his peers) in which he required the most support and assistance. John’s parents remained in phone contact with me and periodically would bring him in for sessions to address acute social/behavioral issues.

As John got older, his resistance to therapy grew, and he was reluctant to participate in sessions that addressed his deficits. He believed that he didn’t require any intervention and that even if he did, he felt that what he got at school was certainly more than enough. Therefore, when John arrived for the session described below, his resistance to working with me was undisguised, and so, too, were his problems. His mother reported that John was often talking about not being liked by his teacher and his peers. He perceived feedback from his teacher or comments from his peers as personal affronts to his intelligence, a personal characteristic that he valued.

Although John’s ability to relate well to his peers at school was apparently improving according to parent and teacher reports, he continually spoke of how inept and stupid he was (internal and global attributions), how he always did the wrong thing and always got in trouble (stable attribution), and how no one liked him (global attribution). As John’s mother reported the increase in these types of statements and described their perseverative nature, it was clear to me that John’s internal, stable, and global attributions, which have been strongly associated to depression, either were likely depressing him or were at least putting him at risk for depression (Seligman, 1989, 1990). Given his difficulty in identifying or articulating his feelings, it was difficult to determine whether he was currently depressed and, if so, to what degree. His language and sad demeanor certainly suggested it was a reasonable concern.

Choosing to address John’s perceptions and cognitive style became important targets for intervention if John’s social-skills behavior and mood were to improve.
Because of John’s resistance to therapy and addressing his issues “head-on,” a formal hypnotic approach was employed in order to reduce his resistance and to alter our usual patterns of interaction he had come to expect in therapy.

John’s particular area of interest was the ocean, and going to the beach was a favorite activity. John’s interest in the ocean was used in the following hypnosis session in order to (a) help him focus on increasing his flexibility in social interaction, (b) be more accurate in his attributions, and (c) enhance his ability to shift his focus from an internal self-absorption to an awareness of external social cues through a pattern interruption strategy. It was deemed especially important to help John change the specific pattern of his negative behavior of focusing on his own interests without any apparent regard for his listener’s interests. John was able to focus for brief periods of time, and he was interested in and receptive to the experience of hypnosis in our sessions.

Session Transcript: Building an External Orientation

I wonder if you can remember what it is like to dream when you sleep. … If you do this while you’re awake, it’s called daydreaming. … You can daydream … here … for a little while. … Using your imagination in new ways … that can feel good to you … and help you feel good about yourself … in ways that might surprise even you. … Just as your face has eyes that can see, your mind can see … you have a mind’s eye that sees things in your dreams … so if you want … you can close your eyes … or you can even lie on the floor … if you want … and let your day … dream … begin. One of the nice things about dreaming … is that your body gets to relax … while your mind can think … and imagine … and wonder … all kinds of things … and … there is no one to tell you what to say … or do. … You can be in charge … of your dreams. … You can think anything you want to think … while your body gets even more comfortable. … And one of the things you may want to think about is the ocean … and you know how much you like to swim … and you know how comfortable you feel in the water. … I wonder if you are just floating on the surface … or if you are going deeper … and I don’t know if you hear the sounds of the water … or if it is quiet where you are … and as you imagine being in the water … you can choose to focus on many different things … maybe it will be how the water feels … or it might be the sights … or perhaps the sounds … of the water … or maybe it is wonderfully quiet … yes, that’s right … your breathing begins to slow down … as you relax … and enjoy being in the water … and I don’t know what you might notice … yet … but we both know and we both really enjoy knowing … that the ocean has many different fish … and many different forms of life … like the seaweed that you might notice … or the shells that wash up on the beach … and there are so many fish who live in the saltwater of the ocean … fish of every size and color you can imagine … but not all fish can live in the ocean … there are some fish that can only live in fresh water … and that’s where they thrive. … Being in the right place … for a particular fish … is obviously very important to their survival. … There are some fish that are very colorful and other fish that seem to be without any color … and as you … go deeper … there are many more things in the ocean to notice … when
you learn to notice … and you can learn to notice … them … so, there may be
a rock … or what you think is a rock … that as you … look closer … starts to
move … yes, that’s right … just slight movements … and then you start to notice
that it is not a rock after all … but a clever fish that camouflages itself … so that
it can look … and act … like a rock sometimes … and at other times, it looks
and acts like a fish … and isn’t it interesting that fish can adapt … as a way of
protecting themselves … and as a way of growing and thriving … something you
can think about when you need to adapt … and thrive … and I wonder if you will
notice the fish that change colors … a good reminder that change is possible …
or if your attention was focused on something else … that’s right … there are
many different things that you can focus on … your attention can shift … from
this … to that … as the water moves from here … to there … and with each wave
of the water … you go deeper … more comfortable … that’s right … and I wonder
what you might choose to notice … there are so many things to focus on … and
maybe it will be the octopus that lies on the ocean floor seemingly unaware of
its surroundings, only to see how quickly it can respond … when the circumstances
are right … that’s right … you know all about fish … you know they act differently
depending on their circumstances … they will change … color or shape … or
maybe they will change the speed with which they move … and … you know fish
… change to survive … just like you … can begin to notice … when it is good to
talk about fish … and when … it is good to choose something else to talk about.
… Just like when you watch fish … you are so focused … you are so very focused
… when you talk about fish … you can start to notice so many details … at the
same time … you can start to notice … changes in people too … people don’t
change their size … or shape … or color … but they do change their eye contact
… they do adjust the position of their bodies … and they do change topics of
conversation … and you can start to notice at least as much about changes in
people … as you notice about changes in fish … like when you notice that you
can change … the subject … and you notice that your friends talk to you more
… and you can change … your focus from fish … to subjects your friends want
to talk about … and as you begin to shift your focus … and change … you can
enjoy discovering that the world of people … is at least as interesting as the
world of fish … and as you become more and more observant … skillful in noticing
… you can enjoy noticing how much people can find in you to enjoy … because
you’re not the same as you used to be … you’re changing … and growing … in
ways I’ve noticed … and your mom has noticed … that you can notice, too …
and I think it will be very soon … that you notice you’re feeling better about
yourself … more aware you have the ability to notice things … and you can begin
to start the process of coming out of the daydream. … As you begin the ascent
from the ocean deep up to the surface … you can comfortably adjust to the
changing light conditions … as you approach the surface … noticing the sun
through the water … and noticing the sounds of my office … and looking around
again at all the familiar things you can notice here … that’s right … like seeing
the books on the shelf and the toys in the room … and even the look on my face
… and the expression in my eyes … that’s right, you can open your eyes and
notice many things now and later today … that feel good to notice. …
Follow-Up and Discussion

In the above transcript, John’s interest in fish was utilized to highlight the importance of context: fish need the right environment to thrive. The indirect message was directly extended into his own life, encouraging him to notice and respond to others in order to also thrive. The session was considered useful for John; he commented on how he could choose to look at certain things and notice more things, and he liked that idea. We discussed the metaphor further and used it to offer each other examples of what is important to notice when you’re a fish, and especially what’s important to notice in the environment when you’re a human. His level of enthusiastic participation in the discussion was an impressive reversal of his previous apathy. The experience of hypnosis seemed to soften some of his rigidities.

Because John’s issues had extended into realms outside the usual practice parameters of a speech–language pathologist, including his newly recognized obsessive-compulsive behaviors (another common comorbid condition in AS), a referral to a psychologist was made at the conclusion of this session. John has responded well to the cognitive-behavioral approaches used by the psychologist to whom he was referred. He is no longer berating himself, and he has been doing well in school. He has continued to work with the psychologist on addressing his cognitive patterns, especially the obsessive-compulsive disorder, and has recently returned to work with me on issues associated with written language.

The formal hypnosis session above was just one of many different therapeutic strategies used with this client. It was not intended to be a single-session intervention; the need for repetition and rehearsal across many different situations is essential in working with individuals with AS, so pervasive are their detriments. Their ability to generalize and apply new skills outside of the immediate context in which they were learned is generally poor. However, hypnosis can help in this regard, because the use of posthypnotic suggestions can help to contextualize the resources outside of the therapeutic relationship (M. Yapko, 2003). It can be suggested to the client, for example, that the more these suggestions relate specifically to his or her personal experiences and areas of interest, the more easily he or she will access such information when it is needed outside of therapy. This can hold true for working with individuals with AS in general, whether or not formal procedures involving hypnosis are utilized in the treatment process.

Understanding ambiguity and metaphor is another difficult area for this population, so the suggestions provided in hypnosis must be, at least in part, direct and relate specifically to the salient issues (Burns, 2001). Indirect suggestions may also be used, of course, but helping AS clients to interpret them and remember their essential message is important given their cognitive and linguistic profiles. The clinician must take the initiative to make easily grasped connections for the client, particularly if he or she is also depressed and less proactive, rather than assuming that the client will somehow do it on his or her own. Finally, a child’s focus in general is typically short, and an AS child’s focus is likely to be
even shorter. Thus, keeping the hypnotic experience brief is important unless and until you can build the focus and interest of the person to be more enduring in such experiences.

TO HYPNOTIZE OR NOT TO HYPNOTIZE?

Determining whether to use hypnotic strategies with individuals on the autistic spectrum is essentially the same as determining whether to use any other intervention strategy. Specifically, a clinician must ask him or herself several questions: (a) what goal is to be accomplished, (b) how might the session’s goal best be achieved with this particular individual, (c) what strengths and interests (e.g., personal resources) does this client have that would be appropriate and helpful to utilize, (d) what deficits might this person have that may interfere with utilizing a particular strategy, and (e) how much attentional focus and concentration does this client have at this time?

The more linguistically impaired the client, the less likely a verbal approach of any kind will be effective. As this chapter has primarily focused on individuals with AS, their language skills would generally not preclude a hypnotic approach. However, the specific language used must be at an appropriate level for the ideas to be understood, accepted, and utilized by the client. As previously stated, individuals with AS have difficulty with figurative language, idioms, metaphors, humor, and sarcasm. They are also very concrete in their understanding and use of language. Therefore, hypnotic suggestions must be offered within the range of their language abilities. Furthermore, connections (i.e., associations) between the suggestions given and their personal life must be made for them because their ability to generalize information from one context to another is a well-known deficit area (Klin, Volkmar, & Sparrow, 2000; Lawson, 2001). Temple Grandin has often described how she “thinks in pictures” (1996). Wendy Lawson, another adult with ASD who has also written about her personal experiences, has described the need to have those pictures put into a meaningful context, including intention and relationship to previously learned information (2001). Hypnosis may be considered a valuable means for facilitating visualizations as well as putting images and ideas into a meaningful context for generalization.

CONCLUSION

As valuable as hypnosis might be in treating AS individuals, hypnosis cannot be thought of as a therapy or a means of curing AS. Currently, there is no information documenting the benefits of using hypnosis in therapies with individuals who have symptoms on the autistic spectrum and also have symptoms of depression. Despite no controlled research having been conducted yet in this area, there is ample clinical evidence that hypnosis enhances the treatment process. This chapter has described some of the benefits to be attained by integrating hypnotic
techniques with other, better established depression therapies, such as cognitive-behavioral therapies, with individuals on the autistic spectrum.

Treatment effectiveness is associated with defining explicit goals of treatment. Therefore, specific targets have been identified in this chapter for the purpose of developing goals in therapy, including reducing the classic cognitive and perceptual rigidity seen in this population, reducing their anxiety, helping with sleep, developing social skills, dealing with ambiguity, clarifying control issues, building attentional focus, fostering a more future-oriented temporal orientation, enhancing the ability to compartmentalize, and reducing perseverations and ruminative thoughts.

Hypnosis is a therapeutic tool that can be used effectively to enhance a variety of interventions. This chapter introduces readers to ways hypnosis can be applied with a clinical population that has not previously received such attention. How hypnosis, when used properly by well-trained professionals, may be helpful in supporting treatment protocols already in place with individuals on the autistic spectrum is an exciting wilderness of uncharted territory that is ripe for exploration.

EDITORS SUMMARY

- Individuals with autistic spectrum disorder (ASD), a complex neurobiological pervasive developmental disorder, often suffer depression as a comorbid condition.
- The relationship between ASD and depression has received little attention thus far, but there is some evidence to suggest they share some common etiological factors, especially a pervasive sense of helplessness.
- Diagnostic criteria for ASD are provided, and the relationship to depressive symptoms is described.
- Social skill deficits, cognitive rigidity, and a concrete cognitive style are identified as overlapping patterns between ASD and depression.
- Cognitive-behavioral therapy (CBT) has been applied in the treatment of ASD, and some of its associated strategies are also relevant for treating comorbid depression.
- Applying hypnosis to enhance CBT in treatment has a plausible underlying rationale but has not yet been studied in depressed individuals in general or in comorbid ASD individuals in particular.
- Hypnosis has been shown to be effective in clinical practice, however, particularly when applied in the context of teaching specific skill-building strategies.
- The utilization approach emphasizing more natural forms of hypnotic intervention seems to have greater impact on individuals with comorbid depression and ASD when teaching such skills as “pragmatic language,” making distinctions, and clarifying controllability.
Patterns of personalization, a past orientation, and rumination are identified as common targets of intervention for both depression and ASD.

A detailed case example of hypnotic intervention with a comorbid ASD and depressed individual is provided.

REFERENCES


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HYPNOSIS AND TREATING DEPRESSION


Section IV

SPECIAL CONSIDERATIONS REGARDING HYPNOTIC TREATMENT
Medication and Suggestion in the Treatment of Depression

IRVING KIRSCH

In June, 2003, British drug regulators warned that paroxetine causes depressed children to become more suicidal and should not be prescribed for them. Six months later, the ban was extended to all but one selective serotonin reuptake inhibitor (SSRI). The exception was fluoxetine (Prozac). Then, in September 2004, it was reported that the risk of suicide was increased by fluoxetine as well.

Why should SSRIs increase the risk of suicide only in children? In fact, the data suggest that the risk is much wider. A meta-analysis of the clinical trial data in adults reveals that patients given SSRIs are five times more likely to commit suicide than those given placebo (Healy, 2003). Furthermore, the increased risk of suicide is seen for each of the antidepressant medications evaluated (sertraline, paroxetine, nefazodone, mirtazapine, bupropion, citalopram, and fluoxetine).

Data indicating that SSRIs pose a serious threat to patients present clinicians with a problem. Are the benefits of these medications worth the risk? This dilemma is based on the assumption that SSRIs are effective treatments for depression, an assumption that matches the widespread perception of health care professionals, patients, and the population at large. But is that assumption

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HYPNOSIS AND TREATING DEPRESSION

warranted? This has been the topic of two meta-analyses that my colleagues and I have conducted and is the subject of this review.

LISTENING TO PROZAC BUT HEARING PLACEBO

I began working in this area not because of any interest in evaluating the effects of antidepressants, but because of my long-standing interest in the effects of response expectancy (Kirsch, 1985). Response expectancies are anticipations of automatic subjective reactions, such as changes in depression, anxiety, pain, and so on. I have argued that response expectancies are self-confirming. The world in which we live is ambiguous, and one of the functions of the brain is to disambiguate it rapidly enough to respond quickly. We do this, in part, by forming expectancies. So what we experience at any given time is a joint function of the stimuli to which we are exposed and our beliefs and expectations about those stimuli (Kirsch, 1999).

This response expectancy hypothesis has been the focus of most of my research. The particular topic areas (hypnosis, psychotherapy, placebo effects, etc.) were chosen merely because they provided a convenient opportunity for examining expectancy effects. It seemed to me that depression ought to be particularly responsive to expectancy effects. This is because hopelessness is a central feature of depression (Abramson, Seligman, & Teasdale, 1978), and hopelessness is an expectancy. Specifically, it is the expectancy that a negative state of affairs will not get better, no matter what one does to alleviate it.

If you asked depressed people what the worst thing in their lives is, many will tell you that it is their depression. They believe that their depression will continue, no matter what they do—a very depressing thought indeed. As John Teasdale (1985) noted, these people are depressed about their depression.

If this is the case, then the expectancy of improvement should produce improvement. That is, the belief that one will improve is the opposite of the hopelessness that may be maintaining the depression or at the very least is an important component of it. In other words, there ought to be a substantial placebo effect associated with the treatment of depression.

It is with this in mind that my colleague, Guy Sapirstein, and I undertook to evaluate the placebo effect in depression (Kirsch & Sapirstein, 1998). We searched the literature for studies in which depressed patients had been randomized to receive antidepressant medication, an inert placebo, psychotherapy, or no treatment at all. We included studies of psychotherapy, because those were the only ones in which patients had been randomized to a no-treatment control condition, and we needed that condition to evaluate the placebo effect.

One needs no-treatment control conditions to assess the placebo effect because the response to a medication is not the same as the effect of that medication. Instead, that response may be partly due to the placebo effect, the passage of time, spontaneous remission, the natural history of the disorder, and regression...
to the mean. That is the reason for using placebo controls in a clinical trial. Similarly, the response to a placebo is not the same as the effect of the placebo. The placebo response (as opposed to the placebo effect) may at least in part be due to the passage of time, spontaneous remission, the natural history of the disorder, and regression to the mean. Just as the difference between the drug response and the placebo response is deemed to be the drug effect, so the difference between the placebo response and improvement in a no-treatment control group can be interpreted as the placebo effect.

The results of our meta-analysis indicated substantial improvement among patients given medication (1.55 standard deviations) or psychotherapy (1.60 SDs). However, patients given placebos also improved (1.16 SDs), whereas those in no-treatment control groups showed relatively little improvement (0.37 SDs).

We had expected to find a substantial drug response, and we had expected to find a substantial placebo response as well. What we did not expect was to find such a small drug effect. One way of understanding our data is with respect to the antidepressant pill illustrated in Figure 12.1. If we partition the response to antidepressant medication into its components, we find that about 25% of the improvement would have occurred without any treatment whatsoever and 50% is associated with the administration of a placebo, leaving only 25% as a drug response.

Our surprise at the outcome of our analysis led us to wonder whether it may have been due to the diversity of antidepressants in the clinical trials we had analyzed. Perhaps some of the medications were very effective and others not, leading us to underestimate the drug effect.

To assess this possibility, we returned to our data set and classified the various studies in terms of the type of medication evaluated. We categorized them into four types: tricyclic medications, SSRIs, miscellaneous other antidepressants, and other medications. The consistency was remarkable (see Figure 12.2).

![Figure 12.1 Partitioning the antidepressant drug response.](image-url)
Regardless of the type of medication studied, about 75% of the response was duplicated by placebo, leaving a true drug effect of only 25%. What makes this particularly surprising is the response to what we have labeled other medication. These are active drugs that are not regarded as antidepressants (e.g., lithium, barbiturates, and thyroid medication given to depressed patients who were not suffering from depression). They, too, produced substantial improvement in depression, as great as that produced by tricyclics, SSRIs, and other antidepressants.

So what is it that all of these medications have in common that they do not share with inert placebo? One thing they have in common is that they all produce side effects. Placebos can also produce side effects, but they do so to a much lesser degree than these active medications. Why is this important? Imagine that you are recruited to a clinical trial for an antidepressant medication. As this is a double-blind trial, you are told that you may receive medication or you may receive placebo. You are also told that the active medication has been reported to produce a number of side effects, such as dry mouth and drowsiness, and you are told that the therapeutic effect may not become evident for some weeks. You are likely to wonder to which group you have been assigned, the active drug group or the placebo control group. You notice that your mouth has become dry and that you feel drowsy. At this point, you are likely to conclude that you have been assigned to the drug condition. Indeed, data indicate that about 80% of patients assigned to the active drug condition in clinical trials of antidepressants break blind and conclude that they are in the active drug condition (Rabkin et al., 1986). Being more certain that you have been assigned to the drug group, you will have a stronger expectancy for improvement, which according to the response expectancy hypothesis should produce greater improvement. In other words, it is possible that the superiority of active antidepressant to inert placebo is due to the breaking of blind by patients in the active drug condition. Rather than being a true drug effect, it is an enhanced placebo effect.
THE EMPEROR’S NEW DRUGS

Needless to say, these data proved to be quite controversial. Their publication led to heated exchanges. The response from critics was that these data could not be accurate. Perhaps our search had led us to analyze an unrepresentative subset of clinical trials. Antidepressants had been evaluated in many trials, and their effectiveness had been well established.

In an effort to respond to these critics, we decided to replicate our study with a different set of clinical trials (Kirsch, Moore, Scoboria, & Nicholls, 2002). We used the Freedom of Information Act to request that the U.S. Food and Drug Administration (FDA) send us the data that pharmaceutical companies had sent to it in the process of obtaining approval for six SSRIs that accounted for the bulk of antidepressant prescriptions being written at the time.

There are a number of advantages to the FDA data set. First, the FDA requires that the pharmaceutical companies provide information on all of the clinical trials that they have sponsored. Thus, we had data on unpublished trials as well as published trials. Second, the same primary outcome measure—the Hamilton Depression Scale (HAM-D)—was used in all of the trials. That meant that we could pool the data without having to calculate effect sizes and that we would be able to understand their clinical significance. Third, these were the data on the basis of which the medications were approved. In that sense, they have a privileged status. If there is anything wrong with them, the decision to approve the medications in the first place can be called into question.

Figure 12.3 shows the mean response to medication and placebo for each of the SSRIs about which the FDA had sent us data. For each medication, most

![Figure 12.3](image_url)

*Means for failed trials not reported

[Drug] [Placebo]

Figure 12.3 Response to medication and placebo for six SSRIs.
of the drug response was duplicated in the placebo condition. But this chart overestimates the drug effect. Although the FDA required that information on all trials be sent to them, the manufacturers of paroxetine, sertraline, and citalopram did not send the actual numbers associated with failed trials. Instead, they merely reported that these trials had not revealed a significant benefit for medication over placebo. Because they exclude the trials showing the least benefit for their drugs, the data supplied for these medications overestimate the drug–placebo difference.

Pooling across the three medications for which we have complete data, we find that 82% of the drug response was duplicated by placebo. More important, the difference between drug and placebo was less than 2 points on the HAM-D. In clinical terms, this difference is meaningless. In other words, when published and unpublished data are combined, they fail to show a clinically significant advantage for antidepressant medication over inert placebo.

There are two types of design that were used in these clinical trials. The most common involved allowing prescribing physicians to adjust the dose as needed during the course of the trial. In some respects, this variable-dose design is commendable because it mimics what happens in real-life settings and thereby enhances the ecological validity of the trial. But there is a critical piece of information that is not provided by this design: it fails to provide information about what constitutes an effective dose of the medication. To accomplish this, another design was used in approximately one quarter of the trials. In this fixed-dose design, patients are randomized to receive particular doses of the medication. Again, this is a commendable design, but it did present a problem vis-à-vis the interpretation of our meta-analysis. The problem is that the data we analyzed may have included patients who were assigned to receive an inadequate or subclinical dose of the medication. If this were the case, then we might have underestimated the drug effect.

To check out this possibility, we performed an additional analysis on the fixed-dose clinical trials. Specifically, we compared improvement among patients given the lowest dose used in the trial with those with improvement among patients given the highest dose. We found that improvement at the lowest dose (9.57 points on the HAM-D) was virtually identical to improvement at the highest dose (9.97 on the HAM-D). Nor was there any apparent advantage for midrange doses. In fact, out of approximately 40 comparisons of different doses of the same antidepressant, only one significant difference was reported. In a study of fluoxetine (Prozac) in moderately to severely depressed patients, the two lower doses were significantly more effective than the high dose, which was not significantly more effective than placebo.

THE “DIRTY LITTLE SECRET”

Whereas the response to our earlier meta-analysis was incredulity, the response to our analysis of the FDA data indicated unanimous acceptance among 12 groups
of independent scholars—some of them clinical trialists who had carried out evaluations of antidepressants for pharmaceutical companies—who had been invited to comment on the paper. As one group of commentators put it, “Many have long been unimpressed by the magnitude of the differences observed between treatments and controls, what some of our colleagues refer to as the ‘dirty little secret’ in the pharmaceutical literature” (Hollon, DeRubeis, Shelton, & Weiss, 2002).

This raises an interesting question. How was this information kept secret? How is it that the lack of efficacy of antidepressant medication (compared to placebo) is not more widely known, not even among prescribing physicians?

The first clue to the solution of this puzzle can be found in a surprising finding in the data we analyzed: Most of the clinical trials sponsored by the pharmaceutical companies failed to find significant differences between antidepressant medication and placebo. In fact, significant differences were reported in only 43% of the trials. The second clue relates to what happens to these trials after the data have been analyzed. These data are owned by the drug companies and can be submitted for publication only with their permission. As a result, most of the studies showing significant effects are published, whereas most of those failing to find significant differences remain on the shelf and are never seen by other researchers or physicians, let alone by the public (Melander, Ahlqvist-Rastad, Meijer, & Beermann, 2003).

Perhaps the most disturbing aspect of the keeping of this secret is the complicity of the FDA. Among the data we received using our Freedom of Information request were copies of internal memos. One of these, written by the director of the Division of Neuropharmacological Drug Products, includes the following revealing information:

The Clinical Efficacy Trials subsection within the Clinical Pharmacology section not only describes the clinical trials providing evidence of citalopram’s antidepressant effects, but make[s] mention of adequate and well controlled clinical studies that failed to do so. I am mindful, based on prior discussions of the issue, that the Office Director is inclined toward the view that the provision of such information is of no practical value to either the patient or prescriber. I disagree. I believe it is useful for the prescriber, patient, and 3rd party payer to know, without having to gain access to official FDA review documents, that citalopram’s antidepressants [sic] effects were not detected in every controlled clinical trial intended to demonstrate those effects. I am aware that clinical studies often fail to document the efficacy of effective drugs, but I doubt the public, or even the majority of medical community, are aware of this fact. I am persuaded they not only have a right to know, but should know. Moreover, I believe that labeling that selectively describes positive studies and excludes mention of negative ones can be viewed as potentially “false and misleading.” (Paul Leber, internal memo, May 4, 1998, p. 11)
HOW DID THESE DRUGS GET APPROVED?

How is it that medications with such weak efficacy data and with serious—indeed, life-threatening—side effects were approved by the FDA? The answer lies in an understanding of the approval criteria used by the FDA. The FDA requires two adequately conducted clinical trials showing a significant difference between drug and placebo. But there is a loophole: there is no limit to the number of trials that can be conducted in search of these two significant trials. Trials showing negative results simply don’t count. Furthermore, the clinical significance of the findings is not considered. All that matters is that the results are statistically significant. If enough subjects are run (and in these trials, the number of subjects often runs into hundreds), even tiny differences of no clinical importance can be statistically significant.

A typical example of the implementation of this criterion is provided by the FDA file on citalopram (Celexa). Seven controlled efficacy trials were conducted. Two showed small but significant drug–placebo differences. Two were deemed too small to count. Three failing to show any significant benefit for the drug were deemed “adequate” and “well controlled,” but were “not counted against citalopram” because there was a “substantial placebo response” (Thomas P. Laughren, FDA team leader for psychiatric drug products, internal memo, [March 26, 1998]). And so, citalopram was approved.

CLINICAL CONCLUSIONS

To summarize, there is a strong therapeutic response to antidepressant medication. But the response to placebo is almost as strong. This presents us with a therapeutic dilemma. Generally, the effect of a drug is estimated to be the difference between the response to the drug and the response to placebo. This is termed the drug effect. So the data suggest that clinical responses to antidepressants are largely placebo effects. But the response is also a large and meaningful one. So what are we to do?

One possibility would be to prescribe placebos, but this entails deception. Besides being ethically questionable, it runs the risk of undermining trust, which may be one of the most important tools that therapists have at their disposal. Another possibility that has been proposed is to use antidepressants as active placebos (Hollon et al., 2002; Moerman, 2002). But the side effects associated with antidepressants render this alternative problematic.

A third possibility is the use of alternative treatments. Physical exercise, for example, has been shown to produce clinical benefit in moderately depressed people (Doyne et al., 1987). This might also be a placebo effect, but the difference in the side effect profile can be considered. Side effects of antidepressants include sexual dysfunction, insomnia, diarrhea, nausea, anorexia, bleeding, forgetfulness, seizures, and increased suicide risk. Side effects of physical exercise include
enhanced libido, better sleep, decreased body fat, improved muscle tone, longer life, increased strength and endurance, and improved cholesterol levels.

Finally, psychotherapy, especially in a hypnotic context, might be considered as a first-choice treatment for depression. The data indicate that psychotherapy is as effective as medication, and its effects may be longer lasting (Hollon, Shelton, & Loosen, 1991). The induction of hypnosis has been shown to enhance the effectiveness of many psychological treatments, even when the difference in procedure between “hypnotic” and “nonhypnotic” treatment is limited to the use of the term hypnosis (Kirsch, Montgomery, & Sapirstein, 1995). So at the very least, hypnosis can be considered a nondeceptive means of eliciting the placebo effect (Kirsch, 1994).

EDITOR’S SUMMARY

- Some commonly prescribed antidepressant medications (ADMs) have been associated with increased suicidality, highlighting previously unknown or underestimated risks associated with their use.
- Response expectancy in the treatment context refers to the beliefs and expectations the client holds regarding the potential merits of a specific form of treatment.
- Hopelessness is a negative expectancy affecting depression. Thus, positive expectancy may help reduce depression. This has been studied in regard to the placebo effect, described as a “deceptive” means of instilling expectancy.
- The placebo effect is described as a significant factor in ADM studies and, in fact, may well account for most of any positive treatment responses generated. The actual drug effect was statistically determined to be a relatively small one.
- In light of the evidence for the small drug (and large placebo) effect, there appears to be legitimate basis for questioning whether the benefits of ADMs outweigh their risks.
- There also appears to be a legitimate basis for questioning why drug studies have emphasized and even exaggerated the merits of ADMs when the benefits appear to be statistically unimpressive.
- Hypnosis has been shown to enhance other treatments and so is advocated as an alternate means of treating depression without the risks associated with the use of ADMs.

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Experiential Cognitive Hypnotherapy: Strategies for Relapse Prevention in Depression

ASSEN ALLADIN

INTRODUCTION

Although the majority of the acutely depressed patients seeking treatment are successfully treated either pharmacologically or psychologically, or with a combination of both, the current concern is that many of these successfully treated patients will eventually relapse in the future. Clinicians are therefore beginning to make a concerted effort to prevent recurrence and relapse in their depressed patients. This chapter describes a multimodal psychological approach, named experiential cognitive hypnotherapy (ECH), to prevent recurrence and relapse of depression. Experiential cognitive hypnotherapy is based on principles derived from the extensive research literature on depression and from the experiences of using an integrated (combining cognitive-behavioral therapy, or CBT, with hypnosis) approach to treating depression for over 20 years.

THE CHANGING FACE OF DEPRESSION

Although there has been an impressive accomplishment in the treatment of depression over the past 20 years, there is an odd paradox to this success. Although many pharmacological and psychological interventions have been effective in the alleviation of acute symptoms, clinicians have generally been less successful with the prevention of recurrence, chronicity, and impairment.
The beginning of the 1990s was marked by optimism emanating from the new developments in antidepressant medications and the proven effectiveness of brief psychotherapies. The introduction of a new class of antidepressant medications known as selective serotonin reuptake inhibitors (SSRIs) in 1987 began a revolution in the treatment of depression. These new antidepressants proved to be effective with a wider spectrum of depressive disorders than older antidepressants (tricyclics and MAOIs), and because of their reduced side effects, there was an increase in treatment compliance. In the realm of psychotherapy, CBT and interpersonal psychotherapy (ITP) became recognized as the “gold standards” for the psychological treatment of depression.

With these new and effective pharmacological and psychological treatments, the majority of depressed patients receiving treatment recovered from the acute depressive episode. Unexpectedly, though, follow-up research from around the world started to show a return of new episodes of depression in people with a history of depression (Segal, Williams, & Teasdale, 2002). These findings changed the scope of the problem with treating depression. The current alarming consensus is that both relapse and recurrence are common even among successfully treated depressed patients. Relapse is defined as the return of symptoms associated with the treated episode, whereas recurrence describes the onset of a wholly new episode (Frank et al., 1991). Remission is defined as the point at which symptoms first go away, whereas recovery is defined as the point at which the underlying episode has actually run its course (Hollon, Haman, & Brown, 2002).

This chapter will describe a multimodal hypnotherapeutic approach, known as ECH, for preventing relapse in depression. Before describing the ECH approach, the clinical literature on relapse prevention with depression is briefly reviewed in order to highlight the need for prevention and the importance of utilizing psychological approaches in the management of recurrence and relapse of depression.

**CHRONICITY AND RELAPSES OF DEPRESSION**

Keller, Lavori, Lewis, and Klerman (1983) were the first investigators to follow up a group of depressed patients who were successfully treated. They followed 141 patients with major depressive disorder (MDD) for 13 months and found that 43 (30.5%) relapsed after having been well for at least 8 weeks. A more recent study by Paykel et al. (1995) found that at least 50% of patients who recover from an initial episode of depression will have at least one subsequent depressive episode, and those patients with a history of two or more past episodes will have a 70 to 80% likelihood of recurrence in their lives (Consensus Development Panel, 1985). These findings led Judd (1997) to conclude that “unipolar depression is a chronic, lifelong illness, the risk for repeated episodes exceeds 80%, [and] patients will experience an average of 4 lifetime major depressive episodes of
20 weeks’ duration each” (p. 990). These findings drew attention to the new perspective that relapse and recurrence following successful treatment of depression are common. Prior to these findings, relatively little attention was paid to depressive patients’ ongoing risk.

The number of past episodes is one of the most reliable predictors of future depression (Segal et al., 2002). The Keller et al. (1983) data suggested a large difference in prognosis between patients with no past history of depression and those with at least three previous depressive episodes. The relapse rate for the “first timers” was 22%, whereas the relapse rate for patients with a past history of three or more episodes was 67%. This trend indicates that patients recovering from their first episode of depression are at a critical juncture in the development of the course of their disorder. Keller et al. warned that these patients have “a substantial probability of prompt relapse, and should they relapse, they have approximately a 20% chance of remaining chronically depressed” (p. 3303). Segal et al. (2002) considered two past episodes of depression to be critical (or to set the threshold). In fact, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association [APA], 2000) uses two or more major depressive episodes as one of the criteria for the diagnosis of recurrent MDD. First and Tasman (2004) stated that a history of two episodes is associated with a 70 to 80% risk of future episodes. Three or more episodes are associated with extremely high rates of recurrence (Consensus Developmental [sic] Panel, 1985). Because the majority of cases of MDD recur, continuation treatment and ongoing education regarding warning signs of relapse or recurrence are essential in ongoing clinical care. (p. 750)

Coryell, Endicott, and Keller (1990), from a 5-year follow-up study of patients with chronic and nonchronic depression, found that patients who relapse very soon after recovery are likely to develop into chronic depressives. Moreover, individuals with recurrent episodes of depression are also at greater risk of developing bipolar disorder (First & Tasman, 2004).

STRATEGIES UTILIZED FOR RELAPSE PREVENTION

From the above reviews, it is evident that there is an urgent need for expanding the range of available treatment strategies to prevent the relapse and recurrence of depression. Dobson and Ottenbreit (2004) identified three approaches for relapse prevention from their review of the literature: (a) optimizing acute-phase treatment, (b) treating residual symptoms and maintenance treatment, and (c) developing specific relapse prevention programs. These three approaches are briefly reviewed in the next section. These approaches provide the rationale for the development of ECH, and hence, ECH utilizes several components from them.
Optimizing Treatment during the Acute Phase

There is accumulating evidence that the very experience of depression itself can serve as an important risk factor for relapse into depression (Judd et al., 1998, 2000). In other words, the existence of residual symptoms in depressed patients who are in remission is associated with an elevated risk of relapse. These findings highlight the importance of producing complete recovery from symptoms during the first episode of depression, rather than simply focusing on symptom reduction or simple remission.

Both pharmacological and psychotherapeutic strategies have been used to optimize treatment during the acute phase in order to reduce the risk of relapse. The pharmacological approach focuses on either maintenance medication (i.e., continuing at the same dosage that provided a therapeutic response) or having patients strategically cross over from one medication to another if the first medication does not work. Several follow-up studies (Belsher & Costello, 1988; Paykel et al., 1999; Rafanelli, Park, & Fava, 1999) found that approximately 50% of depressed patients who are in remission or recovered from depression relapse following the discontinuation of either tricyclic medication or SSRIs. On the basis of these findings, many psychiatrists recommend that the focus of drug treatment in depression be shifted from acute-phase treatment to long-term use of medication for maintenance. Prien and Kupfer (1986) found continuation treatment with antidepressants using the acute treatment dose to be associated with reduced relapse rates compared with placebo. The optimal length of continuation treatment ranges from 4 to 9 months. It is notable that a longer time of continuation therapy was not found to be more effective than placebo in preventing relapse (Reimherr et al., 1998). Regarding the strategy of switching antidepressants, Koran et al. (2001) found that more aggressive combinations of medication led to better clinical outcome and long-term prognosis than can be obtained from any single medication.

Cognitive-behavioral therapy is the main psychological intervention used in the relapse prevention of depression. There is strong evidence that CBT has an enduring effect that reduces subsequent risk for relapse or recurrence following successful treatment (Hollon, Shelton, & Loosen, 1991). Several studies have shown that patients treated to remission with CBT are less likely to relapse after the termination of treatment than patients treated to remission with medication (e.g., Blackburn, Eunson, & Bishop, 1986; Evans et al., 1992). Gloaguen, Cottraux, Cucherat, & Blackburn (1998), from their meta-analysis of the effects of CBT for depression, concluded that CBT has better outcomes than medication and that the average risk of relapse after CBT was 25% as opposed to 60% following pharmacotherapy at follow-up periods of 1 to 2 years. Because CBT is associated with a lower risk of relapse than medication, Dobson and Ottenbreit (2004) examined the reasons for the differential outcome. They believed CBT produces lasting changes in negative cognitions and also teaches depressed patients coping skills for dealing with stressors that may potentiate a relapse.
They further noted that depressed patients who show rapid reduction in depressive symptoms are less likely to relapse in the future.

There is a large body of literature devoted to the examination of the role of life events as a risk factor for depression. Although the relationship between life events and depression is very complex, most investigations have supported the conclusion that both major negative life events and minor “hassles” increase the risk of depression (Paykel & Cooper, 1992). Events that involve either loss or personal diminishment are found to be particularly risky for depression (Clark, Beck, & Alford, 1999). However, the relationship between life events and depression is much more complex, and therefore most experts examining life events in the context of depression have adopted a diathesis-stress model. This model postulates that life events interact with some individual risk factors or vulnerabilities to predict depression (Kessler, 1997; Paykel, 1994). Thase, Kupfer, and Buysse (1995) have mapped the biological characteristics of depressed patients who relapse after acute-phase treatment. They found this group of patients to have more marked disturbances in their sleep patterns, more activity in their neuroendocrine system, and more “endogenous” symptoms (e.g., early-morning waking and worse mood in the mornings), and their depressions vary with changing circumstances. The ECH program described in this chapter uses a combination of CBT and hypnosis to potentiate the psychological effect. The program describes a particular technique for developing antidepressive pathways that deal, in part, with biological vulnerabilities.

How one responds to negative life events also depends on one’s coping strategies. A number of studies have established that coping strategies, especially a ruminative coping style, are significantly associated with the onset, course, and severity of depression. Rumination, when associated with depression, is repetitively and passively thinking about negative emotions and simultaneously focusing on distress. Rumination is very akin to negative self-hypnosis (NSH), and this observation led Alladin (1992a) to conceptualize certain types of unipolar depression as a form of dissociative state. Rumination prolongs and intensifies depressive episodes, predicts chronicity, and also predicts the presence of comorbid anxiety (Just & Alloy, 1997; Nolen-Hoeksema, 2000).

The ECH approach includes social skills training, problem-solving strategies, and behavioral rehearsal (future projection) to teach depressed patients to better deal with current and future negative life events.

It is well established that depressed individuals hold unrealistically negative views about themselves, their worlds, and their futures (the negative cognitive triad), and consequently are prone to a host of information-processing distortions (e.g., arbitrary inference or selective abstraction) that make it difficult for them to either benefit from positive experiences or self-correct these maladaptive beliefs (Beck, 1991). Their thoughts are filled with negative ruminations that arise automatically, and they are organized in accordance with certain underlying core beliefs and dysfunctional attitudes that put them at risk for future depressions. These maladaptive beliefs and information-processing proclivities are part of an
integrated knowledge structure or schema that influences both what can be remembered and the way judgments are formed. These schemata often function as “silent” propensities that are activated by some kind of stressful (or symbolic) life event(s) (Hollon & Beck, 2004; Hollon et al., 2002). The schemata may be continuously activated in patients with chronic distress. Although it is unclear precisely how CBT produces positive effect, Hollon et al. (2002) indicated, “[O]ur own work suggests that changes in core beliefs and information-processing propensities may be more central to the prevention of subsequent relapse and recurrence” (p. 393). Goldapple et al. (2004) provided functional neuroimaging (positron emission tomography, or PET) evidence that CBT produces specific cortical regional changes in treatment responders. Although CBT produced significant directional changes in the frontal cortex, cingulate, and hippocampus, an SSRI antidepressant medication (specifically, paroxetine) produced significant changes in the limbic and subcortical regions (brain stem, insula, and subgenual cingulate). The authors concluded that CBT, “like other antidepressant treatments affect[s] clinical recovery by modulating the functioning of specific sites in limbic and cortical regions” (p. 34). Guided by the above findings, I consider CBT, hypnosis, and the development of antidepressive pathways to be important components for ECH, particularly because the primary goal of the intervention is to prevent relapse and recurrence of depression.

Management of Residual Symptoms and Maintenance Treatment

This approach focuses on applying continuing treatment to patients who are in remission, but not fully recovered. A number of studies have provided support that a continuation of medication does reduce relapses in depression. Glen, Johnson, and Shepherd (1984) demonstrated that 50% of patients who were switched to a placebo after successful treatment relapsed compared with only 20% of patients who relapsed when continuing to be treated with active medication. Similarly, Thase, Nierenberg, Keller, and Papagides (2001), from a 40-week follow-up study period, reported a 19.7% relapse rate in depressed patients with continuation medication compared with a 43.9% relapse rate from a placebo group. Forshall and Nutt (1999), from their review of 91 articles that examined continuation or maintenance pharmacotherapy for depression, recommended that antidepressant medication be continued at the same dosage as during the acute phase for depression for 4 to 6 months following remission of symptoms. For patients with more chronic patterns of depression, they recommended long-term medication. These findings led many clinicians to endorse the view that antidepressant medication should be prescribed prophylactically in order to prevent future episodes of depression.

Although antidepressant medication is demonstrated to be very important beyond the initial recovery phase, long-term use of medication presents several difficulties. Surgery, pregnancy, noncompliance (many patients are concerned
about the potential long-term effects on bodily organs such as the liver, kidneys, and especially the brain), and side effects (e.g. weight gain and sexual dysfunction) may interfere with the prophylactic use of antidepressants. Moreover, medication can lose its effectiveness with continued use (a phenomenon commonly known as the “poop-out” effect), and the ongoing cost for medication can be high.

It is therefore necessary to explore alternative methods, namely psychotherapeutic approaches, of relapse prevention. Fava et al. (Fava, Grandi, Zielezny, Canestrari, & Morphy, 1994; Fava, Grandi, Zielezny, Rafanelli, & Canestrari, 1996; Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998; Fava et al., 2004; Fava & Kaji, 1994) reported on the long-term effects of CBT in patients who went into remission in response to antidepressant medication, but who continued to show residual symptoms. The relapse rates following CBT were 15% at 2 years, 35% at 4 years, and 50% at 6 years, whereas the relapse rates for the clinical management condition were 35% at 2 years, 70% at 4 years, and 75% at 6 years. Paykel et al. (1999) and Blackburn and Moore (1997) have also reported on the relapse prevention potential of CBT in residual depression. These findings indicate that the preventative effect of CBT is stronger than medication, with CBT relapse rates being consistently lower than those associated with continued medication (Dobson & Ottenbreit, 2004). Teasdale et al. (2001) have suggested that CBT may be successful in relapse prevention by changing the manner in which previously depressed persons respond to negative thoughts. Some of the ECH techniques described below were developed in response to some of these findings.

Relapse Prevention Programs

Another strategy for reducing the incidence of relapse in depression is to institute programs for fully recovered depressed patients. Such programs are referred to as “true” relapse prevention because they involve strategies for identifying and dealing with risk factors that may precipitate the onset of a depressive episode. As it does not appear feasible to medicate fully recovered patients for the reasons mentioned above, the true relapse programs have been psychological in their approach. From their review of the literature, Dobson and Ottenbreit (2004) identified four psychological approaches to preventing true relapses. The first approach, which focused on self-criticism (Berlin, 1985), was not found to be effective at preventing relapse. The second approach, consisting of providing nonspecific booster sessions to recovered depressed patients (Baker & Wilson, 1985), was also found to be ineffective at relapse prevention. The third approach, known as “well-being therapy,” was developed by Fava and colleagues (Fava et al., 1998) to emphasize positive aspects of functioning and to optimize well-being in recovered depressed persons. The program consists of 7 components: self-monitoring of symptoms, environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and developing positive relationships. To evaluate the well-being therapy, Fava et al. (2004) followed up 40 recovered depressed patients for 6 years. At 2-year follow-up, 25% of the patients from the program
relapsed compared with 80% of the patients from a clinical management group (Fava et al., 1998). At 6-year follow-up, 40% of the patients from the program relapsed compared with 90% from the clinical management group (Fava et al., 2004). Fava et al. (2004) attributed the differential relapse rate primarily to the abatement of residual symptoms. Experiential cognitive hypnotherapy uses various hypnotherapeutic techniques to deal with residual symptoms of depression as well.

The most ambitious “true relapse” program for recovered depressed patients, labeled mindfulness-based cognitive therapy (MBCT), was reported by Teasdale and colleagues (Teasdale et al., 2000). This therapy is based upon the idea that changing a person’s emotional processing (termed decentering) can reduce the individual’s risk of relapse. Decentering is achieved by teaching patients various exercises to help them disengage from depression-related thoughts without catastrophizing. In a 60-week follow-up trial with 145 recovered depressed patients, Teasdale et al. (2000) found a 40% rate of relapse from the MBCT group versus a 66% rate of relapse from the “treatment as usual” group. These results were replicated in a second study by Ma and Teasdale (2004). The authors attributed the favorable effects of MBCT to a disruption of “autonomous” and “relapse-related cognitive-affective ruminative processes reactivated by dysphoria at times of potential relapse” (p. 39).

Although the risk of relapse in depression is well documented and the target population can be easily identified, there has been a paucity of true relapse prevention studies. In a future study, I am planning to evaluate the ECH as a true relapse prevention program for depression.

HYPNOTHERAPEUTIC STRATEGIES FOR RELAPSE PREVENTION

Hypnosis has not been widely used in the management of depression, possibly due to the erroneous belief among some writers that hypnosis can exacerbate suicidal behaviors in depressed patients. For example, Hartland (1971) warned that “hypnosis should never be used in depressional states in which suicidal impulses are present unless the patient is an in-patient under hospital supervision” (p. 335; note that never was italicized in the original text). Recently many clinicians have argued that hypnosis, especially when it forms part of a multi-modal treatment approach, is not contraindicated with either inpatient or outpatient depressives (e.g. Alladin & Heap, 1991; Yapko, 1992, 2001). In fact, Yapko (1992) used hypnosis to reduce symptoms of hopelessness, which is a predictor of suicidal behavior, in the early stages of his comprehensive approach to psychotherapy for depression. However, the bulk of the published literature on the application of hypnosis in the management of depression consists only of case reports, and unfortunately, there is a great deal of variation in what therapists
Several writers (e.g., Golden, Dowd, & Friedberg, 1987; Tosi & Baisden, 1984; Yapko, 2001) have described the integration of CBT and hypnotherapy with depression, but they have not, with the exception of myself (Alladin, 1989, 1992b, 1994; Alladin & Heap, 1991), provided an elaborated scientific rationale for combining these two approaches to treatment. I have described a working model of nonendogenous depression, referred to as the cognitive dissociative model of depression (CDMD), which provides a theoretical framework for integrating cognitive and hypnotic techniques with depression. Moreover, I have presented data (Alladin, 2003, 2006) to demonstrate the increase in effect size when hypnosis is combined with CBT in the management of chronic depression. The CDMD is not a new theory of depression, but an extension of Beck’s (1967) circular feedback model of depression, which was later elaborated on by Schultz (1978). In combining the cognitive and hypnotic paradigms, the CDMD incorporates ideas and concepts from the domains of information processing, selective attention, brain functioning, cerebral lateralization, and the neodissociation theory of hypnosis (Hilgard, 1977). It is referred to as the cognitive dissociative model of depression because it (a) encompasses the dissociative theory of hypnosis, (b) proposes that nonendogenous depression is akin to a form of dissociation produced by negative self-hypnosis, (c) provides a window for understanding how one can inadvertently construct the “depressive reality,” and (d) explains how the circular feedback cycle between cognition and affect repeats itself in a manner similar to a computer reverberating through an infinite loop (Schultz, 1978) to produce the depressive pathways. The CDMD consists of 12 interrelated components that form into a circular feedback loop (see Alladin, 1994, for a detailed description of the model). Any of these 12 components, singly or in concert with other components, can synergistically trigger, exacerbate, or maintain the depressive affect.

The CDMD takes a multidimensional view of depression. The 12 factors forming the depressive loop are all interrelated, forming a constellation of emotional, cognitive, behavioral, physiological, and unconscious processes. Focusing on any of the factors allows the patient and the therapist a point of entry into the depressive loop. Once the patient and the therapist gain access into this set of relationships, they can deploy various techniques as tools to unravel and reorganize this interrelated set. Any of the factors can be used as an initial target for intervention, which can, in turn, influence other processes because of their interrelated nature (Simons, Garfield, & Murphy, 1984). Because depression is a complicated disorder, a multifactorial treatment strategy as appropriate to the needs of the depressed patient is recommended (Williams, 1992). I (Alladin, 1992b; Alladin & Heap, 1991) have developed such a multidimensional treatment approach, termed cognitive hypnotherapy (CH). This approach normally consists of 16 weekly sessions, which can be expanded or modified according to the patient’s clinical needs.
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Encouraged by the findings (see Alladin, 2003, 2006) that CH produces a larger effect size than CBT in the management of acute-phase depression, and that patients from the CH group continue to improve after discharge, I expanded the CH approach to actively deal with relapse prevention. The approach is called experiential cognitive hypnotherapy (ECH) because it uses hypnosis and mindfulness techniques to help depressed patients decenter from negative feelings, images, and thoughts, and explore a variety of nondepressive (mainly pleasant) affect conditions.

The rest of this chapter will describe the components of ECH, which is a multimodal approach to the management of clinical depression, with special focus on relapse prevention. The strategies are designed to: (a) optimize the acute-phase treatment, (b) treat the residual symptoms, and (c) provide maintenance treatment. Although the ECH strategies can be repeated at different stages of treatment, some of the strategies are specially developed to deal with a particular stage of treatment.

ECH for Acute-Phase Treatment: Cognitive-Behavioral Therapy

Because CBT is highly effective with depression, at least four of the initial sessions are devoted to CBT, educating the client as to CBT concepts and methods. However, the number of CBT sessions is determined by the needs of the specific patient and the severity of the presenting symptoms. Cognitive-behavioral therapy is utilized to help the patient identify, challenge, and eventually correct the dysfunctional beliefs that may be triggering and maintaining the depressive affect. As CBT techniques are fully described in several excellent books (e.g., Beck, 1995), they are not described in detail here. To maximize the effect of CBT:

- Patients are provided a detailed but practical explanation of the cognitive model of depression (ABC model of psychopathology).
- Patients are advised to read Feeling Good: The New Mood Therapy (Burns, 1999).
- Patients are encouraged to identify the number of cognitive distortions (from the list of 10 described by Burns in Chapter 3 of Feeling Good, 1999) with which they ruminate.
- Patients are instructed to record the ABC Form (a form with three columns: A = event, B = automatic thoughts, and C = emotional responses; see Alladin, 2006). This homework helps the patients discover the link between thoughts and feelings, rather than attributing emotional responses to events only.
- During the second session of CBT, patients are introduced to disputatıon (D) after they have had the opportunity to log the ABC form for a week. D forms part of the Cognitive Restructuring Form
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(see Table 13.1). This form is an expanded version of the ABC Form, and includes two more columns (D = Disputation, and E = Consequences of Disputation).

- In order to get a better grasp of how to complete this form, the patients are given a completed version of the Cognitive Restructuring Form (with disputation of cognitive distortions in column D and the modification of emotional and behavioral responses in column E as a consequence of cognitive disputation; see Table 13.1).
- Patients are coached to differentiate between superficial (e.g., “I can’t do this”) and deeper (e.g., “I’m a failure”) cognitive distortions, and the focus of later sessions is on restructuring deeper self-schemata.
- Patients are advised to constantly monitor and restructure their negative cognitions until it becomes a habit.

**Experiential Hypnotherapy.** Hypnosis is introduced to provide leverage to the psychological treatment of depression. Hypnosis is used to (a) induce relaxation (50 to 76% of depressives may have comorbid anxiety; see Dozois & Westra, 2004), (b) reduce distraction, (c) maximize concentration, (d) facilitate divergent thinking, (e) amplify and expand experiences, and (f) provide access to unconscious psychological processes. However, the focus of the first two hypnotic sessions is predominantly on (a) relaxation (to prove that the patient can relax), (b) somatosensory changes (to reinforce the idea that the patient can have different feelings and sensations), (c) demonstration of the power of the mind (via eye and body catalepsy), and (d) increasing confidence in self-hypnosis.

To optimize the effects of hypnosis, patients are given various ego-strengthening suggestions and are taught self-hypnosis. When patients achieve a satisfactory deep level of “trance,” a modified version of Hartland’s (1971) ego-strengthening suggestions are given. Alladin and Heap (1991, p. 58) considered ego strengthening to be “a way of exploiting the positive experience of hypnosis and the therapist-patient relationship in order to develop feelings of confidence and optimism and an improved self-image.” However, to ensure credibility and acceptance of the ego-strengthening suggestions, it is of paramount importance to first create a positive feeling and a “pleasant state of mind,” and the ego-strengthening suggestions need to be crafted in such a way that they sound credible and logical to the patient. For example, rather than stating globally the old maxim, “Every day you will feel better,” it is advisable to suggest more specifically, “As a result of this treatment and as a result of your listening to your tape every day, you will begin to feel better.” Not only does this set of suggestions sound logical, but also improvement becomes contingent upon continuing with the therapy and listening to the self-hypnosis tape daily. At the end of the first hypnosis session, the patient is provided with an audiotape of self-hypnosis designed to create a good frame of mind, offer ego-strengthening suggestions, and provide useful posthypnotic suggestions. The homework assignment provides continuity of treatment between sessions and offers the patient the opportunity to learn self-hypnosis. Before
### Table 13.1 Cognitive Restructuring Form

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTIVATING EVENT</th>
<th>IRRATIONAL BELIEFS</th>
<th>CONSEQUENCES</th>
<th>DISPUTATION</th>
<th>EFFECT OF DISPUTATION</th>
</tr>
</thead>
</table>

1. Depressed, unhappy, miserable.
2. Weak, tired, head heavy.
3. Don’t want to go, prefer staying in bed.
4. I will never be able to enjoy myself again.
5. Everyone will hate me. I will spoil it. I can never be happy.

1. How do I know I won’t enjoy it? The chances are I may like being in company. I may still feel depressed, but I can cope with it. Nothing bad will happen.
2. No one hates you when you feel down, it’s just my wrong belief. I may be quiet but not spoil it for all.
3. Out of bed, ironing clothes for the party tomorrow, wish to be present at party.
4. Even if I feel depressed, I can make myself happy by going out to social functions.
terminating the hypnotic session, posthypnotic suggestions are given to counter negative self-hypnosis (NSH) or harmful self-affirmations. Depressives tend to ruminate with negative self-suggestions, particularly after a negative affective experience (e.g., “I will not be able to cope”). This can be regarded as a form of posthypnotic suggestion (PHS), which can too easily become part of the depressive cycle. In order to break the depressive cycle, it is very important to counter the NSH. Here’s an example of a set of PHSs specifically worded to counter NSH:

As a result of this treatment, as a result of your listening to your tape everyday … everyday you will become less preoccupied with yourself … less preoccupied with your feelings … and less preoccupied with what you think other people think about you. … As a result of this, everyday you will become more and more interested in what you are doing and what is going on around you.

Once the depressed patient becomes familiar with hypnosis and CBT, the next few sessions attempt to integrate cognitive and hypnotic strategies in the treatment. The specific focal points of the sessions are on (a) cognitive restructuring in hypnosis, (b) expansion of awareness and amplification of experiences, (c) development of antidepressive pathways, (d) reduction of guilt and self-blame, (e) social skills training, (f) increasing physical exercise, and (g) preparation for discharge.

Cognitive Restructuring in Hypnosis

While deeply absorbed in hypnosis, the patient is given suggestions to imagine a situation that normally causes him or her feelings of upset. Then the patient is instructed to focus on any dysfunctional cognition that might be present and any associated emotional, physiological, and behavioral responses. Encouragement is given to identify or “freeze” (frame by frame, as though a movie) the faulty cognitions in terms of thoughts, beliefs, images, fantasies, and daydreams. Once a particular set of faulty cognitions is frozen, the patient is coached to replace it with more appropriate thinking or imagination, and then to attend to the resulting (desirable) “syncretic” (matrix of affective, cognitive, somatic, and behavioral responses) response. This process is repeated until the set of faulty cognitions related to a specific situation is considered to be successfully restructured.

Another method of cognitive restructuring under hypnosis uses the metaphor of editing or deleting old computer files. This method is particularly appealing to children and adolescents. When the patient is in a fairly deep state of hypnosis, the patient is instructed to become aware of the “good feelings” (suggested amplified positive feelings and associated ego-strengthening suggestions) he or she is capable of experiencing; the patient is directed to focus on personal achievements and successes. Here, attempts are made to get the patient to focus on higher order faculties of cognition, synthesis, integration, reality testing, and clear judgment. Once this is achieved, the patient is ready to work on modification of old learning and experiences. The patient is then instructed to “imagine opening
an old computer file that requires editing or deletion.” At the outset of the session, it is usually decided on which file the patient would benefit from working (e.g., whenever the patient is planning to attend a social function, a flurry of negative cognitions about his or her impoverished social skills is activated). The patient is instructed to open the file and then to edit or delete it, paying particular attention to dysfunctional cognitions, maladaptive behaviors, and negative feelings. By metaphorically deleting and editing the file, the patient is able to mitigate cognitive distortions, magical thinking, self-blaming, and other such self-defeating mental scripts (i.e., NSH).

Hypnosis also provides a vehicle whereby cognitive distortions below the level of awareness can be explored and expanded into consciousness for easier identification and correction. Very often in the course of CBT, a patient is unable to recognize cognitions preceding certain negative emotions. As hypnosis can provide access to unconscious cognitive distortions and negative self-schemata, unconscious maladaptive cognitions can more easily be retrieved and restructured under hypnosis. This is achieved by directing the patient’s attention to the psychological content of an experience or situation. The patient is guided to focus attention on a specific area of concern and to establish the link between cognition and affect. Once the negative cognitions are identified, the patient is instructed to restructure the maladaptive cognitions and then to attend to the resulting (desirable) syncretic responses. For example, if a patient reports, “I don’t know why I felt depressed at the party last week,” the patient is hypnotically regressed back to the party and encouraged to identify and restructure the faulty cognitions until the patient can think of the party without being upset. Other hypnotic uncovering or restructuring procedures such as affect bridge, age regression, age progression, and dream induction can also be used to explore and restructure negative self-schemata (Edgette & Edgette, 1995; Hammond, 1990).

**Expansion of Awareness and Amplification of Experiences**

Hypnosis provides a powerful tool for expanding awareness and amplifying experience. Brown and Fromm (1990) described a technique called “Enhancing Affective Experience and Its Expression,” which can be used to expand and intensify positive feelings by (a) bringing underlying emotions into awareness, (b) creating awareness of various feelings, (c) intensifying positive affect, (d) enhancing “discovered” affect, (e) inducing positive moods, and (f) increasing motivation. Such a procedure not only disrupts the depressive cycle but also helps to develop antidepressive pathways.

**Development of Antidepressive Pathways**

As mentioned earlier, Goldapple et al. (2004) provided functional neuroimaging evidence that CBT produces specific cortical regional changes in treatment responders. Similarly, Kosslyn, Thompson, Costantini-Ferrando, Alpert, and Spiegel (2000) demonstrated that hypnosis can modulate color perception. These investigators observed hypnotized subjects who were able to produce changes in
brain function (measured by PET scanning) in response to suggestions that were similar to those that occurred during actual visual perception. These findings lend support to the claim that hypnotic suggestions can produce distinct neural changes correlated with real perception. Moreover, Schwartz (1976) has provided electromyographic evidence that depressive pathways can be developed through conscious negative focusing. His investigation led him to believe that if it is possible to produce depressive pathways through negative cognitive focusing, then it would likely be possible to develop antidepressive or even happy pathways by focusing on positive imagery (Schwartz, 1984). Guided by the above findings, I consider it important to include the development of antidepressive neural pathways in the ECH program, especially if the goal of the psychotherapy is to optimize the acute-phase therapy. Because CBT can produce specific cortical changes on its own, it is not unreasonable to assume that the addition of the hypnotic component, specifically the hypnotic induction of positive mood, is likely to potentiate or kindle the cortical effect. Therefore, at least one session (but the technique can be repeated in other sessions) is devoted to introducing the antidepressive concept to the patient.

Prior to inducing hypnosis, the patient is provided a scientific rationale for the importance of producing antidepressive pathways, and it is emphasized to the patient that home practice is likely to strengthen the development of the antidepressive pathways, resulting in the weakening of the depressive pathways. When in deep hypnosis, the patient is instructed to focus on a positive experience, which is then amplified by the assistance from the therapist. The technique is very similar to the one described above in the Expansion of Awareness and Amplification of Experiences section. However, to develop antidepressive pathways, more emphasis is placed on producing somatosensory changes in order to induce more pervasive physiological changes (see Alladin, 2006). The technique is repeated with at least three positive experiences, and before terminating the hypnosis session, the patient is given posthypnotic suggestions about “positive focusing” and “whenever possible, imagine playing a happy tape in your mind.”

The antidepressive technique was successfully used with Jennifer (not her real name), a 17-year-old high school student. Jennifer was admitted to the psychiatric adolescent unit with an acute episode of major depressive disorder. After 4 weeks she was discharged from the unit with the understanding that, as an outpatient, she would continue to see both me for psychotherapy and a psychiatrist to monitor her medication. Jennifer was highly susceptible to hypnosis, and therefore I started her on ECH while she was an inpatient. With the help of ECH, she was particularly interested in producing changes in her brain to ensure she would have no relapse once she returned to school. Three situations—(a) flying by herself to meet her friend, (b) having a barbecue at her friend’s house, and (c) organizing a jumble sale for her local church—were preselected for positive mood induction under hypnosis. When in fairly deep hypnosis, the following suggestions were used to amplify the good feelings associated with the barbecue.
Now I would like you to go back in time and place in your mind to the barbecue at your friend’s house you told me about. ... I want you to remember the description of the place [Pause.] ... the description of the garden [Pause.] ... the people who were there [Pause, then indirect suggestions for visual imagery.] ... Can you imagine the description of the place in your mind? [She nods her head; ideomotor signals were set up: nodding head for yes, shaking head side to side for no.] As you imagine the description of the place, you remember more and more detail of the place. ... And as you remember the detail, you become more and more absorbed ... and soon you will feel as if you are there, reexperiencing everything....

Now I want you to remember the barbecue itself [Indirect suggestions for olfactory and gustatory imagery.] ... Remember the food they were barbecuing [Pause; she nods.] ... the smell of the food [Pause; she nods.] ... the food you ate [Pause; she nods.] ... the drink you had [Pause; she nods.] ... Can you imagine and remember the food you had? [Pause; she nods.] ... The drink you had [Pause; she nods.] ... the taste of the food [Pause; she nods.] ... the smell of the food [Pause; she nods.] ... the taste of the drink. [Pause; she nods.] As you remember the detail, you are becoming more and more absorbed ... drifting into a deeper and deeper hypnotic trance ... and soon you will feel you are there ... reexperiencing everything. ...

Now can you remember the weather? [Indirect kinesthetic suggestion.] ... It was a summer day [Pause.] ... nice and sunny [Pause.] ... perhaps you remember whether you felt warm or hot. Let me know when you remember the warm feeling. [After a short pause, she nods]. Feeling nice and warm and becoming more and more absorbed, drifting into a deeper and deeper trance. Do you feel you are there, experiencing the warm sensation? [She nods after a short pause.] ...

And now you can remember the good feeling you had ... the happy feeling you had ... you felt so good being there. [Indirect suggestions for positive affect; she nods after a pause.] Just become aware of the good feeling you are having ... the happy feeling ... feeling happy being with your friend. For the next few moments, just continue to enjoy the good feeling ... the happy feeling ... feeling good both mentally and physically ... sense of well-being ... feeling calm ... feeling peaceful and satisfied ... just becoming aware of the good feeling. ...

From now on, whenever you think of this barbecue party, you will soon become absorbed in the details of the situation and remember all the good feelings associated with it. [Posthypnotic suggestion.] As you practice, you will find it easier and easier to get involved and absorbed into the situation ... feeling you are there ... reexperiencing everything. Gradually you find it easier and easier to play this happy tape in your mind. ... As a result of this, you will strengthen the happy pathways and weaken the depressive pathways in your brain. ...

Reduction of Guilt and Self-Blame
Depression can often be maintained by conscious or unconscious feelings of guilt and self-blame (what some have called old garbage). Various hypnotherapeutic
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Techniques can be used to reframe the patient’s past experiences that cause guilt or self-regret. Hammond (1990) provided several techniques for dealing with guilt and self-blame. For example, Watkins (1990) described a technique for reducing guilt that she calls “The Door of Forgiveness,” and Hammond (1990), and Stanton (1990) described two techniques for “dumping the rubbish.”

Social Skills Training

Youngren and Lewinshon (1980) have provided evidence that a lack of social skills may cause and maintain depression in some patients. Social skills deficits may operate as risk factors for depression under certain circumstances, such as in the presence of negative life events (Segrin, 2001). Furthermore, there is evidence that a particular instance of impaired social skills, known as negative feedback seeking, may also serve as a risk factor for depression (Joiner, 2002). Negative feedback seeking is defined as the tendency to actively (and self-injuriouly) solicit criticism and other negative interpersonal feedback from others. These propensities, or diatheses, reinforce the negative self-schemata of depressed patients. In order to modify this diathesis, two to three sessions (or more, if required) of the ECH is devoted to teaching social skills, and the patient is advised to read the appropriate bibliography that is provided for him or her. The behavioral skills taught are amplified by behavioral rehearsal under hypnosis and posthypnotic suggestions.

Increasing Physical Exercise

When patients have made some improvement (usually around 8 to 10 sessions), they are encouraged to start some sort of physical exercise regimen. Research has confirmed the relationship between physical fitness and emotional health. Five conclusions have emerged from this research: (a) active people are less anxious and depressed than inactive people (Farmer et al., 1988); (b) poor fitness is a risk for relapse in nondepressed individuals (Camacho, Roberts, Lazarus, Kaplan, & Cohen, 1991); (c) the effect of exercise in depressed patients is comparable to the effect of psychotherapy (North, McCullagh, & Tran, 1990) and antidepressant medication (Blumenthal et al., 1999); (d) physical exercise has a lower risk than antidepressant medication for relapse in depression (Babyak et al., 2000); and (e) exercise has beneficial effects on depression, stress, anxiety, and anxiety-related disorders (Fox, 1999). Paterson (2002) believes that exercise alleviates depression by creating a sense of exhilaration or euphoria (“runner’s high”), producing improvement in mood, increasing energy, and reducing stress.

In order to increase compliance with suggestions for increased exercise, the scientific findings of the link between exercise and depression are shared with the patients, and they are encouraged to join a gym or a health club. Hypnosis and ego-strengthening suggestions can also be used to increase confidence and compliance.
Preparation for Discharge From Acute-Phase Treatment

Toward the end of the acute-phase ECH (usually after 16 weekly sessions), when patients have been able to alter their deeper patterns of belief, affect, and behaviors, the last phase of the treatment is devoted to reinforcing the pattern of changes produced by the patients. The focus of the last few sessions of therapy is on setting realistic goals for the future. In hypnosis, the patient is instructed to imagine ideal but realistic future goals and then to imagine planning appropriate strategies and taking necessary actions for achieving them (forward projection with behavioral rehearsal). The transcript presented below contains suggestions Sam (not her real name) was given under hypnosis to effectively rehearse dealing with the stress that might be caused by her “dominant” and “unsympathetic” husband in the future. Focus was particularly on countering NSH and controlling anxious and depressive feelings. Sam was a 40-year-old housewife with a moderately severe 6-year history of recurrent major depressive disorder. She was recently treated by me for a major depressive episode. Sam lives with her husband and their two boys (4 and 7 years old). Sam did fairly well with outpatient treatment consisting of individual psychotherapy and antidepressant medication. Her relapses were often related to her difficulties with her husband. Her husband is a business executive who often travels, and according to Sam, he has a dominating personality and does not believe in psychological disorders. He strongly believes that Sam “can kick off her depression if she tries hard.” So whenever Sam is feeling unwell, he would undermine her depression and accuse her of not trying hard enough to get out of her depression. (Sam’s husband was brought up in a poor family, and through hard work, he managed to become a business executive with a well-known chain of grocery stores). On the other hand, Sam has indicated that her husband is very caring, and she genuinely believes that his intention is to help her, and not to cause her further distress. However, Sam was fearful that such incidents would make her vulnerable to relapse in the future. The following transcript is from a session with Sam preparing her for future inevitable difficulties:

Just notice how relaxed you are…. Feeling calm … peaceful … and confident. Imagine yourself every day, as a result of this treatment, and as a result of your listening to your tape everyday, you are becoming less anxious … less depressed every day, more and more relaxed, more and more confident…. You are coping better and better with the challenges of life every day … learning to focus more on your successes than on your failures…. Every day you notice feeling less depressed and more optimistic…. You notice feeling calmer and beginning to enjoy the struggles and challenges of life…. 

As in any relationship, at times you are going to have conflicts with your husband…. If your husband disagrees with you or does not understand how you feel, it does not mean he does not love you, he does not care for you. … His intent is not to hurt you but to encourage you to take action. …
Imagine, in the future, you are feeling down and your husband is encouraging you to go to the gym, as you have not been to the gym for several days. ... Instead of getting upset or angry about it, imagine yourself taking a deep breath and letting yourself go.... You realize, since he cares for you, he wants you to feel better.... Rather than getting upset with him, imagine his words remind you of getting better and the way to make yourself strong is to keep going, not giving up, doing everything you need to do to feel better.... You can feel pleased that your husband believes in trying hard and not giving up.... You can also remember during our session we reviewed the importance of physical exercise in relapse prevention.... This realization suddenly makes you realize that your husband is supportive and caring, and suddenly you feel this rush of energy.... You feel like making a move, and you feel you should be listening to your hypnosis tape regularly, and exercising regularly.... Suddenly you realize it was not what your husband was saying that was upsetting you, but what you have been thinking about.... And you know how to reason with your negative thoughts....

Imagine thanking your husband for reminding you to look after yourself, and imagine saying to him that you intend to listen to your tape soon and have decided to go to the gym regularly.... Imagine yourself, later on, listening to your tape and feeling calm, peaceful, relaxed, and energized. Imagine going to the gym regularly and every time you work out, you feel good, you feel revived, and you feel strong and healthy.... You begin to enjoy the struggles and challenges of life....

**ECH for Treating Residual Symptoms**

Following the acute-phase ECH, the patients with residual symptoms are encouraged to attend the clinic on a monthly basis for a year. During these sessions, some of the techniques used during the acute-phase treatment are reinforced. Moreover, the following new strategies are introduced: (a) first aid for depression, (b) attention switching and positive mood induction, and (c) active interactive training.

**First Aid for Depression.** First Aid for Depression is a technique for producing short-term relief from depressive affect elicited by environmental stressors. The technique can be used whenever a patient becomes depressed in response to some environmental stressor. Because depressives tend to become easily overwhelmed by feelings of low mood, hopelessness, and pessimism, any immediate relief from these feelings can provide a sense of hope and promote the therapeutic alliance and a positive expectancy. Overlade (1986) described a first aid technique for producing immediate relief from the depressive mood. I (Alladin, 1994; Alladin & Heap, 1991) have expanded this technique into seven stages. These are as follows:
1. The patient is encouraged to talk about the trigger(s) that exacerbated the depressive affect and to ventilate feelings of distress and frustration.

2. A plausible biological explanation (a “tucking reflex”) of acute depression is provided. It is explained to the patient that we often adopt a depressive state, or a “tucking response,” as a defense mechanism in order to protect ourselves from further insults. Such an explanation can reduce the guilt of feeling depressed.

3. The patient is helped to alter the depressive posture (“tucking response”) by adopting an antidepressant posture (holding head high and broadening the shoulders).

4. The patient is encouraged to make deliberate attempts to smile by imagining looking into a mirror and forcing him or herself to smile.

5. The patient is encouraged to imagine a “funny face.”

6. The patient is encouraged to “play a happy mental tape.”

7. The patient is conditioned to a positive cue word. By uttering the conditioned word, the patient will be able to modify the depressive affect in the future.

Attention Switching and Positive Mood Induction. Depressives have the tendency to become preoccupied with catastrophic thoughts and images in response to a stressor. Such preoccupations can easily become ruminative in nature and may impede therapeutic progress (remission). To break the negative ruminative cycle, depressives are trained to switch attention away from negative cognitions and to focus on more positive experiences. To achieve this, the patient is advised to make a list of 10 to 15 pleasant life experiences and to practice holding each experience in his or her mind for about 30 seconds. The patient is encouraged to practice with the list four or five times a day and to switch off from negative or “undesirable” experiences (whenever the patient dwells on these) to one of the pleasant items from his or her list. This procedure provides another technique for weakening the depressive pathways and strengthening “happy pathways.” In other words, the patient is learning to replace NSH by positive self-hypnosis. Yapko (1992) argued that because depressives utilize NSH to create the experience of the depressive reality, they can equally learn to use PSH to create an experience of an antidepressive reality.

Active Interactive Training. When interacting with their internal or external environment, depressives tend to passively dissociate (perhaps to a negative feeling or a distressing situation) rather than actively interact with the relevant external information. Active interaction means being alert and “in tune” with the incoming information (conceptual reality), whereas passive dissociation is the tendency to anchor to “inner reality” (negative schemata and associated syncretic feelings), which inhibits reality testing or an effective appraisal of conceptual reality. The Active Interactive Training instructs patients how to break the “dissociative” habits and associate with the relevant (external) environment.
To prevent passive dissociation, a person must (a) become aware of such a process occurring, (b) actively attempt to inhibit it by switching attention away from “bad anchors,” and (c) actively attend to relevant cues or conceptual reality. In other words, the patient learns to actively engage the left-brain hemisphere by becoming analytical, logical, realistic, and syntactical. Edgette and Edgette (1995, pp. 145–158) described several techniques for developing adaptive dissociation. For example, a patient with habitual maladaptive dissociation can be trained to adopt adaptive dissociation (Alladin, 2006), which helps to do the following:

- Counter maladaptive dissociation
- Break a continuous pattern of negative rumination
- Halt a sense of pessimism and helplessness
- Associate with success
- Integrate different parts of self
- Detach from toxic self-talk

**ECH for Maintenance Treatment**

This phase of treatment is developed to prevent fully recovered depressed patients from relapsing. After the termination of the acute-phase ECH, these patients are encouraged to attend the clinic once a month for a year. Paterson (2002) stated three reasons for treating recovered depressed patients:

1. It is a bad idea for a previously depressed person to “feel truly miserable” before initiating coping strategies. The lower the mood, the more difficult it is to pull out of it. If a person can catch him or herself before things get out of hand, it will be less difficult to handle it.
2. Emotions and a sense of well-being provide valuable feedback about the current situation. Feelings of anxiety, depression, or insecurity provide cues as to how the person is handling a situation. Such feedback can be used to generate coping strategies. Ignoring such feedback may exacerbate the bad feelings, and then one can more easily spiral down into depression.
3. Mental and physical health are much more than an absence of illness. Taking care of oneself when one is feeling good leads to feeling even better.

Most patients are happy to continue with this phase of treatment because they see this as a preventative measure and also as an opportunity to consolidate the skills they acquired during the acute-phase treatment. The focus of the maintenance phase of ECH is on (a) enhancing social connections, (b) developing a sense of gratitude, (c) enhancing mindfulness and acceptance, (d) developing a spiritual path, (e) recognizing biases in one’s thinking, (f) strengthening antidepressive pathways, and (g) using more self-hypnosis.
Enhancement of Social Connection. Human beings are social creatures, having evolved to live in small human communities. Most human activities involve at least some interaction with other people. Human beings tend to do poorly when they are isolated. There is considerable evidence that social support is a significant protective factor against the onset of depressive symptoms and that it aids in recovery (Lara, Leader, & Klein, 1997). In order to attain and/or preserve social support, depressed patients are encouraged to widen their social network. Paterson, McLean, Alden, and Koch (1996) suggested three ways of increasing or improving one’s social network: deepening current relationships, reviving old friendships, and starting new friendships. Patients are provided full details and “coaching tips” on how to enhance each strategy for building or improving a social network. Hypnosis, particularly future projection and behavioral rehearsal, is used to make the learning more experiential. In the case described above, Sam was encouraged to expand her social connection as her husband travels a lot and very often she feels left out and isolated. Sam was coached how to increase her social connection, and she was offered various suggestions in hypnosis to enhance motivation to make friends.

Just imagine how helpful it would be for you to be spending some time with your friends when your husband is away on business rather than feeling angry and upset…. [She nods her head.]

We have explored different ways you can expand and maintain your connection with other people…. [She nods.]

You can deepen your relationship with Jane, Diane, and Marty. You can often call your old friend Barb to revive your friendship. You can look for the opportunity to connect with some of the people you meet at the gym. We are going to focus on deepening your relationship with Jane…. [Jane lives a short distance away from Sam’s house. Sam and Jane have been friends for many years, but recently Sam has been avoiding her, believing that Jane does not value her friendship as she has depression.]

As we talked before, we agreed that friendship needs to be nurtured and cultivated, and it often requires effort. [She nods.] So imagine yourself calling Jane at least once a week…. You begin to enjoy calling her; realizing this is not a chore, but necessary to strengthen your friendship with Jane…. You like being with Jane, and she likes being with you, as you and she have many things in common…. She, too, has two kids, and she likes spending time with you and your kids…. If you call her and she happens to be busy, or not able to talk to you for long, or not able to meet with you, it does not mean she is avoiding you or is not interested in your friendship. …. If you happen to be upset, become aware of your thoughts and feelings and try to decenter from them. And soon you feel calm, relaxed, and in control. You become more interested in what Jane has to say, and you become more and more decentered from your own negative thoughts.
and feelings. Remember the cardinal rule for friendship—you make your friend feel valued and important.

For the next few minutes continue to imagine, in the future, you’ve gotten into the habit of calling Jane regularly, and this is paying off. She too has started to call you regularly, and both of you seem to be spending a fair amount of time together. Now you realize the value of strengthening friendship and you feel motivated to strengthen other friendships. You feel happy and pleased with your progress, and no longer feeling lonely or isolated.

**Sense of Gratitude.** Modern society is largely preoccupied with ambition and materialism. There is nothing innately wrong with having goals and ambitions and wanting the comforts of consumer goods. However, it becomes a problem for people when they begin to base their sense of worth, happiness, and fulfillment on these features and objects. For example, one depressed patient said, “I can never be happy because I didn’t get promoted and didn’t get a raise. What’s the point of going to work if I can’t afford to buy whatever I want?”

Patients are taught to be grateful for what they have. Experiential cognitive hypnotherapy uses hypnosis to reinforce this idea. The excerpt below illustrates how the suggestions are crafted. It is recommended that the suggestions are given following ego strengthening and when the patient is in fairly deep hypnosis:

> Just notice feeling calm, peaceful, and a sense of well-being. Feeling calm ... peaceful ... and a sense of harmony. No tension ... no pressure ... completely relaxed both mentally and physically ... sense of peace ... sense of harmony ... sense of gratitude. Notice feeling at peace in your heart ... you feel calm in your heart ... you feel a sense of gratitude in your heart.

> All the major religions state that when you wake up in the morning ... if you have a roof over your head ... if you have bread to eat, and water to drink ... and you’re in fairly good health ... then you have everything. Just become aware of all the good things you have ... all the wonderful things you are grateful for. It is okay to have goals and ambitions. When we achieve goals and ambitions, they are bonuses and plusses. When we don’t achieve our goals and ambitions, it may be disappointing ... but we have enough to live a comfortable life. We have enough compared with many people....

This approach prepares depressed patients for dealing with loss related to goals, ambitions, and material things, and it helps them adopt the realistic philosophy that no one can “have it all.” It also helps patients shift their attention from their mind to their heart, providing a more balanced approach for grounding affect. Western science and philosophy attach more importance to the brain or the mind, whereas eastern psychology and religion attach more importance to the heart. Nevertheless, both eastern and western individuals validate their
reality by the way they feel. Although cognition can interact or precede affect, people don’t usually validate reality by their thinking. Encouraging and training depressed people to feel “calm,” “peace,” and “gratitude” in their heart help them feel good, and in turn they feel more comfortable and satisfied mentally. Ultimately, people validate reality by the way they feel, not by the way they think.

**Mindfulness and Acceptance.** Teasdale, Segal, and Williams (1995) developed a mindfulness-based cognitive therapy (MBCT) that draws on strategies from dialectical behavior therapy (acceptance and meditation) to help teach patients to distance themselves from their depressive ruminations. Patients are trained to focus not so much on the content of their thinking as on its process. They are encouraged to become aware of the occurrence of their thoughts without responding to them emotionally and without examining the accuracy of their beliefs. This strategy teaches patients to learn to separate themselves from their feelings and thoughts. An emotion or a thought is seen as a behavior, a part of the person, but not the whole person. This ability to distance or decenter away from a cognition or affect helps the patient maintain control over thoughts (e.g., not catastrophizing) and feelings (e.g., not becoming overwhelmed with negative affect). Sam found the following hypnotic suggestions helpful in decentering from negative feelings and affect:

*Whenever a negative thought comes into your mind, become aware of it and identify what kind of a cognitive distortion it is.... Becoming aware of the thought and identifying what kind of cognitive distortion it is help you to distance away from the thought.... And you realize it’s just a thought, the thought is not you, just a part of you, just one behavior.... Realizing this makes you feel calm and relaxed, and you feel you are in control....*

*Similarly, when you have a bad feeling, become aware of it and identify what you are feeling.... Recognizing the feeling helps you to decenter away from the feeling, realizing the feeling is only a small part of you, the feeling is not you, just a behavior....*

*As a result of this treatment and as a result of this new understanding, and with practice, you will become more and more successful at distancing yourself away from negative feelings and thoughts.... As a result of this habit, you will have more and more control over your thoughts and feelings. You feel happy to know that feelings and thoughts don’t control you—you control them....*

**Development of a Spiritual Path.** There is research evidence that people with religious faith or spiritual practice have lower rates of depression compared with those without religious or spiritual involvement (McCullough & Larson, 1999). Murphy et al. (2000) suggested that an aspiration toward religious belief
may be a worthy quest for some patients with mood disorders. According to Paterson (2002), two aspects of spirituality have been found to be helpful with depression: (a) privately held religious belief and practice, and (b) involvement in a spiritual community, group, or organization focused on spiritual practice. A search for a spiritual community, or development of a spiritual path, may be particularly helpful to depressed people who have previously derived benefit from faith, who feel at home with the supportive community to which they belong, and if their depression was triggered by some sort of religious or spiritual crisis. Paterson (2002, p. 276) provided four suggestions for developing a spiritual path:

1. Explore different faiths and practices until a particular faith or practice becomes meaningful to the person.
2. Sample different spiritual communities until one becomes comfortable with a particular spiritual community.
3. If a religious or faith-based community does not appear fulfilling to the person, he or she can consider other alternatives, such as getting closer to nature by taking walks in the forest.
4. Recognize that spirituality is not a prerequisite for overcoming depression. Spirituality should be pursued by people who feel comfortable with it.

**Recognizing Bias in Thinking.** Patients are encouraged to become familiar with the thinking errors or cognitive biases listed below. The next step is to recognize the biases in thinking and then to counteract them, perhaps by employing the following reminders (see Table 13.2). The list of cognitive biases and reminders below is adapted from Paterson (2002, pp. 198–199), and is derived from the writings of Aaron Beck (Beck, Rush, Shaw, & Emery, 1979) and David Burns (1999).

Recognizing bias in thinking and counteracting is akin to catching and halting NSH.

**Strengthening the Antidepressive Pathways.** Patients are encouraged to continue with the positive mood induction exercises regularly. Particularly depressed patients who have been presenting vegetative symptoms (see Thase et al., 1995, p. 7) during the acute phase of their depression are encouraged to use the positive mood exercise daily for a year.

**More Self-Hypnosis.** Patients are encouraged to continue to listen to their self-hypnosis tapes daily. They are also encouraged to utilize self-hypnosis techniques regularly until doing so becomes a well-practiced habit. In the CH trial, many patients reported that listening to the self-hypnosis tape daily was the most important factor preventing the return of their depression.
Experiential cognitive hypnotherapy has not yet been subjected to formal evaluation. However, there is some evidence that the acute-phase treatment is effective. Recently, I (Alladin, 2003, 2006) empirically validated the effectiveness of cognitive hypnotherapy (ECH is an extension of CH to deal with remission and maintenance phases of depression). The study compared the effects of CH with a well-established treatment, CBT, with a sample of 84 chronic depressives. The patients were randomly assigned to 16 weeks of either CH or CBT, and they were followed up at 6 and 12 months. The outcome measures consisted of the revised Beck Depression Inventory (BDI-II), the Beck Anxiety Inventory (BAI), and the Beck Hopelessness Scale (BHS). The inclusion criteria were DSM-IV (APA, 1994) diagnosis of recurrent major depressive disorder and a minimum objective

Table 13.2 List of Biases in Thinking and Counteracting Reminders

<table>
<thead>
<tr>
<th>Bias</th>
<th>Reminder:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filtering</td>
<td>I need to pay attention to the whole picture.</td>
</tr>
<tr>
<td>Disqualifying the Positive</td>
<td>Positives count, too, not just negatives—no excuses.</td>
</tr>
<tr>
<td>The Mood-Congruent Memory Bias (tendency to remember bad things)</td>
<td>I also have good memories; I need to look harder for them.</td>
</tr>
<tr>
<td>The Fortune-Teller Error</td>
<td>You don’t own a crystal ball.</td>
</tr>
<tr>
<td>Catastrophizing</td>
<td>Deal with the event, not with imaginary consequences.</td>
</tr>
<tr>
<td>Overgeneralization</td>
<td>There are absolutely no absolutes.</td>
</tr>
<tr>
<td>Labeling</td>
<td>Focus on the event, not on the person.</td>
</tr>
<tr>
<td>Magnification and Minimization</td>
<td>Use the same scale for everyone—you yourself included.</td>
</tr>
<tr>
<td>All-or-Nothing Thinking</td>
<td>Where are the shades of gray in this?</td>
</tr>
<tr>
<td>Mind Reading</td>
<td>Stay in your own head.</td>
</tr>
<tr>
<td>Emotional Reasoning</td>
<td>Don’t believe everything you feel.</td>
</tr>
</tbody>
</table>

THE EFFECTIVENESS OF ECH

Experiential cognitive hypnotherapy has not yet been subjected to formal evaluation. However, there is some evidence that the acute-phase treatment is effective. Recently, I (Alladin, 2003, 2006) empirically validated the effectiveness of cognitive hypnotherapy (ECH is an extension of CH to deal with remission and maintenance phases of depression). The study compared the effects of CH with a well-established treatment, CBT, with a sample of 84 chronic depressives. The patients were randomly assigned to 16 weeks of either CH or CBT, and they were followed up at 6 and 12 months. The outcome measures consisted of the revised Beck Depression Inventory (BDI-II), the Beck Anxiety Inventory (BAI), and the Beck Hopelessness Scale (BHS). The inclusion criteria were DSM-IV (APA, 1994) diagnosis of recurrent major depressive disorder and a minimum objective
score of 3 on the Barber Suggestibility Scale. The measures were administered in the 1st, 4th, 8th, 12th, and 16th sessions, and at the 6-month and 12-month follow-ups. At the end of the 16-week treatment, the majority of the patients from both groups significantly improved compared with baseline scores. However, the CH group produced significantly larger changes in the BDI-II, \( t(41) = 15.9, p < .001 \); the BAI, \( t(41) = 12.2, p < .001 \); and the BHS, \( t(41) = 12.4, p < .001 \) scores. The improvements were maintained at 6-month and 12-month follow-ups. In addition, effect size calculations indicated the CH group produced 6.03% greater reduction in depression, 5.08% greater reduction in anxiety, and 8.05% greater reduction in hopelessness than the CBT group at the termination of treatment. The effect size was maintained at 6-month and 12-month follow-ups. This indicates that depressives from the CH group continued to improve after the termination of treatment. This can be attributed to the self-hypnosis tape. The subjects from the CH group reported that they found it very helpful to listen to their self-hypnosis tape daily after the termination of the treatment.

I am planning to conduct the clinical evaluation of the ECH in the near future. Current clinical impression indicates that the program is effective in relapse prevention with depression. Because clinical depression is a complex disorder, the multimodal approach provided by the ECH program may be particularly helpful. The first goal is to evaluate the whole program and then to use a dismantling research design to tease out the effective components of the program.

**SUMMARY**

This chapter reviewed the literature on relapse prevention in depression and provided an innovative psychological approach to preventing recurrence and relapse in depression. There is an urgent need to develop and evaluate various psychological programs, alone or in combination with pharmacotherapy, to optimize the acute-phase treatment and to maximize residual and maintenance treatments. Experiential cognitive hypnotherapy offers a variety of treatment interventions for relapse prevention from which a therapist can choose the “best-fit” strategies for a particular phase of treatment. It also offers innovative techniques for becoming mindful of relapse and for developing antidepressive pathways. However, it is very important to evaluate the clinical effectiveness of ECH. The trial of CH (Alladin, 2003, 2006) provides indirect evidence that ECH is effective in the treatment of acute-phase depression. It is only through appropriate evaluation that the effectiveness of ECH can eventually be established. Plans are underway at the time of this writing to have the ECH evaluated in the near future. In the interim, readers can be informed that there are many different ways to responsibly incorporate hypnosis into the treatment of depression, including treatments aimed at preventing recurrences and relapses of depression.
EDITOR’S SUMMARY

- Many, perhaps most, successfully treated depressed patients eventually suffer relapses, making relapse prevention a primary goal of effective therapy for depression.
- A multimodal psychological approach that the author calls *experiential cognitive hypnotherapy* (ECH) is designed to prevent recurrence and relapse and is described in this chapter.
- Relapse prevention involves optimizing acute phase treatment, treating residual symptoms and providing maintenance treatment, and developing specific relapse prevention programs.
- Cognitive-behavioral therapy (CBT) has been shown to have an enduring effect that reduces subsequent risk for relapse or recurrence. Hypnosis has been shown to enhance the effects of CBT.
- A specific model of hypnosis for intervention in depression called the *cognitive dissociative model of depression* (CDMD) is presented.
- The ECH and CDMD models are described as parallel intervention models across phases of relapse prevention.
- Hypnosis to teach cognitive skills (e.g., self-correcting cognitive distortions) is emphasized as vital to treatment.
- Specific hypnotic interventions are provided and illustrated with sample transcripts.

REFERENCES


EXPERIENTIAL COGNITIVE HYPNOTHERAPY


HYPNOSIS AND TREATING DEPRESSION


Appendix: Websites of Note

DEPRESSION-RELATED THERAPY ISSUES AND SUPPORT WEBSITES

Academy of Cognitive Therapy
www.academyofct.org

American Academy of Sleep Medicine
www.aasmnet.org

American Association for Marriage and Family Therapy
www.aamft.org

American Institute of Stress
www.stress.org

American Psychiatric Association
www.psych.org

American Psychological Association
www.apa.org

American Sleep Disorders Association
www.asda.org

Anxiety Disorders Treatment Center
www.anxieties.com

Authentic Happiness
www.authentichappiness.org

Center for Cognitive Therapy, University of Pennsylvania
www.uphs.upenn.edu

Couples’ Communication Program
www.couplecommunication.com

Divorce Busting
www.divorcebusting.com
Join Together
www.jointogether.org

Managing Depression Intelligently
www.managing-depression-intelligently.com

Medscape
www.medscape.com

National Clearinghouse for Alcohol and Drug Information
www.health.org

National Institute of Mental Health
www.nimh.nih.gov

National Sleep Foundation
www.sleepfoundation.org

SleepNet
www.sleepnet.com

Smart Marriages
www.smartmarriages.com

HYPNOSIS-RELATED WEBSITES

American Society of Clinical Hypnosis
www.asch.net

Australian Society of Hypnosis
www.ozhypnosis.com.au

British Society of Clinical Hypnosis
www.bsch.org.uk

British Society of Experimental and Clinical Hypnosis
www.bsech.com

British Society of Medical and Dental Hypnosis
www.bsmdh.org

European Society of Hypnosis
www.esh-hypnosis.org
International Society of Hypnosis
www.ish.unimelb.edu.au

Milton H. Erickson Foundation
www.erickson-foundation.org

Society for Clinical and Experimental Hypnosis
www.sceh.us
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Michael D. Yapko, Ph.D., is a clinical psychologist and marriage and family therapist residing in Fallbrook, California. He is a national and international trainer in brief therapy approaches to psychotherapy and routinely addresses professional audiences all over the world. Yapko is internationally recognized for his work in the active treatment of depression, the strategic use of clinical hypnosis and his advancement of the use of outcome-focused, short-term psychotherapies.

“Michael Yapko has long been a clear and compelling advocate for the merits of hypnosis in enhancing psychotherapeutic treatments for depression. In this new and innovative volume, Dr. Yapko has added the voices of other well-known hypnosis and depression experts to the call for more creative and empowering treatments. The collective wisdom contained herein is impressive by any standards, and will certainly be regarded as a significant contribution to the field.”

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