

EVIDENCE-BASED COGNITIVE HYPNOTHERAPY FOR DEPRESSION

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Abstract

Clinical depression is one of the most common psychiatric disorders treated by psychiatrists and psychotherapists. It also poses special problems to therapists as it is a complex disorder that affects the whole person – emotions, bodily functions, behaviours and thoughts. Although depression is treated successfully with antidepressant medication and psychotherapy, a significant number of depressives do not respond to either medication or existing psychotherapies. It is thus important for clinicians to continue to develop more effective treatments for depression. This article describes Cognitive Hypnotherapy (CH), an evidence-based multimodal treatment for depression, which can be applied to a wide range of patients with depression. The components of CH are described in sufficient detail to allow for their replication and validation. Moreover, CH for depression provides a template for studying the additive effect of hypnosis as an adjunctive treatment with other medical and psychological disorders. Although this article emphasizes evidence-based practice, this approach should not limit the scope of therapists' creativity in the application of hypnosis to the management of depression. Copyright © 2009 British Society of Experimental & Clinical Hypnosis. Published by John Wiley & Sons, Ltd.

Key words: Depression, cognitive hypnotherapy, evidence-based practice, additive effect, creativity

Introduction

The terms major depressive disorder (MDD), depression and depressive disorder are used interchangeably in this article to denote MDD as described in the DSM-IV-TR (American Psychological Association, 2000). MDD is a chronic condition that waxes and wanes over time but seldom disappears (Solomon, Keller, Leon, Mueller, Lavori, Shea, Coryell, Warshaw, Turvey, Maser and Endicott, 2000) and 15% of people with MDD commit suicide (Satcher, 2000). It is highly prevalent and extremely debilitating in terms of poor quality of life and disability (Pincus and Pettit, 2001). The World Health Organization (1998) predicts that by the year 2020 depression will become the second (after chronic heart disease) international health burden, as measured by cause of death, disability, incapacity to work and medical resources used. MDD also co-occurs with other medical and psychiatric disorders, and the most frequent comorbid condition with depression is anxiety disorder. Dozois and Westra (2004) estimated approximately 50% to 76% of depressed patients to experience anxiety and there is considerable symptom overlap between these two conditions (Roy, Neale, Pedersen, Mathé, and Kendler, 1995; Eley

and Stevenson, 1999; Barlow, 2002). In spite of this apparent overlap between anxiety and depression, it is common clinical practice to focus on treating one disorder at a time. This lack of focus on the comorbid condition means that a patient is treated for depression only while he or she is still suffering from anxiety. One of the rationales for combining hypnosis with CBT, as described in this article, is to address symptoms of anxiety when treating depression.

In the past 20 years there have been significant developments and innovations in the pharmacological and psychological treatments of depression. Selective serotonin reuptake inhibitors (SSRIs) have been found to be very effective in relieving severe depression (Pearlstein, Stone, Lund, Scheft, Zlotnik and Brown, 1997), but 40% to 50% of depressed patients do not respond adequately to these drugs, and a substantial number of the remainder is left with residual symptoms of depression (Barlow and Durand, 2005). Moreover, antidepressant medications do not alleviate psychosocial problems such as marital difficulties, interpersonal conflicts and occupational stress that might have caused the depression in the first place. To address these psychosocial issues, and to develop adjunctive or alternative treatment to antidepressants, many forms of psychotherapy for depression have evolved over the past decade. One of the most extensively studied psychosocial treatments for depression has been cognitive behaviour therapy (CBT). Over 80 randomized controlled trials (American Psychiatric Association, 2000; Gillham, Shatte, and Freres, 2000; Hollon and Shelton, 2001) have consistently shown the effectiveness of CBT with depression. As it is with antidepressant medication, a significant proportion of depressed patients do not respond to CBT and, similarly CBT, as a routine do not address anxiety when treating depression.

Hypnosis has not been widely used in the treatment of depression, mainly because (1) until a decade ago the prevailing view was that hypnosis could exacerbate suicidal ideation in depression (Alladin and Heap, 1991; Yapko, 1992, 2001, in press; Alladin, 2006a); (2) a comprehensive guide for the application of hypnosis with depression was lacking (Alladin, in press); and (3) clinical trials of hypnosis with depression were almost nonexistent. Fortunately, in the last decade there has been a renewed interest in the application of hypnosis in the management of depression, largely influenced by the pioneering work of Yapko (1992, 1997, 2001, 2006), which has culminated in the publication of a Special Issue on Hypnosis and Treating Depression in the *International Journal of Clinical and Experimental Hypnosis* (in press). Yapko has emphasized the complex phenomenological nature of depression and described in detail how hypnosis can be effectively utilized as an adjunct in the treatment of depression. This lead was further developed by other clinicians (Tosi and Baisden, 1984; Golden, Dowd, and Friedberg, 1987; Alladin, 1989, 1992a, 1992b, 1994, 2006a, 2007, 2008, in press; Zarren and Eimer, 2001) who specifically combined hypnosis with CBT in the management of depression. Clinical trials (Schoenberger, Kirsch, Gearan, Montgomery, and Pastyrnak, 1997; Bryant, Moulds, Guthrie and Nixon, 2005; Alladin and Alibhai, 2007; Dobin, Maxwell and Elton, 2009;), meta-analysis (Kirsch, Montgomery and Sapirstein, 1995) and detailed review (Schoenberger, 2000) have all substantiated the additive value of hypnosis as an adjunct to CBT in the treatment of various emotional disorders. One comprehensive version of combining hypnosis with CBT in the management of depression has been described by Alladin (1992a; 1994, 2006a, 2007, 2008, in press), known as 'cognitive hypnotherapy' (CH). CH is empirically validated (Alladin and Alibhai, 2007) and it can be applied to a wide range of depressed patients. It is based on the circular feedback model of nonendogenous depression, which provides the theoretical and scientific rationale for combining CBT with hypnotherapy in the management of depression (Alladin

and Heap, 1991; Alladin (1992a, 1992b, 1994, 2006a, 2007, 2008, 2009). CH uses hypnosis to amplify CBT by maximizing concentration, facilitating divergent thinking and experiences, and enhancing access to unconscious processes. This article describes the stages of CH with depression. The treatment protocol is presented in sufficient detail to allow for replication, validation and refinement. CH for depression also serves as a template for studying the additive effect of hypnosis in the management of other specific disorders. CH, however, remains a work in progress as more information about the etiology and treatment of MDD evolves.

Stages of cognitive hypnotherapy

CH for clinical depression consists of 16 weekly sessions, or the sessions can be spread out over 4 to 6 months. The number of sessions and the sequence of therapy, however, can vary according to the patient's clinical needs, areas of concern and presenting symptoms. The stages of CH are briefly described and some of the techniques presented will be illustrated by case examples.

Session 1: clinical assessments

Before implementing CH with a depressed patient, 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 behaviours. The most efficient way to obtain all this information within the context of CH is to use the case formulation approach described by Alladin (2008). The case formulation approach is highly idiographic as it allows the clinician to translate and tailor a nomothetic (general) treatment protocol to the individual (idiographic) patient (Persons and Davidson, 2001; Persons, Davidson, and Tompkins, 2001; Needleman, 2003). Within the case formulation framework, clinical work becomes systematic and hypothesis-driven, rather than being truncated by a hit-and-miss approach to treatment.

Sessions 2–5: cognitive behaviour therapy

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, Rush, Shaw and Emery, 1979). The primary goal of CBT in depression is to educate depressed patients in various techniques that will allow them to examine and modify their depressogenic beliefs and behaviours. As CBT techniques are fully described in several excellent books (e.g. Beck, 1995), they are not described here. For a detailed description of sequential progression of CBT within the CH framework, see Alladin (2007, 2008). The CBT component of CH can be extended over 4 to 6 sessions, depending on the patient's need and the severity of the presenting symptoms.

Sessions 6–7: hypnotherapy

Four to six sessions of CH are devoted to hypnotherapy. This component of CH is introduced to amplify the psychological treatment of depression (Alladin, 2006a, 2007, 2008) and to prevent relapse (Alladin, 2006b; Alladin and Alibhai, 2007). To achieve these goals, the hypnotherapy sessions focus on (1) relaxation training, (2) producing somatosensory changes, (3) demonstration of the power of the mind, (4) expansion of awareness, (5) ego-strengthening, (6) self-hypnosis training, and (7) posthypnotic suggestions.

Relaxation training

As the majority of depressed patients (50% to 76%) experience high levels of anxiety (Dozois and Westra, 2004), relaxation training is considered a very important component of CH. Various hypnotic induction techniques can be utilized to induce relaxation. The author uses the Relaxation with Counting Method adapted from Gibbons (1979; see Alladin, 2007) for inducing and deepening the hypnotic trance as this method is easily adapted for self-hypnosis training. In the CH trial for depression reported by Alladin and Alibhai (2007), most patients indicated that they found the relaxation experience empowering as it boosted their confidence to halt anxious moments in their lives.

Producing somatosensory changes

The most efficient way to change an experience is to create a new experience. Hypnosis is a powerful method for inducing syncretic cognition (Alladin, 2006a), which consists of a matrix of cognitive, somatic, perceptual, physiological, visceral and kinaesthetic changes. Hypnotic amplification and modulation of syncretic cognition (e.g. feeling relaxed, sense of calm, sense of comfort, warmth, heaviness, floating, etc.) offer depressed patients dramatic proof that they can alter their depressive affect and experience. DePiano and Salzberg (1981) believe such positive experience is partly responsible for the rapid and profound behavioural, emotional, cognitive and physiological changes observed in hypnotized patients.

Demonstration of the power of the mind

To further empower depressed patients and to ratify their belief in hypnosis, eye and body catalepsy is induced in hypnosis. The catalepsy demonstrates to the patient that they have the ability to produce changes in their body by utilizing the power of their mind. This procedure helped Bob, a 55-year-old electronic engineer, with a 6-year history of moderate MDD and social phobia specific to board meetings, reduce his scepticism about hypnosis and establish a strong alliance with the therapist (see Alladin, 2006a). Bob strongly believed that his anxiety and depression were biochemical disorders, inherited from his father, who suffered with anxiety and depression throughout his adult life. Bob did not show good response to antidepressant medication, but he was convinced that CBT would help. He read an article in the newspaper about cortical changes produced by CBT and 'he was convinced that CBT would help him; thus he requested referral to the author' (Alladin, 2006a: 178). Five sessions of hypnosis were needed to help Bob acquire a positive image of hypnosis:

Because Bob was so preoccupied with the biological cause of his anxiety and depression, it was decided to devote several sessions of hypnotherapy at the initial stage of his therapy. The sessions were devoted for ego-strengthening, positive mood induction, expansion of awareness, and demonstration of the power of his mind over his body (by producing eye and body catalepsy and challenging him to open his eyes and get out of the reclining chair). Following these sessions, Bob became fascinated with hypnosis and started reading books on it. He was intrigued that he could not open his eyes or get out of the chair, which reinforced his belief that he could change and strengthen his mind and body. He started to show significant improvement and indicated to the therapist that he likes coming to therapy and he looks forward to his 'fascinating sessions'.

(Alladin, 2006a: 179–80)

This case illustrates the unique potential of hypnosis to produce dramatic cognitive, emotional and somatosensory changes in depressed patients.

Expansion of awareness

The range of emotions experienced by depressives is severely constricted due to their constant rumination with their symptoms and the consequences of their symptoms (Nolen-Hoeksema, 1991, 2000, 2004; Papageorgiou and Wells, 2004). However, this does not mean that depressives do not have many feelings; it means ‘patients are dimly aware of the emotional undercurrent in interactions with others’ (Brown and Fromm, 1990: 322). Hypnosis provides a method for expanding awareness and amplifying experience. The ‘Enhancing Affective Experience and Its Expression’ technique developed by Brown and Fromm (1990: 322–4) can be effectively used with depressed patients (a) to bring underlying emotions into awareness, (b) to create awareness of various feelings, (c) to intensify positive affect, and (d) to enhance ‘discovered’ affect. The object of this procedure is to help depressed patients create, amplify and express a variety of negative and positive feelings and experience. The following script illustrates how underlying emotions can be brought to consciousness, verbally described, and amplified:

As you continue to relax, you may become aware of a specific feeling... The specific feeling will become clearer... and clearer... and you will be able to describe it to me... Now, what is it that you are feeling now?

Once the patient is able to describe the feeling, the next step is to amplify it.

Now I am going to count slowly from one to five... by the time I reach five you will become even more aware of the feeling... you will begin to experience the feeling in your body... notice where in the body you hold this feeling... notice the feeling in your heart... notice the muscles in your face... notice what goes through your mind... notice the feeling growing stronger and stronger.

Ego-strengthening

Bandura (1977) has provided experimental evidence that self-efficacy, the expectation and confidence of being able to cope successfully with various situations, enhances treatment outcome. Individuals with a sense of high self-efficacy tend to perceive themselves as being in control. If depressives can be helped to view themselves as self-efficacious, then they are likely to perceive themselves as being in control and hopeful about the future. The most popular method for increasing self-efficacy within the hypnotherapeutic context is to provide ego-strengthening suggestions. The principles behind ego-strengthening are to remove anxiety, tension and apprehension, and to gradually restore the patient’s confidence in themselves and their ability to cope with their problems (Hartland, 1971). Thus ego-strengthening suggestions consist of generalized supportive suggestions to increase a patient’s confidence, coping abilities, positive self-image and interpersonal skills. Hartland (1971) believes patients need to feel confident and strong enough to let go of their symptoms. However, when working with depressed patients it is important to craft the ego-strengthening suggestions in such a way that they appear credible and logical. For example, rather than stating ‘every day you will feel better’, it is advisable to suggest: ‘as a result of this treatment and as a result of you listening to your self-hypnosis tape/CD 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 (see Alladin, 2008: 247–9, for a list of ego-strengthening suggestions).

Posthypnotic suggestions

Depressed patients have the proclivities to ruminate with negative self-suggestions, particularly when subjected to a negative experience (e.g. *'I can't handle this'*; *'I will not be able to cope'*). This can be regarded as a form of negative self-hypnosis (NSH) or negative self-affirmation (posthypnotic suggestions, PHS) that can become part of the depressive cycle. To counter problem behaviours, negative emotional response, dysfunctional cognitions (NSH), and negative self-affirmations (negative PHS), empowering PHS are offered in hypnosis as a routine toward the end of each hypnotherapy session. Here are some examples of PHS provided by Alladin (2006a: 162) for countering NSH in depression:

- 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.

PHS serves as a powerful means for enhancing perceived self-efficacy. Yapko (2003) considers PHS to be a very necessary part of the therapeutic process as they motivate the patients to integrate new behaviours and positive experience in future situations. Clarke and Jackson (1983) have provided evidence that PHS enhance the effect of *in vivo* exposure among agoraphobics. They believe PHS acts as a form of higher-order conditioning.

Self-hypnosis training

The self-hypnosis component of CH is designed to create positive affect, counter NSH and generalize skills learned in the therapy sessions to real situations. At end of the first hypnotherapy session, each patient is routinely provided with an audiotape/CD of the session. The script of the tape/CD consists of hypnotic induction, relaxation training, ego-strengthening suggestions, and posthypnotic suggestions. As part of their homework assignment, the patients are encouraged to listen to the tape/CD daily as this provides continuity of treatment between sessions and creates the setting for learning self-hypnosis. The ultimate goal of CH is to help the depressed patient establish self-reliance. Alman (2001) and Yapko (2003) believe that, by learning self-hypnosis, patients can achieve independence, personal power and self-correcting behaviours that give them control over their lives. These observations were confirmed in the studies reported by Alladin and Alibhai (2007) and Dobin et al. (2009). In the latter study, Dobin et al. (2009) examined the effectiveness of self-hypnosis in the management of depressive symptoms in depressed patients from primary care settings. Patients who were provided self-hypnosis CDs exhibited significant reduction in self-reported depressive symptoms and 50 of 58 patients who participated in the study chose self-hypnosis over medication for the treatment of their depressive symptoms.

Sessions 8–10: cognitive restructuring under hypnosis

Once the depressed patient has had some experience with CBT and hypnosis, the goals of the next three sessions are to integrate cognitive and hypnotic strategies. In the course of CBT, occasionally patients report the inability to identify cognitions preceding their depressive affect (Alladin, in press). Since cognitive theory of depression assumes the primacy of affect, in the absence of conscious cognitive distortions, cognitive restructur-

ing is not viable. This represents a major limitation of CBT that can be easily remedied by integrating hypnosis with CBT (Alladin, 2007, in press). Hypnosis provides a variety of hypnotic strategies for accessing and restructuring conscious, semi-conscious (automatic) and unconscious cognitive distortions and negative self-schemas. These hypnotic strategies can be conveniently contextualized and described under (1) regression to recent activating event, (2) regression to the original trauma, and (3) editing and deleting 'unconscious files' (Alladin, in press).

Regression to recent activating event

This technique is utilized to access maladaptive cognitions connected to a recent event that triggered depressive affect, which the patient cannot recall. While in hypnosis, the patient is given suggestions to recall the situation that caused the recent upset, e.g. '*Can you remember the situation that made you depressed last Tuesday?*' Once the situation is identified, the patient is instructed to remember the emotional, physiological and behavioural responses connected with the situation, and then to become aware of the associated dysfunctional cognitions: '*Remember the feelings and the emotions you experienced. Remember the physical and body sensations you felt. What was your behavioural reaction? And what kind of negative thoughts were going through your mind?*' Next, the patient is directed to identify or 'freeze' (frame by frame, as in a movie) the faulty cognitions linked to the event. Once a particular set of faulty cognitions is frozen, the patient is coached to replace them with more appropriate thinking or imagination, and then to attend to the ensuing (adaptive or desirable) syncretic response. This process is repeated until the set of faulty cognitions connected to a specific situation is considered to be successfully restructured. This procedure was used effectively by Alladin (2006a: 164–5; in press) to treat Rita, a 39-year-old mother and housewife, with a 10-year history of recurrent MDD, who felt anxious in some social situations and was inhibited about sexual activities, but was unable to identify the associated maladaptive cognitions. The hypnotic regression helped her to bridge the link between her affect and her cognitions. Once the association between her anxiety and her maladaptive cognitions were established, her 'adult ego lenses' were used to reframe the faulty cognitions.

Regression to the trauma

This strategy is used when in therapy it becomes important to identify the core beliefs or the origin of core beliefs. In Rita's case, although CBT and regression to recent events improved her anxiety and depressive symptoms, her sexual dysfunction continued, which often served as a trigger for her depression. Whenever her husband showed an interest in her, including nonsexual scenarios, she would freeze and withdraw, often spiralling into depression. The only cognitions that she could link to her feelings were that she felt uncomfortable being around her husband, especially in the bedroom. Rita was 'convinced there was something wrong with her at an unconscious level that might be affecting her sexual desire and sexual activity' (Alladin, 2006a: 176–7). Deep hypnotic regression helped Rita identify the 'initial sensitizing event (ISE)' (Banyan and Kein, 2001) that shaped her core beliefs about men and sexuality. During hypnotic regression she was able to remember an incident when she was molested by her uncle when she was 7 years old. Because she had so much love and respect for her uncle, his actions confused her and she did not know what to think of him, and then it occurred to her that 'men are bad; I will never let them come near me'. Since then she carried the deep beliefs, although unconscious, that men are bad and harmful and therefore 'you should protect yourself from them'. Rita's way of protecting herself was not to allow men, including her husband,

to come near her. These beliefs were reframed in hypnosis; she realized that her withdrawal from her husband and her hyposexual desire represented self-protection, which is no longer required as her husband is very loving and caring towards her. In hypnosis she also gave herself the permission to break the promise that she will never allow a man to touch her, as this promise was made during childhood when she was in a confused state. The core beliefs were also subjected to cognitive re-evaluation until she came to the understanding that not all men are bad.

Editing and deleting the unconscious file

This method of cognitive restructuring in hypnosis is particularly appealing to children and adolescents as it involves the computer metaphor of editing and deleting old files. The procedure consists of two stages: (1) bringing forth the adult ego state, and (2) symbolically rewriting a set of maladaptive old learning or experience. To bring forth the adult ego state, while in hypnosis, following ego-strengthening suggestions and amplification of positive affect, the patient is instructed to become aware of the 'good feelings' and then directed to focus on personal achievements and successes (adult ego state). Once this is achieved, the patient is instructed to imagine opening an old computer file containing outdated behaviours, experiences and learning that require editing or deletion. Then the patient is instructed to edit or delete the file, paying particular attention to dysfunctional cognitions, maladaptive behaviours and negative feelings. By metaphorically deleting and editing the file, the patient is able to mitigate cognitive distortions, magical thinking, self-blaming and other self-defeating mental scripts (NSH). Other 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-schemas in hypnosis.

Symbolic imagery techniques

Depression can be triggered, exacerbated or maintained by conscious or unconscious 'emotional garbage' such as inappropriate anger, doubts, guilt, fears and self-blame. Various hypnotherapeutic techniques can be used to reframe patients' past experiences that cause these inappropriate feelings. Alladin (2007, 2008, in press; also see Hammond, 1990) has summarized four symbolic imagery techniques for dealing with guilt and self-blame, including 'The Door of Forgiveness' (Watkins, 1990), 'Dumping the "Rubbish"' (Stanton, 1990), 'Room and Fire' (Stanton, 1990) and 'The Red Balloon Technique' (Hammond, 1990). For instance, the 'Room and Fire' (Stanton, 1990) technique uses the image of a fireplace for burning unwanted garbage. In hypnosis, the patient is asked to imagine going down in the lift from the tenth floor of a hotel to the basement. In the basement there is a very cosy room with a large stone fireplace and a fire burning. The patient is asked to imagine throwing into the fire 'Things you may not wish to keep in your life, such as fears, doubts, anxieties, hostilities, resentments, and guilts... one at a time, feeling a sense of release as they are transformed into ashes' (Stanton, 1990: 313).

Sessions 11–12: attention switching and positive mood induction

Depressives are inclined to ruminate with catastrophic thoughts and negative images (Nolen-Hoeksema, 2004; Wells, 2004). Such negative rumination or brooding can intensify and maintain the depressive affect, and further kindle depressive neuro pathways, thus impeding therapeutic progress (Post, 1992; Monroe and Harkness, 2005). To counter

negative ruminations, the depressed patient is instructed to practise 'attention switching' and to prevent kindling of the depressive neuropathways, the 'positive mood induction' technique is used.

Attention switching

To break the negative ruminative cycle, depressives are trained to switch attention away from negative cognitions and to focus more on positive experiences (see Alladin, 2007 for detailed description of this technique). To achieve this, the patient is advised to make a list of 10 to 15 pleasant life experiences and to 'practise holding each experience in your mind for about 30 seconds'. The patient is encouraged to practise with the list for at least three times a day and to get into the habit of switching off from negative or 'undesirable' experiences (whenever the patient dwells on these) and to 'replace them with one of the pleasant items from your list'. By utilizing this technique, the depressed patient learns to substitute NSH by positive self-hypnosis. Yapko (1992) has argued that since depressives use NSH to create their experience of the depressive reality, they can equally learn to use positive self-hypnosis to create an experience of anti-depressive reality.

Positive mood induction

Just as the brain can be kindled to produce depressive neuropathways through conscious negative focusing (Schwartz, Fair, Salt, Mandel and Klerman, 1976), the brain can also be kindled to develop anti-depressive 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 behaviour and cognitive flexibility (see Alladin, 2007). Within this theoretical and empirical context, Alladin (1994, 2006a, 2007) has devised the 'positive mood induction' technique to counter depressive pathways and to develop anti-depressive neuropathways.

The positive mood induction technique consists of five steps: (1) education, (2) making a list of positive experiences (the same as for attention switching), (3) positive mood induction, (4) posthypnotic suggestions, and (5) home practice. To educate the patient, the therapist provides a scientific rationale for developing anti-depressive neuropathways. When in deep trance, the patient is instructed to focus on a positive experience from the attention switching list, which is then amplified with assistance from the therapist. The procedure is repeated with at least three positive experiences from the list of pleasant experiences. Posthypnotic suggestions are provided that the patient, with practice, will be able to regress completely when practising at home with the list. Apart from providing a systematic approach for developing anti-depressive neuropathways, this technique also fortifies the brain to withstand depressive symptoms, thus preventing relapses and recurrence of future depressive episodes.

Session 13: active interactive training

When interacting with their internal or external environment, depressives are predisposed to unintentionally dissociate rather than actively interact with the pertinent internal or external information. The 'active interacting training' is devised to help break the 'dissociative' habits and establish 'association' with the relevant information or experience. The training involves four steps. First, the depressed patient is trained to differentiate between 'active interaction' and 'passive dissociation' and to become aware of these processes occurring. *Active interaction* requires being alert and 'in tune' with conceptual reality (incoming information), whereas *automatic* or *passive dissociation* is the

tendency to anchor in 'inner reality' (negative schemas and associated syncretic feelings), which inhibits reality testing or appraisal of conceptual reality. Secondly, the patient actively attempts to inhibit the 'disassociation' (once the patient becomes aware of this process occurring) by switching attention away from the 'bad anchors' or 'negative inner reality'. Thirdly, the patient actively attends to pertinent internal or external cues (conceptual reality) after switching off from the 'disassociation'. A constellation of strategies, including 'grounding' or 'anchoring' techniques (Dolan, 1991; Simonds, 1994; Philips and Frederick, 1995; Gold and Seibel, 2009), have been described in the literature for learning to directly counteract dissociative reactions. What this group of techniques has in common is that they all involve learning to direct one's attention to the immediate surrounding environment and current interpersonal interaction (Gold and Seibel, 2009). In other words, the patient learns to actively engage in higher-order executive processes. Recent neuroimaging studies have shown depressed patients to manifest *hyperactivity* in the limbic regions that are important for perceiving emotional aspects of information and *hypoactivity* in areas of the prefrontal cortex that exert inhibitory control over those limbic regions (Drevets, 2000). CBT appears to affect cortical functions (Mayberg, 2003; Siegle, Carter, and Thase, 2006), that is, it bolsters higher-order executive functioning centred in the prefrontal cortex (Seminowicz, Mayberg, McIntosh, Goldapple, Kennedy, Segal, et al., 2004). Since active interactive training is a cognitive-behavioral technique, it is not unreasonable to assume that this technique might be producing similar cortical changes to CBT. Edgette and Edgette (1995: 145–58) have also described several techniques for developing adaptive dissociation. They have put forward the view that if a patient is naturally adept with maladaptive dissociation, then the patient could equally be trained to embrace adaptive dissociation, which would counter maladaptive dissociation, apprehend sense of pessimism and sense of helplessness, and wean off toxic self-talk.

Session 14: social skills training

Although it is not clear whether poor social skills are antecedents or consequences of depression (Joiner and Timmons, 2009), the majority of depressed patients have interpersonal difficulties such as making friends, marital distress, low frequency dating, a lack of close friends, insufficient social support, trouble initiating new relationships, strained relationship with co-workers, and impoverished social networks (Youngren and Lewinshon, 1980; Segrin, 2000). Moreover, social skills deficits may interact with other factors such as negative life events and operate as a risk factor for depression (Segrin, 2000). Furthermore, there is evidence that two particular instances of impaired social skills, known as *excessive reassurance seeking* (Joiner and Metalsky, 2001; Abela, Zuroff, Ho, Adams, and Hankin, 2006) and *negative feedback seeking* (Joiner, 2002) may also serve as risk factors for depression. Negative feedback seeking is defined as the tendency to actively solicit criticism and other negative interpersonal feedback from others. These propensities or diatheses reinforce the negative self-schemas of depressed patients. In order to modify this diathesis and to improve social skills, two to three sessions (or more if required) of CH is devoted to teaching social skills training (SST).

SST is a generic term that refers to a number of specific forms of training such as assertion skills, conversational interaction skills, dating skills, and job-interviewing skills (Segrin, 2000). Alladin (2007: 182–8) has summarized some of the common SST techniques that can be easily integrated with CH and these include instruction, modeling, rehearsal, role playing and homework assignments. The following excerpt from

Segrin (2003: 387) provides an example of how a therapist can utilize direct instruction, coaching and explanation for showing interest in other people:

The social skills trainer might start by stating that showing interest and paying attention to our conversational partners make them feel valued. Further, most people respond very positively to others who make them feel worthwhile, valued, and cared for. The latter information provides an explanation for how and why showing interest in others work, and how it can be functional. In direct instruction and coaching the trainer must explain how to enact the behaviors and how they work to create rewarding social interactions and relationships. The therapist might offer suggestions for how to show interest in other people. 'How's it going today?' and then following up with another inquiry or a positive response to what the other person has to say. Similarly the therapist might suggest that the client ask questions such as 'How was your weekend?' or 'What have you been up to lately?' Of course, it would be important to work on developing these conversation starters in more extended interactions in which the client responds appropriately to the discourse of his or her partner. These suggestions would be coupled with discussions and explanations of their effect on other people (e.g., making them feel valued, letting them know that other people care about them, and so on).

Studies examining the effects of this training show clear improvements in social skills and self-reported measures of depression at 3- and 6-month follow-ups (Hersen, Bellack and Himmelhoch, 1980). SST has also been found to be as effective as CBT, pharmacotherapy, and other forms of psychotherapy in the management of clinical depression (Bellack, Hersen and Himmelhoch, 1981, 1983). These SST techniques can be easily integrated with CH and the effects of SST can be amplified by hypnotherapy. Future projections and rehearsals (imagining role-playing when in trance) can be utilized to amplify perceived self-efficacy. Ego-strengthening and posthypnotic suggestions can be used to increase compliance and homework practice.

Session 15: behavioural activation

Behavioral activation therapy is based on the theory that reinforcement of health behaviours is lacking in the life of depressed people, while unhealthy or depressive behaviours may be excessively reinforced (Zinbarg and Griffith, 2008). For example, a person without much opportunity for social reinforcement might develop feelings of loneliness and isolation. This low social functioning might be maintained through reinforcement of unhealthy behaviours. For example, a spouse or a friend might reinforce depression behaviour by increased positive attention. Lewinshon and his colleagues (e.g. Lewinshon and Graf, 1973; Lewinshon, 1974) have shown that one effective treatment for depression was to increase the frequency of positive events and to engage in self-monitoring so that patients could learn what activities were related to various mood states.

A dismantling study of CBT (Jacobson, Dobson, Truax, Addis, Koerner, Gollan et al., 1996) has shown behavioural activation to be the most active ingredient in reducing depressive symptoms and a randomized study (Gortner, Gollan, Dobson and Jacobson, 1998) comparing BA with CBT found equal outcomes for both treatments with depressed outpatients. Encouraged by these findings, Martell, Addis and Jacobson (2001) have developed a protocol for treating depression, based on behavioural activation. This BA protocol was recently compared to CBT and to pharmacotherapy (paroxetine) in a randomized, placebo-controlled clinical trial (Dimidjian, Hollon, Dobson, Schmaling, Kohlenberg, Addis et al., 2006) and the outcomes for the three treatments were comparable at the end of the treatment and at follow-up (Dobson, Hollon, Dimidjian, Schmaling, Kohlenberg, Gallop et al., 2008).

From the above review it would appear that behavioural activation is one of the important components in the management of depression. Therefore, at least one or two sessions of CH are devoted to BA therapy. Alladin (2007: 172–81) has described several behavioural, physical and hypnotherapeutic methods that can be used within the CH context to reduce avoidance and inactive behaviours. The behavioural methods include *weekly activity schedule* (engages depressed patient in planned daily activities that increases access to reinforcement) and *behavioural activation training* (helps patients change their behaviours in such a way as to bring them into contact with positive reinforcers in their natural environment; e.g., instead of avoiding, commitment is made to go to the gym three times a week). Physical exercise is one of the most efficient means for countering avoidant behaviours in depressed patients (Patterson, 2002). In addition, physical exercise has the capacity to prevent mental illness, foster positive emotions (Biddle, Fox and Boutcher, 2000; Stathopoulou, Powers, Berry, Smits and Otto, 2006) and buffer individuals against the stresses of life (Mutrie and Faulkner, 2004). The National Health Service in the United Kingdom lists exercise on their website as one of the recommended treatments for depression (<http://cebmh.warne.ox.ac.uk/cebmh/elmh/depression/new.html>).

Patterson (2002) recommends either aerobic or anaerobic exercises for depression. An exercise is considered aerobic if it raises the heart rate into a specified target range for a specified period of time. Activities such as running, swimming and cross-country skiing are considered aerobic exercises. Activities such as yoga, tai chi and walking are considered anaerobic because these exercises are not designed to raise the heart rate or sustain the heart rate for a specified length of time. Hypnotherapeutic strategies such as forward projection, imaginal rehearsal, ego-strengthening and posthypnotic suggestions can also be used to reduce avoidant behaviours and augment behavioural activities (Alladin, 2007, in press). For example, Yapko (in press) uses hypnosis to catalyze experiential learning in depressed patients in order to encourage behavioural activation and transform ruminative coping style. Torem (2006: 104) uses a hypnotic age progression strategy called 'Back from the Future' for helping depressed patients counter symptoms of hopelessness. This hypnotic technique regresses the depressed patient to 'travel to a specific time in the future', where the patient feels 'positive feelings, images, and sense of accomplishment' which are brought back to the present moment.

Session 16: mindfulness training

Depression involves withdrawing or turning away from experience to avoid emotional pain (Germer, 2005). Such withdrawal can deprive the depressed person of the life that can only be found in direct experience. Germer believes successful therapy outcome emanates from changes in a patient's relationship with his or her particular form of suffering. For instance, if a depressed patient decides to be less upset by events then his or her suffering is likely to decrease. Mindfulness training helps the depressed person become less upset by unpleasant experience and hence less reactive to negative events in the present moment. Teasdale, Segal, Williams, Ridgeway, Soulsby and Lau (2000) have provided empirical evidence that mindfulness-based CBT reduces relapses in depression.

Mindfulness can be easily integrated with hypnotherapy in the management of depression (Alladin, 2006b; Lynn, Das, Hallquist, and Williams, 2006; Lynn, Barnes, Deming, and Accardi, in press). Within the CH context, mindfulness training is introduced at the later part of the treatment protocol. The author finds the following sequential training

of mindfulness helpful to the depressed patients: (1) education, (2) training, and (3) hypnotherapy.

The educational component of mindfulness education consists of providing the depressed patient with information about the risk factors involved in the exacerbation, recurrence and relapse of depression, the different strategies used for relapse prevention, and the simplicity and effectiveness of mindfulness training. Once the patient agrees to mindfulness training, the complexity of the human being is discussed and within this context it is emphasized that feelings and thoughts are part of us and not our whole self. It is pointed out that feelings and thoughts are not objective reality but transitory states that 'come and go just like a cloud, but the sky stays the same'. Mindfulness training involves *informal* mindfulness training consisting of the 'Body Scan Meditation' exercise adapted from Segal, Williams and Teasdale (2002: 112–13). The exercise focuses on teaching depressed patients to become aware of their breathing and the feeling in different parts of the body. The goal of this exercise is to help the depressed focus on the present moment and learn to appreciate that feelings are transitory states and not permanent state. For a detailed script of the Body Scan Meditation, refer to Alladin (2008: 54–6).

Alladin (2006a) and Lynn et al. (2006, in press) recommend using hypnosis to catalyze mindfulness-based approaches. For example, Alladin (2006a) utilizes hypnosis to consolidate and amplify the education and the meditation components of mindfulness training. Lynn et al. (2006) use hypnotic suggestions to provide the basic instructions for practising mindfulness. They also recommend using hypnotic and posthypnotic suggestions to encourage patients (1) to practise mindfulness on a regular basis; (2) not to be discouraged when attention wanders off when training; (3) to learn to accept what cannot be changed; (4) not to personally identify with feelings as they arise; (5) to learn to tolerate troublesome feelings; and (6) to appreciate that troublesome feelings and thoughts are not permanent.

Booster and follow-up sessions

CH normally requires about 16 weekly sessions of therapy. Some patients may, however, require fewer or more sessions. Follow-ups and booster sessions may also be provided if the needs arise.

Summary

CH offers a variety of hypnotic and cognitive-behavioural strategies for the management of depression from which a therapist can choose the best-fit treatment for a particular depressed patient. The case formulation approach adopted by CH guides the therapist to select the most effective intervention for his/her patient. The number of sessions and the sequence of the stages of CH are determined by the clinical needs of each patient. CH also offers innovative treatment techniques for depression such as the development of anti-depressive pathways and the catalyzing of mindfulness training. Although there is some empirical evidence for the effectiveness of CH, further studies are required before it can achieve the APA status of well-established treatment for depression. Conducting this kind of research is necessary if clinical hypnosis is to become recognized as a bona fide psychotherapy. On the other hand, as the treatment approach to CH is highly idiosyncratic, the scope of the therapist's creativity should not be curtailed by evidence-based practice. CH for depression also provides a template for studying the additive effect of hypnosis as an adjunctive treatment with other medical and psychological disorders.

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