

Hypnotherapy with a Psychiatric Disorder: Depression

SUMMARY

This chapter describes the circular feedback model of depression (CFMD), which provides the rationale for combining hypnotherapy with cognitive-behavioral therapy (CBT) in the management of clinical depression. Cognitive hypnotherapy (CH), based on the model, provides a variety of treatment interventions for depression, from which a therapist can choose the best-fit strategies for a particular depressed client. CH also offers an innovative technique for developing antidepressive pathways. Although there is some empirical evidence for the effectiveness of CH, further studies are required before it can be established as an alternative treatment for depression.

INTRODUCTION

This chapter describes in detail how hypnotherapy can be integrated with cognitive behavior therapy (CBT) in the management of a severe emotional disorder – major depressive disorder (MDD). MDD is among one of the most common psychiatric disorders treated by psychiatrists and psychotherapists. Although MDD can be treated successfully with antidepressant medication and psychotherapy (Moore and Bona, 2001), a significant number of depressives do not respond to either medication or psychotherapy. It is therefore important for clinicians to continue to develop more effective treatments for depression.

Clinical depression also poses special problems to therapists because it is a complex disorder and it ‘takes over the whole person – emotions, bodily functions, behaviors, and thoughts’ (Nolen-Hoeksema, 2004, p. 280). This chapter will describe cognitive hypnotherapy (CH), a multimodal treatment approach to depression that may be applicable to a wide range of people with depression. The chapter also highlights the role of depressive rumination or negative self-hypnosis in the triggering, exacerbation and maintenance of the depressive disorder.

DESCRIPTION OF DEPRESSION

Depression is characterized by feelings of sadness, lack of interest in formerly enjoyable pursuits, sleep and appetite disturbance, feelings of worthlessness, and thoughts of death and dying (Alladin, 2007). Depression is extremely disabling in terms of poor quality of life and disability (Pincus and Pettit, 2001) and 15% of people with MDD commit suicide (Satcher, 2000). MDD is on the increase (World Health Organization, 1998), and it is estimated that out of every 100 people, approximately 13 men and 21 women are likely to develop the disorder at some point in their lives (Kessler *et al.*, 1994) and approximately one-third of the population may suffer from mild depression at some point in their lives (Paykel and Priest, 1992).

The prevalence rate of major depression is so high that the World Health Organization Global Burden of Disease Study ranked depression as the single most burdensome disease in the world in terms of total disability-adjusted life years among people in middle years of life (Murray and Lopez, 1996). According to the World Health Organization (1998), by the year 2020 clinical depression is likely to be second only to chronic heart disease as an international health

burden, as measured by cause of death, disability, incapacity to work and medical resources used.

Major depression is a very costly disorder in terms of lost productivity at work, industrial accidents, bed occupancy in hospitals, treatment, state benefits and personal suffering. The illness also adversely affects interpersonal relationships with spouses and children (Gotlib and Hammen, 2002) and the rate of divorce is higher among depressives than among non-depressed individuals (e.g. Wade and Cairney, 2000). The children of depressed parents are at elevated risk of psychopathology (Gotlib and Goodman, 1999).

Approximately 60% of people who have a major depressive episode will have a second episode. Among those who have experienced two episodes, 70% will have a third, and among those who have had three episodes, 90% will have a fourth (American Psychiatric Association, 2000). Recurrence is very important in predicting the future course of the disorder as well as in choosing appropriate treatments. The median lifetime number of major depressive episodes is four, and 25% of depressives experience six or more episodes (Angst and Preizig, 1996). Depression is therefore considered to be a chronic condition that waxes and wanes over time but seldom disappears (Solomon *et al.*, 2000). The median duration of recurrent depression is five months.

Depression also co-occurs with other disorders, both medical and psychiatric. Kessler (2002), from his review of the epidemiology of depression, concludes that 'comorbidity is the norm among people with depression' (p. 29). For example, the Epidemiologic Catchment Area Study (Robins and Regier, 1991) found that 75% of respondents with lifetime depressive disorder also met criteria for at least one of the other DSM-III disorders assessed in that survey.

The most frequent comorbid condition with depression is anxiety, and in fact there is considerable symptom overlap between these two conditions. The presence of poor concentration, irritability, hypervigilance, fatigue, guilt, memory loss, sleep difficulties and worry may suggest a diagnosis of either disorder. The symptom overlap between the two conditions may indicate similar neurobiological correlates. At a psychological level it seems reasonable to assume that depression can result from the demoralization caused by anxiety; for example, in a case of an agoraphobic who becomes withdrawn because of the fear of going out. Conversely, a person with depression may become anxious due to worry about being unable to hold gainful employment.

Although there is an apparent overlap between anxiety and depression, it is common clinical practice to focus on treating one disorder at a time. The lack of an integrated approach to treatment means that a patient is treated only for

depression while still suffering from anxiety. One of the rationales for combining hypnosis with cognitive behavior therapy, as described in this chapter, is to address symptoms of anxiety. The cognitive hypnotherapy approach to treatment described here is based on the author's experience of working with chronic depressives over the past 25 years.

TREATMENT OF DEPRESSION

In the past 20 years there have been significant developments and innovations in the pharmacological and psychological treatments of depression. The pharmacological, psychotherapeutic and hypnotherapeutic approaches to treatment are briefly reviewed below.

Pharmacotherapy

Over the past 20 years the tricyclics and the monoamine oxidase inhibitors (MAOIs) have been replaced by a second generation of antidepressants known as selective serotonin reuptake inhibitors (SSRIs), which have become extremely popular in the treatment of depression. Although these drugs are similar in structure to the tricyclics, they work more selectively to affect serotonin, which means the side-effects are less severe and they produce improvement within a couple of weeks. Moreover, these drugs are not fatal in overdose and they appear to help with a range of disorders, including anxiety, binge eating and premenstrual symptoms (Pearlstein *et al.*, 1997).

A number of other drugs such as Remeron, Serzone, Effexor and Wellbutrin have also been introduced during the past decade. They share some similarities with SSRIs, but they cannot be classified in any one of the previously mentioned categories. Sometimes these drugs are used in conjunction with SSRIs. Presently there is a variety of antidepressants available, but there are no consistent rules for determining which to use first. In clinical practice several antidepressants are often used before finding one drug that works well and with tolerable side-effects.

Antidepressant medications have relieved severe depression and undoubtedly prevented suicide in tens of thousands of patients around the world. Although these medications are readily available, many people refuse – or are not eligible – to take them. Some are wary of long-term side-effects. Women of childbearing age must protect themselves against the possibility of conceiving while taking antidepressants because they can damage the fetus. In addition, 40 to 50% of patients do not respond adequately to these drugs, and a substantial number

of the remainder are left with residual symptoms of depression (Barlow and Durand, 2005, p. 238).

ECT is often given to patients who do not respond to drug therapies, and is known to relieve depression in 50 to 60% of depressives (Fink, 2001). ECT, however, remains a controversial treatment for several reasons, including cognitive and memory impairments, the idea of passing electrical current through a person's brain appears primitive, and it is still not known how ECT works.

Psychotherapy

Although antidepressant medications work well for many depressed patients, they obviously do not alleviate the problems that might have caused the depression in the first place. Bad marriages, unhappy work situations, or family conflicts that precede depression cannot be fixed by pills. Therefore, many depressed people benefit from psychotherapies designed to help them cope with the difficult life circumstances or personality vulnerabilities that put them at risk for depression. Psychotherapy is also indicated for people who have medical conditions (such as pregnancy and some heart problems) that preclude the use of medications.

Cognitive behavior therapy (CBT), which is the most popular psychosocial treatment for depression, has been studied in over 80 controlled trials (American Psychiatric Association, 2000). It has been found to be effective in the reduction of acute symptoms and compares favorably with pharmacological treatment among all but the most severely depressed patients. CBT also reduces relapse (Hollon and Shelton, 1991) and it can prevent the initial onset of the first episode or the emergence of symptoms in those at risk who have never been depressed (Gillham *et al.*, 2000).

CBT is predicated on the notion that teaching patients to recognize and examine their negative beliefs and information-processing proclivities can produce relief from their symptoms and enable them to cope more effectively with life's challenges (Beck *et al.*, 1979). The primary goal of the CBT therapist is to educate patients in the use of various techniques that allow them to examine their thoughts and modify maladaptive beliefs and behaviors. The main role of CBT is to help the patient learn to use these tools independently. Such skills are not only important for symptom relief, but may also minimize the chances of future recurrence of symptoms. The goals of CBT are achieved through a structured collaborative process consisting of three interrelated components: exploration, examination and experimentation (Hollon *et al.*, 2002).

Hypnotherapy

Hypnosis has not been widely used in the management of clinical depression. The little published literature that exists can be categorized into case studies and adjunctive techniques. Alladin (2006, 2007) attributes the lack of progress in the application of hypnosis to depression to the myth created by some well-known writers that hypnosis can exacerbate suicidal behaviors in depressives. Alladin and Heap (1991) and Yapko (1992, 2001) have argued in response that hypnosis, especially when it forms part of a multimodal treatment approach, is not contraindicated with depression.

The bulk of the published literature on the clinical application of hypnosis to depression consists of case reports. These record the use of a variety of hypnotherapeutic techniques, but lack clarity on what therapists do with hypnosis in the management of depression (Burrows and Boughton, 2001). Nevertheless, several clinicians have used hypnosis as an adjunct to other forms of psychotherapy. For example, Golden *et al.* (1987), Tosi and Baisden (1984), Yapko (2001) and Zarren and Eimer (2001) have reported effective integration of CBT with hypnotherapy with depression in their clinical practice. However, with the exception of Alladin (1992a, 1992b, 1994; Alladin and Heap 1991), these writers have not provided a scientific rationale or a theoretical model for combining CBT with hypnosis in the management of clinical depression.

I have described a working model of non-endogenous depression which provides a theoretical framework for integrating cognitive and hypnotic techniques with depression (Figure 5.1). I revised the model (Alladin, 2007) and called it the circular feedback model of depression (CFMD). This model is briefly described below because it provides the theoretical underpinnings of the cognitive hypnotherapy for depression described in the rest of the chapter. The description of the model also highlights how hypnosis can be used as a useful construct to study and understand certain aspects of the depressive phenomenology.

COGNITIVE HYPNOTHERAPY FOR DEPRESSION

The CFMD gives three pragmatic reasons for combining cognitive and hypnotic paradigms in the treatment and understanding of depression. First, since hypnosis can produce cognitive, somatic, perceptual, physiological and kinesthetic changes under controlled conditions, the combination of the two paradigms may provide a conceptual framework for studying the psychological processes by which cognitive distortions produce concomitant psychobiological changes underlying clinical depression.

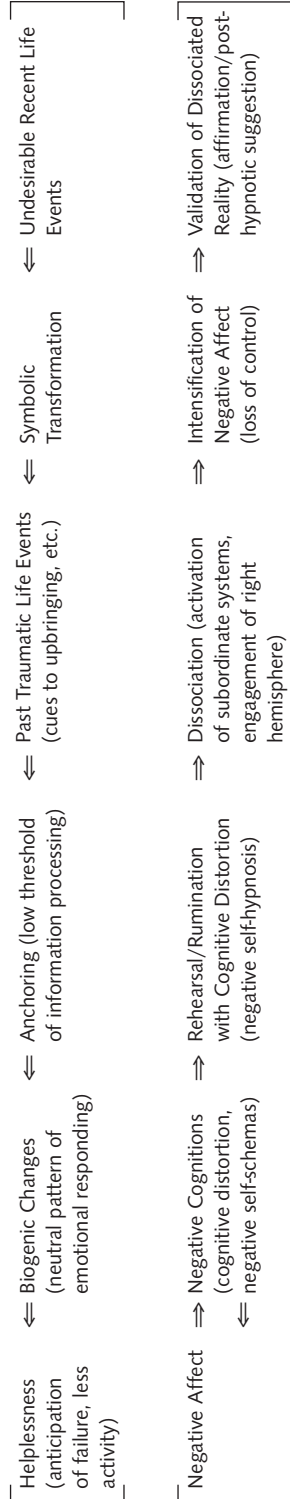


Figure 5.1 Circular Feedback Model of Depression (CFMD) showing the constellation of 12 factors forming the depressive loop

Second, hypnosis provides insight into the phenomenology of depression (Yapko, 1992). Like hypnosis, depression is a highly subjective experience. It allows remarkable insights into the subjective realm of human experience, thus providing a paradigm for understanding how experience – normal or abnormal – is molded and patterned.

Third, after reviewing the strengths and limitations of CBT and hypnotherapy with depression, I concluded that each treatment approach has marked limitations (Alladin, 1989). For example, CBT does not allow access to unconscious cognitive restructuring, while hypnosis provides such access. On the other hand, hypnosis does not focus on systematic cognitive restructuring, while CBT's main focus is on cognitive restructuring via reasoning and Socratic dialogue. I have argued that some of the shortcomings of each treatment approach can be compensated for by integrating both treatment approaches (Alladin, 1989).

There is also some empirical evidence for combining hypnosis with CBT. Recently there has been a growing body of research evaluating the use of hypnosis with cognitive-behavioral techniques in the treatment of various psychological disorders. Schoenberger (2000), from her review of the empirical status of the use of hypnosis in conjunction with cognitive-behavioral treatment programmes, concluded that the existing studies demonstrate substantial benefits from the addition of hypnosis with cognitive-behavioral techniques. Similarly, Kirsch *et al.* (1995), from their meta-analysis of 18 studies comparing a cognitive-behavioral treatment with the same treatment supplemented by hypnosis, found the mean effect size of the difference between hypnotic and non-hypnotic treatment was 0.87 standard deviations. The authors concluded that hypnotherapy was significantly superior to non-hypnotic treatment.

I have just completed a study comparing the effects of CBT with cognitive hypnotherapy with 84 chronic depressives (Alladin and Alibhai, 2007). The results showed an additive effect of combining hypnosis with CBT. The study also met criteria for *probably efficacious* treatment for depression as laid down by the American Psychological Association Task Force (Chambless and Hollon, 1998), and it provides empirical validation for integrating hypnosis with CBT in the management of depression.

Circular feedback model of depression

The circular feedback model of depression (CFMD), which is a revised version of the cognitive dissociative model of depression (Alladin, 1994), was conceptualized to emphasize the bio-psychosocial nature of depression and to explicate the role of multiple factors that can trigger, exacerbate or maintain the

depressive affect (Alladin, 2007). The model is not a new theory of depression or an attempt to explain the causes of depression. It is an extension of Beck's (1967) circular feedback model of depression, which was later elaborated by Schultz (1978, 1984, 2003) and Alladin (1994). In combining the cognitive and hypnotic paradigms, the CFMD incorporates ideas and concepts from information processing, selective attention, brain functioning, adverse life experiences, and the neodissociation theory of hypnosis (Hilgard, 1977).

The initial model was referred to as the cognitive dissociative model of depression because it encompassed the dissociative theory of hypnosis and proposed that non-endogenous depression was akin to a form of dissociation produced by negative cognitive rumination, which can be regarded as a form of negative self-hypnosis. The CFMD consists of 12 interrelated components that form a circular feedback loop (*see* Figure 5.1). The 12 components represent some of the major factors identified from the literature that may influence the course and outcome of depression. The components are described in detail elsewhere (*see* Alladin, 1994, 2006, 2007), so they are only briefly mentioned here to highlight the relationship among the 12 components forming the depressive loop.

The model attaches particular importance to the interaction between affect and cognition, and maintains there is a mutually reinforcing interaction between cognition and affect: thought influences feelings, but feelings too can influence thought content (hence the bi-directional arrows between negative affect and negative cognitions in Figure 5.1). The relationship between dysfunctional cognition and depressive affect is well documented in the literature (e.g. Haas and Fitzgibbon, 1989). An event (internal or external) can trigger a negative schema, which through cognitive rehearsal can lead to dissociation. In depression, Beck (1967, 1976) has noted patients' constant stereotypic preoccupation with their alleged negative personal attributes. I have argued (Alladin, 1992a) that such negative ruminations among some depressives is a form of negative self-hypnosis (Araoz 1981, 1985), which may lead to a state of partial or profound dissociation. Araoz (1981) regards negative self-hypnosis as the common denominator of all psychogenic problems.

Imagery is also considered by the model to be an important aspect of cognition in determining, maintaining and alleviating depression. Many writers (e.g. Ley and Freeman, 1984) claim that images have a greater capacity than language to attract and retrieve emotionally laden associations. Individuals predisposed to depression tend to focus on negative thoughts and images. Schultz (1978, 1984, 2003), Starker and Singer (1975) and Traynor (1974) have provided

evidence that with increasing levels of depression, depressives tend to change the contents of their imagination to negative fantasies, and consequently are unable to redirect their thinking and imagery from their current problems and negative life concerns. In other words, the circular feedback cycle between cognition and affect repeats itself almost like a computer reverberating through an infinite loop (Schultz, 1978) as the depression worsens, thus validating the depressive reality in the form of self-affirmations or post-hypnotic suggestions. Neisser (1967) views such narrowing and distortion of the environment by a few repetitive behaviors and self-attributions as characteristic of psychopathology (i.e. there is an absence of reality testing).

The CFMD also attaches importance to both conscious and non-conscious information processing. Although we are capable of rational operations, most judgements are highly influenced by what is 'available' (particularly vivid information) in current memory at the time (Kahneman *et al.*, 1982). Shevrin and Dickman (1980), after reviewing the research evidence for non-conscious processes, concluded that no psychological model of human experience could ignore the concept of unconscious psychological processes. CBT, which relies on recognition and alteration of conscious cognition, may be ineffective here. Hypnosis provides a tool for accessing non-conscious information. Integration of non-conscious information processing within the CFMD widens our understanding, assessment and treatment of the depressive state. It was this realization that encouraged me to combine hypnosis with cognitive therapy. Several techniques for dealing with non-conscious cognitive influence are described under the treatment section.

Undesirable life events may further contribute to the maintenance of the depressive cycle (Schultz, 1978). However, Klinger (1975) points out that it is the 'symbolic transformation' of these events that is the critical factor. He suggests undesirable life events may serve as cues to past traumatic experiences. Depressives gradually not only become more sensitive to stimuli resembling past traumatic life events, but their reactions may also generalize to innocuous events or situations.

Such selective attending or 'anchoring' may explain the low threshold of information processing to emotional stimuli in depressives. Through repeated and automatic anchoring, biogenic changes may occur. Schwartz (1976, 1977, 1984) has provided evidence for the development of certain neurological pathways resulting from conscious cognitive focusing. It is feasible that depressives, through negative cognitive focusing, develop 'depressive pathways'. Individuals with anomalous developmental history (Guidano, 1987) and those

who are biologically vulnerable (Oke *et al.*, 1978) or genetically predisposed to depression will be more prone to develop these depressive pathways.

When depressed, people with depression have the tendency to think more negatively (Beck *et al.*, 1979) and hence perceive the future as a continuous pattern of failure, relentless hardship and inability to cope. Such catastrophic preoccupation (negative self-hypnosis) promotes feelings of helplessness and hopelessness about the future. These feelings are further exacerbated if the individual lacks social skills (Youngren and Lewinshon, 1980), is surrounded by adverse environmental factors (Paykel *et al.*, 1969), or lacks social support (Brown and Harris, 1978). It is at this point in the depressive cycle that depressives are more vulnerable to suicide, or the depression can become more inflated, leading to aggravation of vegetative symptoms. Thus any of the 12 components in the loop can trigger depression, and the interrelationship among the factors allows the depressive loop to continue to reverberate. The purpose of therapy is to break the depressive loop and to learn a variety of skills to counter the factors that lead to the reverberation of the depressive cycle.

Treatment planning

The CFMD takes a multi-dimensional view of depression. The 12 factors forming the depressive loop are all interrelated, forming a constellation of emotional, cognitive, behavioral, physiological and non-conscious processes. Focusing on any of the factors allows the client and the therapist a point of entry into the depressive loop. Once the client and the therapist gain access into this set of relationships, they can deploy various techniques (some of these are described below) as tools to unravel and reorganize this interrelated set. Any of the factors can be used as a target for intervention, which can simultaneously influence other processes because of their interrelated nature (Simons *et al.*, 1984).

Because depression is a complicated disorder involving multiple factors, it is unlikely that a single causative factor – either biological or psychological – will be found. Therefore any single intervention is unlikely to be effective with every depressed patient. Although a clinical trial of CH has demonstrated that adding certain hypnotic techniques (hypnotic induction, relaxation, ego-strengthening, projection of problem-solving imagery and self-hypnosis) augments the effectiveness of CBT (Alladin and Alibhai, 2007), the treatment approach described below recommends multiple interventions. This is to encourage the therapist to develop a variety of techniques dealing with each factor, rather than being constrained by a few strategies.

This approach also reminds therapists that depression is often associated

with various psychosocial difficulties and other comorbid conditions. Hence Williams (1992), in his comprehensive review of the psychotherapies for depression, concluded that the more techniques that are used, the more effective is the treatment. CH, based on the CFMD, provides a multi-factorial treatment approach to depression. A therapist can easily combine the most appropriate strategies to suit a particular patient.

STAGES OF COGNITIVE HYPNOTHERAPY

Cognitive hypnotherapy (CH) generally consists of 16 weekly sessions, which can be expanded or modified according to the patient's clinical needs, areas of concern and presenting symptoms. The stages of CH are described below. The sequence of the stages of treatment can be altered to suit the clinical needs of the individual patient.

Session 1: Clinical assessment

Before initiating CH it is important for the therapist to take a detailed clinical history to formulate the diagnosis and identify the essential psychological, physiological and social aspects of the patient's behaviors. The most efficient way to obtain all this information is to take a case formulation approach. The main function of a case formulation is to devise an effective treatment plan. The case formulation approach allows the clinician to translate and tailor a homothetic (general) treatment protocol to the individual (idiographic) patient.

I have described in great detail how to conduct cognitive hypnotherapy case formulation in order to select the most effective and efficient treatment strategies (Alladin, 2007). This approach emphasizes the role of cognitive distortions, negative self-instructions, irrational automatic thoughts and beliefs, schemas, and negative ruminations or negative self-hypnosis. By conceptualizing a case, the clinician develops a working hypothesis of how the patient's problems can be understood in terms of the cognitive-dissociative model. This understanding provides a compass or a guide to understanding the treatment process. The evidence suggests that matching treatment to particular patient characteristics improves outcome (Beutler *et al.*, 2000).

Session 2: First aid for depression

Depressives tend to be plagued by feelings of low mood, hopelessness and pessimism, so any immediate relief from these feelings provides a sense of hope and optimism. Alladin (1994, 2006, 2007) and Overlade (1986) have described a

first aid technique for producing immediate relief from the pervasive depressed feeling. The goal of first aid is to:

- break the depressive cycle
- produce positive (non-depressive) feelings
- develop anti-depressive pathways
- establish therapeutic alliance
- produce positive expectancy in the client.

The first aid technique consists of seven stages (*see* Alladin, 2006, 2007 for a detailed description). This technique is particularly effective with a patient who becomes acutely depressed in response to situational stressors such as injustice or being treated unfairly by a spouse. The first aid serves as a crisis intervention, but is specifically devised to alter depressive affect. The first aid for depression can be used with or without hypnotic induction. Following are the seven stages:

1. The patient is encouraged to talk about the situational factor that triggered or exacerbated the depressive affect and is then allowed to ventilate feelings of distress and frustration.
2. A plausible biological explanation (a ‘tucking reflex’) of acute depression is provided to reduce guilt for feeling depressed.
3. The patient is helped to alter the depressive posture or ‘tucking response’ by holding the head high and squaring the shoulders (advised to adopt the posture of a soldier on guard).
4. The patient is encouraged to make deliberate attempts to smile by imagining looking in a mirror.
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 (e.g. ‘bubbles’) that will conjure a smile.

Sessions 3 to 6: Cognitive behavior therapy (CBT)

At least four sessions are devoted to cognitive behavior therapy (CBT). The object of the CBT sessions is to help the patients identify and restructure their dysfunctional beliefs that may be triggering and maintaining their depressive affect. CBT techniques are fully described in several excellent books (e.g. Beck, 1995) so they are not described in detail here. Within the CH framework I

have found the following sequential presentation of the CBT components to be beneficial to depressed patients (Alladin, 2006).

- The patient is offered a practical explanation of the cognitive model of depression.
- The patient is advised to read the first three chapters from *Feeling Good: the new mood therapy* (Burns, 1999).
- The patient is encouraged to identify the cognitive distortions that form part of their negative rumination.
- The patient is advised to record their thoughts and feelings on the ABC form (a form with three columns: A = event; B = automatic thoughts; C = emotional responses). This homework helps the patient discover the link between thoughts and feelings.
- The patient is introduced to the concept of disputation (D) or challenging of cognitive distortions after they have had the opportunity to log the ABC form for a week.
- The ABCDE form is introduced to log disputation and the effects of disputation over negative affect. This form is an expanded version of the ABC form, by including two more columns (D = disputation; E = consequences of disputation).
- The patient is provided with a completed version (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) of the ABCDE form as an example of disputation.
- The patient is coached to differentiate between superficial ('I can't do this') and deeper ('I'm a failure') dysfunctional beliefs (negative self-schemas).
- The patient is coached on how to access and restructure deeper self-schemas.
- The patient is advised to constantly monitor and restructure negative cognition until it becomes a habit.

The number of CBT sessions is determined by the needs of the patient and the presentation of symptoms. The CBT sessions prepare the patient for cognitive restructuring under hypnosis (*see* sessions 9 to 12).

Sessions 7 to 8: Hypnosis

Formal hypnosis is introduced in sessions 7 and 8, although a brief induction procedure may be used to facilitate the first aid technique in the second session. I have argued for the following reasons for utilizing hypnosis within the CH framework (Alladin, 2006); hypnosis:

- induces relaxation
- reduces distraction
- maximizes concentration
- facilitates divergent thinking
- amplifies experiences
- provides access to non-conscious psychological processes.

The focus of the first two hypnotic sessions is on (a) relaxation (to prove to the patient that he or she 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), (d) ego-strengthening, and (e) increasing confidence in the ability to utilize self-hypnosis.

Ego-strengthening is a very important component of the hypnotic sessions. Ego-strengthening is ‘a way of exploiting the positive experience of hypnosis and the therapist–patient relationship to develop feelings of confidence and optimism and an improved self-image’ (Alladin and Heap, 1991, p. 58). When a satisfactory deep level of ‘trance’ is achieved, a modified version of Hartland’s (1971) ego-strengthening suggestions is given. To ensure acceptance of these suggestions, it is of paramount importance to first create a positive mental set and a ‘pleasant state of mind’. Moreover, the ego-strengthening suggestions need to be plausible and logical.

For instance, rather than stating ‘Every day you will feel better’, it is better to suggest, ‘As a result of this treatment and as a result of you listening to your self-hypnosis tape every day, you will begin to feel better’. This set of suggestions not only sounds logical, but improvement becomes contingent on continuing with the therapy and listening to the self-hypnosis tape daily. Here are some examples of the ego-strengthening suggestions adapted from Alladin, 2006 (pp. 161–2).

SUGGESTIONS FOR EGO-STRENGTHENING

- Day by day, as you listen to your self-hypnosis tape, you will become more relaxed, less anxious, and less depressed.
- As a result of this treatment and as a result of you listening to your self-hypnosis tape every day, you will begin to feel more confident and you will begin to cope better with the changes and challenges of life every day.
- You will begin to focus more and more on your achievements and successes than on your failures and shortcomings.

Patients are also offered post-hypnotic suggestions just before the end of the hypnosis session to counter negative self-hypnosis (NSH). Depressives tend to constantly ruminate on negative thoughts, feelings and images (a form of NSH), especially after a negative affective experience (e.g. 'I will not be able to cope'). This can be regarded as a form of negative post-hypnotic suggestion, which can become part of the depressive cycle. To break the depressive cycle it is very important to counter the NSH. Here are some examples of post-hypnotic suggestion for countering NSH (Alladin, 2006, p. 162).

**EXAMPLES OF POST-HYPNOTIC SUGGESTION FOR COUNTERING
NEGATIVE SELF-HYPNOSIS**

- While you are in an upsetting situation, you will become more aware of how to deal with it rather than focusing on your depressed feeling.
- When you plan and take action to improve your future, you will feel more optimistic about the future.
- As you feel involved in doing things, you will be motivated to do more things.

At the end of the first hypnosis session the patient is provided with an audiotape of self-hypnotic procedures for inducing relaxation and creating a positive mental set and a good frame of mind. The self-hypnosis tape also consists of ego-strengthening suggestions and post-hypnotic suggestions. The homework assignment provides continuity of treatment between sessions and offers the patient the opportunity to learn self-hypnosis.

Sessions 9 to 12: Cognitive reframing under hypnosis

The next three sessions integrate the CBT and hypnotic strategies learned so far, and also address non-conscious schemas. More specifically, the sessions focus on cognitive restructuring under hypnosis, expansion of awareness and amplification of experiences, and reduction of guilt and self-blame.

Cognitive restructuring under hypnosis

Hypnosis provides a powerful vehicle for exploring and expanding cognitive distortions below the level of awareness. Sometimes in the course of CBT the patient reports being unable to access cognitions preceding depressive affect. Hypnosis provides access to unconscious cognitive distortions and negative self-schemas, so unconscious maladaptive cognitions can be easily 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 encouraged to restructure the maladaptive cognitions and then attend to the resulting (desirable) responses. For instance, if a person 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.

I used this procedure effectively to treat a depressed patient, Rita, who was unable to identify the cognitions related to social and sexual withdrawal, which were interfering with her relationship with her husband (Alladin, 2006). The following transcript (pp. 164–5) describes the hypnotic procedure of accessing and restructuring non-conscious cognitive schemas.

Therapist: I would like you to go back in time and place in your mind to last Tuesday night when you felt upset and wanted to withdraw yourself from your husband. (Pause) Take your time. Once you are able to remember the situation, let me know by nodding your chin up and down. (ideomotor signals of 'chin up and down for YES' and 'shaking your head side to side for NO' were set up prior to starting the regression).

After a short while, she nodded her chin.

Become aware of the feelings, allowing all the feelings to flow through you. Become aware of your bodily reactions. Become aware of every emotion you feel.

Her breathing and heart rate increased and the muscles in her face started to contract. It became noticeable that she was feeling upset and anxious.

How do you feel? (Pause) Take your time, and you can speak up; speaking will not disturb your trance level.

Rita: I'm scared . . . it's unfair . . . no one told me he was going to be sent away. (She started to cry.)

Rita recounted two traumatic incidents that occurred when she was 10 and 12 years old respectively. When she was 10 years old, her brother Ken (two years older than her) was sent away to live with her grandparents. Ken was supposedly a very naughty child and the parents could not handle him so they 'got rid of him'. Rita was very distressed by it because she was very close to Ken and 'they never told her that Ken was going to be sent away'. She cried for days and for several nights she could not sleep. One night while she was lying in her bed at night, the thought of a dark cave came into her mind and she saw herself being in that dark cave. Although it was frightening initially, later on she felt a sense of comfort, she felt closed in and she did not have to think of anything or feel anything. From this night, whenever she felt upset she would go into the cave in her mind and lock herself in. The second incident happened two years later. One Saturday morning the family got the news that Ken (who was still living with grandparents) died from drowning in the local swimming pool. Immediately, it flashed in her mind that she lost the person she loved most. She felt very upset, but only briefly, because she quickly locked herself in the 'dark cave'. From the regression it became apparent that (a) Rita retreats to the dark cave whenever she feels confronted or stressed out, and (b) she is fearful of getting closer to anyone who loves her (including her husband) in case she loses that person.

Therapist: I want you to come back to Tuesday night when you felt upset. I want you to become aware of the thoughts and images that were going in your mind.

Rita: I can't deal with this. It's too painful. I'll lose him. I don't want to lose him. (She started to cry.)

Therapist: From now on you will become completely aware of all the thoughts that go in your mind when you are upset so that you begin to see the connection between your thinking and your feeling.

The procedure helped Rita to identify the unconscious negative cognitions associated with her upsetting feeling and, consequently, she was able to restructure her thinking and control her emotional and behavioral reactions.

Two further sessions were used to help Rita deal with the two uncovered traumatic events. Her negative experience and the associated faulty cognitions were 'reframed' by utilizing her adult ego state (she was able to reflect on the incidents utilizing her 'adult ego lenses'). Following these sessions Rita's anxiety and sexual difficulties dramatically improved. Through her 'adult ego lenses' she was able conceptualize that it was no longer necessary for her to retreat into the dark cave and she realized there is no direct relationship between loving and losing. Consequently, her relationship with her husband significantly improved. 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 schemas.

Expansion of awareness and amplification of experiences

Hypnosis provides a powerful device for expanding awareness and amplifying experience. Brown and Fromm (in Hammond, 1990, pp. 322–4) describe a technique called 'enhancing affective experience and its expression' for expanding and intensifying positive feelings. The object of this procedure is to help depressed patients create, amplify and express a variety of negative and positive feelings and experience. Enhancing affective experience and its expression is specifically devised to (a) bring underlying emotions into awareness, (b) create awareness of various feelings, (c) intensify positive affect, (d) enhance 'discovered' affect, (e) induce positive moods, and (f) increase motivation. Such a technique not only disrupts the depressive cycle but also helps to develop antidepressive pathways.

An underlying emotion can be brought into awareness by suggesting to the hypnotized patient: 'When I count from ONE to FIVE . . . by the time you hear me say FIVE . . . you will begin to feel whatever emotion is associated with your depressive feeling.' Then the patient is encouraged to amplify the affect by stating, 'When I count slowly from ONE to FIVE . . . as I count you will begin to feel that feeling more and more intensely . . . so that when I reach the count of FIVE . . . at the count of FIVE you will feel it in your body as strongly as you can bear it . . . Now notice what you feel and you will be able to describe it to me.'

The procedure can be easily extended by regressing the patient to past and future projections.

Reduction of guilt and self-blame

In some patients, depression is often maintained by ‘old garbage’ such as guilt and self-regrets. Various hypnotherapeutic techniques can be utilized to reframe the patient’s past experience that causes guilt or self-regrets. Hammond (1990) provides several techniques for dealing with guilt and self-blame. For example, Watkins (in Hammond, 1990, p. 312) describes a technique she calls ‘the door of forgiveness’ for reducing guilt, and Hammond and Stanton (in Hammond, 1990, p. 313) describe two techniques for ‘dumping the rubbish’. One of Stanton’s dumping-the-rubbish techniques is ‘the laundry’ technique.

The laundry technique involves, when in deep trance, imagining (a) a laundry, (b) filling the sink with water, (c) opening a trap door in the head, (d) pulling out the unwanted rubbish (guilt, self-blame and self-regrets) from the brain and dumping it into the water, (e) the water turning blacker and blacker, and (f) finally, pulling the plug, allowing the dirty water (guilt, self-blame and self-regrets) to drain away. Although simple, this metaphor works very well.

Session 9: Attention switching and positive mood induction

Depressives have the tendency to become preoccupied with catastrophic thoughts and images. Such ruminations can easily become obsessional and may also kindle the brain to develop depressive pathways, thus impeding therapeutic progress. To counter the development of depressive pathways the positive mood induction technique is used and attention-switching exercises are devised to break the negative ruminative cycle. These techniques are briefly described below.

Developing antidepressive pathways

Just as the brain can be kindled to produce depressive pathways through conscious negative focusing (Schwartz *et al.*, 1976), the brain can also be kindled to develop antidepressive or happy pathways by focusing on positive imagery (Schwartz, 1984). There is extensive empirical evidence that directed cognition can produce neuronal changes in the brain and that positive affect can enhance adaptive behavior and cognitive flexibility (*see* Alladin, 2007). Within this theoretical and empirical context, I have devised the positive mood induction technique to counter depressive pathways and to develop antidepressive pathways (Alladin 1994, 2006, 2007). Apart from providing a systematic approach for developing antidepressive pathways, the technique also fortifies the brain to withstand depressive symptoms, thus preventing relapse and recurrence of future depressive episodes.

The positive mood induction technique consists of four steps: (1) education, (2) making a list of positive experiences, (3) positive mood induction, (4) post-hypnotic suggestions, and (5) home practice. To educate the patient, the therapist provides a scientific rationale for producing antidepressive pathways. The patient is then advised to make a list of 10 to 15 pleasant or positive experiences. When in deep trance, the patient is instructed to focus on a positive experience from the list of positive experiences, which is then amplified with assistance from the therapist. The technique is very similar to enhancing affective experience and its expression. However, to develop antidepressive pathways, more emphasis is placed on producing somatosensory changes in order to induce more pervasive concomitant physiological changes. The procedure is repeated with at least three positive experiences from the list of pleasant experiences. Post-hypnotic suggestions are provided so that the patient, with practice, will be able to regress completely when practicing at home with the list.

Attention switching

The patient is encouraged to practice with the list four to five times a day. In addition, the patient is encouraged to switch off from negative rumination as soon as he or she becomes aware of it, and to replace it by one of the items from his or her 'pleasant' list. This procedure provides another technique for weakening the depressive pathways and strengthening the 'happy pathways'. In other words, the patient learns to substitute negative self-hypnosis with positive self-hypnosis. Yapko (1992) argues that since depressives utilize negative self-hypnosis to create the experience of the depressive reality, they can equally learn to use positive self-hypnosis to create an experience of antidepressive reality.

Session 13: Active interactive training

This technique helps to break 'dissociative' habits and encourages 'association' with the relevant environment. When interacting with their internal or external environment, depressives tend to passively dissociate 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 schemas and associated syncretic feelings), which inhibits reality testing or appraisal of conceptual reality.

To prevent passive dissociation, a person must (1) become aware of such a process occurring, (2) actively attempt to inhibit it by switching attention away from 'bad anchors', and (3) actively attend to relevant cues or conceptual reality.

In other words, the patient learns to actively engage the dominant hemisphere by becoming analytical, logical, realistic and syntactical. Edgette and Edgette (1995, pp. 145–58) have also discussed several techniques for developing adaptive dissociation. For example, a patient with habitual maladaptive dissociation can be trained to embrace adaptive dissociation, which helps to counter maladaptive dissociation, halt a sense of pessimism and sense of helplessness, and detach from toxic self-talk.

Session 14: Social skills training

Youngren and Lewinshon (1980) have provided evidence that lack of social skills may cause and maintain depression in some patients. A session (or more sessions if required) is therefore devoted to teaching social skills, and the patient is advised to read the appropriate bibliography. The social skills training can be enhanced by hypnosis via imagery training and imaginal rehearsal.

Session 15 to 16: Ideal goals/reality training

Under hypnosis the patient is encouraged to image ideal but realistic goals, and then to imagine planting appropriate strategies and taking necessary actions for achieving them (forward projection with behavioral rehearsal).

Booster and follow-up sessions

Cognitive therapy, as outlined above, normally requires 16 weekly sessions. Some clients may, however, require fewer or more sessions. After these sessions, further booster or follow-up sessions may be provided as required.

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