

EVIDENCE-BASED HYPNOTHERAPY FOR DEPRESSION

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Abstract: Cognitive hypnotherapy (CH) is a comprehensive evidence-based hypnotherapy for clinical depression. This article describes the major components of CH, which integrate hypnosis with cognitive-behavior therapy as the latter provides an effective host theory for the assimilation of empirically supported treatment techniques derived from various theoretical models of psychotherapy and psychopathology. CH meets criteria for an assimilative model of psychotherapy, which is considered to be an efficacious model of psychotherapy integration. The major components of CH for depression are described in sufficient detail to allow replication, verification, and validation of the techniques delineated. CH for depression provides a template that clinicians and investigators can utilize to study the additive effects of hypnosis in the management of other psychological or medical disorders. Evidence-based hypnotherapy and research are encouraged; such a movement is necessary if clinical hypnosis is to integrate into mainstream psychotherapy.

There is no one-size-fits-all treatment for major depressive disorder (MDD) as the condition represents a complex and heterogeneous set of symptoms and patterns involving multiple etiologies. Depression, depressive disorder, major depression, or major depressive disorder (MDD) are terms used interchangeably to refer to MDD as described in the *Diagnostic and Statistical Manual, 4th edition, Text Revised (DSM-IV-TR; American Psychiatric Association, 2000)*. Although randomized controlled trials have shown antidepressant medications, cognitive-behavior therapy (CBT), and interpersonal psychotherapy (IPT) to be effective in the management of MDD, a significant number of depressives do not respond to either medication or CBT or IPT. Thus, it is important for clinicians to continue to develop more effective treatments for MDD.

This need becomes progressively more imperative because MDD is a burdensome disorder that “takes over the whole person—emotions, bodily functions, behaviors, and thoughts” (Nolen-Hoeksema, 2004,

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p. 280). Major depression is a chronic condition and a very costly disorder in terms of lost productivity at work, industrial accidents, high bed occupancy in hospitals, expense of treatment, state benefits, and personal suffering (Solomon et al., 2000). Further, MDD frequently occurs with many other medical and psychiatric disorders. From his review of the epidemiology of depression, Kessler (2002, p. 29) concluded that "comorbidity is the norm among people with depression." The most frequent comorbid condition with depression is some form of anxiety disorder. In fact, there is considerable symptom overlap between these two conditions. In both community and clinical samples, the average comorbidity rate of major depressive disorder and various anxiety disorders is more than 50%, and the lifetime rate is 76% (see Dozois & Westra, 2004). The comorbidity of anxiety and depression is associated with an increased severity of symptoms, psychological distress, overall impairment (Roy-Byrne et al., 2000), and an increased suicide rates (Lecrubier, 1998). Anxiety has been found to be primary in 67.9% of anxiety-depression comorbid cases (Belzer & Schneier, 2004). Although there is an apparent overlap between anxiety and depression (see Lynn, Matthews, Fraioli, Rhue, & Mellinger, 2006), it is common in clinical practice to focus on treating one disorder at a time. While some experts (e.g., Barlow, 2002) argue that treatment of one condition may produce concurrent improvement in the comorbid condition, other investigators (e.g., Clayton et al., 1991; Lecrubier, 1998; Nutt, 2000) have found depressed patients with high-anxiety levels to show less response to antidepressants and poorer long-term prognosis than nonanxious depressed patients. Therefore, lack of an integrated approach to treatment may mean that a patient is treated only for depression while also suffering from anxiety. One of the rationales for combining hypnosis with CBT, as described in this article, is to address symptoms of anxiety concurrently with depression.

Until recently, hypnosis had not been widely used in the treatment of depression because of the prevailing beliefs that depression impairs hypnotic responsiveness and hypnosis may exacerbate suicidal behaviors in depressives (Alladin, 2006a). Alladin (2006a; Alladin & Heap, 1991) and Yapko (1992, 2001) challenged these beliefs and argued that hypnosis, especially when part of a sensible multimodal treatment approach, is *not* contraindicated with either inpatient or outpatient depressives and can, in fact, enhance treatment results.

Another reason for the lack of application of hypnosis in the management of depression can be attributed to the absence of a comprehensive description of hypnotherapy for depression in the literature. What little published literature that existed consisted mainly of case reports, describing only generally a variety of techniques. It was not clear from these reports what therapists actually did with hypnosis in the treatment of depression (Burrows & Boughton, 2001). Recently,

there has been renewed interest in the application of hypnosis in the management of depression, largely due to the pioneering work of Yapko (1988, 1992, 1997, 2001, 2006). Yapko emphasized the complex phenomenological nature of depression and described in detail how hypnosis and hypnosis combined with CBT or interpersonal methods can be effectively utilized in the management of depression. He advanced six clinical reasons for using hypnosis in treating depression: hypnosis (a) amplifies subjective experience; (b) serves as a powerful method for interrupting symptomatic patterns; (c) facilitates experiential learning; (d) helps to bridge and contextualize responses; (e) provides different and more flexible models of inner reality and (f) helps to establish focus of attention (Yapko, 1992).

The field was further expanded by other clinicians who also considered hypnosis to be a useful adjunct to mainstream psychotherapies for depression. For example, Alladin (2006a, 2007, 2008), Chapman (2006), Golden, Dowd, and Friedberg (1987), Lynn and Kirsch, (2006), Tosi and Baisden (1984), and Zarren and Eimer (2001) integrated CBT with hypnosis in treating depression. There is some empirical evidence for combining hypnosis with CBT. Clinical trials (Alladin & Alibhai, 2007; Bryant, Moulds, Guthrie, & Nixon, 2005; Dobbin, Maxwell, & Elton, 2009; Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997), meta-analysis (Kirsch, Montgomery, & Sapirstein, 1995), and detailed review (Schoenberger, 2000) have substantiated the additive value of hypnotic interventions when combined with CBT for various emotional disorders. Moreover, Alladin (1992a, 1992b, 1994, 2006a) provided a scientific rationale or a working model for combining CBT with hypnosis in the treatment of clinical depression. After reviewing the strengths and limitations of CBT and hypnotherapy with depression, Alladin (1989, 2007) concluded that each treatment approach was lacking in several ways. For example, CBT does not encourage unconscious cognitive restructuring; instead, its main focus is on cognitive restructuring via conscious reasoning and Socratic dialogue. Hypnotherapy, on the other hand, has traditionally focused on unconscious restructuring or reframing, paying less attention to a conscious systematic restructuring of dysfunctional cognitions. Alladin (1989, 2007) argued that the shortcomings of each single treatment (i.e., hypnosis and CBT) could be overcome by integrating techniques from both treatment approaches. Schoenberger (2000) proposed that since many CBT procedures are easily conducted with hypnosis or simply relabeled as hypnosis, CBT-oriented clinicians with experience in hypnosis could easily establish a hypnotic context "as a simple, cost-effective means of enhancing treatment efficacy" (p. 244). Moreover, Golden (2006) pointed out that CBT and hypnosis share a number of commonalities such as imagery and relaxation that can make for a natural integration of the two approaches.

Alladin (1994, 2007) described a circular feedback model of nonendogenous depression (CFMD) that embraces the above rationales for combining CBT with hypnotherapy in the psychotherapy of depression. Based on this model, Alladin (1994, 2006a, 2007, 2008) developed an evidence-based multimodal approach, known as cognitive hypnotherapy (CH), for the treatment of clinical depression, which can be applied to a wide range of depressed patients. CH has been empirically validated (Alladin & Alibhai, 2007) and it represents a comprehensive version of hypnotherapy for depression (Alladin, 2007; Gantz, 2009). CH, however, remains a work in progress as more information evolves about the etiology and treatment of MDD. This article describes the major components of CH.

THE MAJOR COMPONENTS OF CH FOR MDD

CH generally consists of 16 weekly sessions that can be expanded or modified according to the patient's clinical needs, areas of concern, and presenting symptoms. The major components of CH are briefly described here. (For a more detailed description of the stages and the components of CH, see Alladin, 2007, 2008.)

Clinical Assessments

As is customary in good clinical practice, it is important for the therapist to take a detailed clinical history to formulate the diagnosis and to identify the essential psychological, physiological, and social aspects of the patient's difficulties before initiating CH. An efficient way to obtain this information within the context of CH is by taking a case formulation approach as described by Alladin (2007, 2008). A case formulation approach allows the clinician to tailor a nomothetic (general) treatment protocol derived from randomized clinical trials to the needs of the individual (idiographic) patient.

COGNITIVE-BEHAVIORAL THERAPY

CBT is currently the most widely studied psychosocial treatment for depression. More than 80 controlled trials have consistently demonstrated CBT to be effective in the reduction of acute symptoms and to compare favorably with pharmacological treatment among all but the most severely depressed patients (American Psychiatric Association, 2000). CBT has also been shown to reduce relapse in depression (Hollon & Shelton, 2001) and may even prevent the initial onset of the first episode of depression or the emergence of symptoms in persons at risk who have never been depressed (Gillham, Shatte, & Freres, 2000). CBT is predicated on the notion that errors in information processing (i.e., cognitive distortions) lead to the formation of negative beliefs and

distressing symptoms. 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 (A. T. Beck, Rush, Shaw, & Emery, 1979).

Although not making reference to dissociation or hypnosis in the CBT model, the following observation of the depressed patient's negative rumination and dysphoric response recorded by A. T. Beck et al. (1979, p. 13) can be considered analogous to the concepts of negative self-hypnosis (NSH) and trance state, respectively.

In milder depressions the patient is generally able to view his negative thoughts with some objectivity. As the depression worsens, his thinking becomes increasingly dominated by negative ideas . . . and [he or she] may find it enormously difficult to concentrate on external stimuli . . . or engage in voluntary activities . . . the idiosyncratic cognitive organization has become autonomous . . . [so] that the individual is unresponsive to changes in his immediate environment. (A. T. Beck et al., 1979, p. 13)

Similarly, Yapko (1992, 1997) considered the depressive affect produced by cognitive distortions to be a form of "symptomatic trance" associated with several misapplied hypnotic phenomena such as age regression and progression, amnesia, catalepsy, dissociation, ideodynamic responses, hallucinations, sensory alterations, and time distortion.

In depression, CBT is utilized to help patients recognize and modify their idiosyncratic style of thinking, typically through the use of evidence and applications of logic. The main objectives of CBT sessions are to help patients identify and restructure dysfunctional beliefs that may trigger and maintain their depressive affect. CBT uses some very well-known and tested reason-based models for interventions such as Socratic logic-based dialogues and Aristotle's method of collecting and categorizing information about the world (Leahy, 2003). CBT therapists regularly engage their patients in scientific and rational thinking by guiding them to examine the presupposition, validity, and meaning of their beliefs that lead to their depressive affect. As CBT techniques are well described elsewhere (see J. S. Beck, 1995), they are not described in detail here. For a detailed description of the sequential progression of CBT within the CH framework, see Alladin (2007, 2008). Within the CH perspective, CBT can be seen as a conscious strategy for countering NSH in order to circumvent the depressive state or the symptomatic trance (Yapko, 1992). The CBT component of CH for this purpose can be extended over four to six sessions. However, the actual number of CBT sessions is determined by the needs of the patient and the severity of the presenting symptoms.

In the context of CH, the question may arise as to whether to apply the hypnotherapy or CBT component first. The answer is determined by the symptomatology and the clinical needs of the depressed patient.

If the patient is overly preoccupied with dysfunctional cognitions and depressive rumination, it is generally advisable to introduce CBT first. But if the depressed patient is overly preoccupied with anxious or depressive affect, hypnotherapy may sensibly be recommended first.

HYPNOTHERAPY

The hypnotherapy component of CH is introduced to provide leverage to the psychological treatment of depression (Alladin, 2006a, 2007; Yapko, 1992, 2001) and to prevent relapses (Alladin, 2006b; Alladin & Alibhai, 2007). The hypnotherapy sessions generally focus on (a) the induction of a relaxation response; (b) the production of somatosensory changes; (c) a demonstration of the power of mind; (d) an expansion of awareness; (e) ego strengthening; (f) accessing and restructuring unconscious psychological processes; (g) teaching self-hypnosis; and (h) offering posthypnotic suggestions for modified responses.

Relaxation Training

One of the important goals for utilizing hypnosis within the CH context is to induce relaxation. Most depressed patients experience high levels of anxiety due either to comorbid anxiety (Dozois & Westra, 2004) or to a lack of confidence in their abilities to effectively handle life challenges. For these reasons, depressed patients often derive significant benefit from simply learning to relax.

Various hypnotic induction techniques can be utilized to induce relaxation. The author often uses the relaxation with counting method adapted from Gibbons (1979; see Alladin, 2007) for inducing and deepening hypnosis, because this technique is easily adapted for self-hypnosis training. Dobbin et al. (2009), in a preliminary study comparing the effects of self-hypnosis with CBT and antidepressant medication in 58 primary care depressed patients, found self-hypnosis was the preferred treatment of their sample, and the treatment effect was comparable to CBT and medication. Similarly, the majority of the depressed patients from the study reported by Alladin and Alibhai (2007) found relaxation training empowering, because it gave them the confidence and skill to interrupt anxious and stressful episodes in their lives.

Producing Somatosensory Changes

Hypnosis is a powerful tool for producing *syncretic cognition* (Alladin, 2006a), which consists of a mixture of cognitive, somatic, perceptual, physiological, visceral, and kinesthetic changes. Hypnotic induction and modulation of syncretic cognition provides depressed patients with direct and compelling evidence that they can alter their subjective experience. Most importantly, the ability to produce novel and varied

experiences can arouse in them a sense of hope that depression can be controlled or at least modified. DePiano and Salzberg (1981) considered such positive experiences to be partly responsible for the rapid and profound behavioral, emotional, cognitive, and physiological changes observed in patients experiencing hypnosis.

Demonstration of the Power of the Mind

To ratify the credibility of hypnosis and demonstrate the power of the mind to influence the body and eye, body catalepsies can be hypnotically induced. This procedure can reduce skepticism about hypnosis, can foster positive expectancy, and can instill confidence in depressed patients that they can tap on personal resources in new ways to produce substantial behavioral and emotional changes.

Expansion of Awareness

Depressives tend to be preoccupied with their symptoms and the consequences of their symptoms (Papageorgiou & Wells, 2004), resulting in the narrowing of their range of experience. Neisser (1967) considered such narrowing of the range of behaviors and self-attributions as characteristic of psychopathology in general. Hypnosis provides a powerful vehicle for expanding awareness and amplifying positive experience. Brown and Fromm (1990) described a technique called *enhancing affective experience and its expression*, which can be used to help depressed patients create, amplify and express a variety of positive feelings and experiences in hypnosis. The expansion of awareness in hypnosis is effective in (a) bringing underlying emotions into awareness; (b) creating awareness of various feelings; (c) intensifying positive affect; (d) enhancing “discovered” affect; (e) inducing positive moods; and, (f) increasing motivation (Brown & Fromm, pp. 322–324). Such a technique not only disrupts the depressive cycle but can also help develop antidepressive pathways.

Positive associations (opposite of maladaptive dissociations), produced by forward projection, can also be utilized to produce “an alternative subjective reality” that helps the depressed patient “feel better” (Yapko, 1992, p. 134). (See Yapko, pp. 144–163, and Edgette & Edgette, 1995, pp. 145–158, for detailed descriptions of hypnotically producing positive associations in depressed patients.)

Ego Strengthening

Ego-strengthening suggestions are utilized to increase self-esteem and self-efficacy. Bandura (1977) provided experimental evidence that self-efficacy, the expectation and confidence of being able to cope successfully with various situations, is one of the key elements in the effective treatment of psychological disorders. Individuals with a sense of high self-efficacy tend to perceive themselves as being in control of

themselves. If depressives can be helped to view themselves as self-efficacious, they may then be able to perceive the future as more hopeful.

A popular method for increasing self-efficacy within the hypnotherapeutic context has been to provide ego-strengthening suggestions. The goals of ego-strengthening suggestions are to reduce anxiety, tension, and apprehension and to gradually restore the patient's self-confidence in his or her ability to cope effectively with problems (Hartland, 1971). Alladin (2008, pp. 247–249) provided a list of generalized ego-strengthening suggestions that can be routinely used in hypnotherapy with a variety of medical and psychological conditions. However, when working with depressives, it is important to craft the ego-strengthening suggestions in such a way that they appear credible and logical to the patients. For example, rather than globally 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 learn new skills and 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/CD daily (Alladin, 2006a, 2007).

Posthypnotic Suggestions

When treating depression, before terminating the hypnotic session, posthypnotic suggestions are routinely given to counter problem behaviors, negative emotions, dysfunctional cognitions, negative self-hypnosis (NSH), and negative self-affirmations. Depressives are predisposed to reflexively ruminate with negative self-suggestions, particularly after experiencing a negative affect (e.g., “I will not be able to cope.”). This can be regarded as a form of NSH or posthypnotic suggestion (PHS), which maintains the depressive cycle. To break this reflexive pattern of thinking, it is important to counter the NSH. Following is an example of a PHS provided by Alladin (2006a, p. 162) for countering NSH: “While you are in an upsetting situation, you will become more aware of how to deal with it well rather than focusing on your depressed feelings.” Yapko (2003) considered posthypnotic suggestions a necessary part of the therapeutic process if the patient is to carry out new possibilities into future experiences based on the hypnosis session.

Self-Hypnosis Training

The self-hypnosis component of CH is designed to create positive affect and counter NSH via ego-strengthening and posthypnotic suggestions. At the end of the first hypnotherapy session, the patient is provided with an audiotape/CD designed to teach self-hypnosis and to cultivate relaxation. In addition, the tape/CD provides ego-strengthening and

posthypnotic suggestions. The homework assignment of listening to the tape/CD daily offers a continuity of treatment between sessions and creates the setting for learning self-hypnosis. The ultimate goal of psychotherapy is to help the depressed patient establish self-reliance and independence. Alman (2001) and Yapko (2003) believe patients can achieve self-reliance, personal power, and self-correcting behaviors that give them control over their lives. These observations were confirmed in the study reported by Alladin and Alibhai (2007) and Dobbin et al. (2009).

COGNITIVE RESTRUCTURING IN HYPNOSIS

Often in the course of CBT, a patient reports the inability to identify cognitions preceding depressive affect. Since the cognitive theory of depression assumes the primacy of affect, in the absence of conscious cognitive distortions, cognitive restructuring becomes unfeasible. This represents a major limitation of CBT (see Alladin, 2007, pp. 34–37, for a review of strengths and limitations of CBT) but one that can be easily remedied by integrating hypnosis with CBT in the management of depression. There is a variety of hypnotic strategies for accessing and restructuring conscious, semiconscious (automatic), and unconscious cognitive distortions and negative self-schemas. Three strategies for uncovering and restructuring maladaptive cognitions in hypnosis are described here, including (a) regression to recent event, (b) regression to the original trauma, and (c) editing and deleting “unconscious files.”

Regression to Activating Event

This technique is utilized to access unconscious maladaptive cognitions related to a recent event that triggered depressive affect. While in hypnosis, the patient is given suggestions to recall the situation that caused a recent upset. Then the patient is instructed to remember his or her emotional, physiological, and behavioral responses and then to become aware of the associated dysfunctional cognitions. Encouragement is given to identify or “freeze” (frame by frame, as in a movie) faulty cognitions evident in the patient’s thoughts, beliefs, images, fantasies, and daydreams. 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 resulting (desirable) syncretic response. This process is repeated until the set of faulty cognitions related to a specific situation is considered to be successfully restructured.

This procedure was effectively used to treat Rita, a patient who felt anxious about social situations and inhibited about sexual activities but was unable to identify the associated maladaptive cognitions. The

following transcript from Alladin (2006a, pp. 164–165) describes the hypnotic procedure used with Rita to access and restructure her 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 head up and down. [Ideomotor signals of “head 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 head.

Therapist: 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.

Therapist: 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 then described two traumatic incidents that occurred when she was 10 and 12 years old, respectively. The first was when she was 10 years old when her 12-year-old brother, Ken, was sent away to live with their grandparents. Ken was considered a very troublesome child. His parents were not able to handle him, so they “got rid of him” by sending him to live with his grandparents in a different city. Rita was very distressed by this event, because she was close to Ken and was never informed of, much less prepared for, that he was going to be sent away. She cried for days when Ken left and for several nights could not sleep. One night while in her bed, the thought of a dark cave came to her mind and she saw herself in that dark cave. Although it was frightening initially, later on she felt the image provided her a sense of comfort; she felt safely “cocooned,” as if she did not have to think 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 traumatic incident happened 2 years later. One Saturday morning, the family received the news that Ken, who was still living with his grandparents, had died from drowning in the local swimming pool. Immediately, it flashed in Rita’s mind that she had lost the person she loved most. She felt very upset but only briefly, because she quickly cocooned herself in the “dark cave.” From the

hypnotic regression, it became apparent that Rita retreated to the dark cave whenever she felt confronted or stressed out, and she feared getting close to anyone who loved her (including her husband) in case she were to lose 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 through 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 through your mind when you are upset so that you can begin to see the connection between your thoughts and feelings.

This procedure helped Rita identify previously unconscious negative cognitions associated with her upset feelings and, consequently, was able to restructure her thinking and to control her emotional and behavioral reactions. Two further sessions were utilized to help Rita deal with the two uncovered traumatic events. Her negative experiences 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 revised perspective, she realized it was no longer necessary for her to retreat into the dark cave. She further came to realize that loving doesn't necessarily mean losing. Consequently, by no longer withdrawing from him, her relationship with her husband significantly improved.

Regression to the Original Trauma

Within the CH context, this strategy can be used when it becomes important to identify the origin of core beliefs. Alladin (2006a) presented the case of Rita, also described above, a 39-year-old housewife with a 10-year history of recurrent major depressive disorder. She responded well to CH yet continued to have symptoms of sexual dysfunction that often served as a trigger for her recurrent depressive affect. Whenever her husband showed an interest in her, even in non-sexual scenarios, she would freeze and withdraw from him.

Rita was convinced there was something unpleasant hidden in her unconscious mind that was negatively affecting her sexual relationship with her husband. Hypnotic regression helped to bridge the link between her affect and cognition by helping her remember an incident from when she was 7 years old in which she was molested by her uncle. She loved and respected her uncle and became deeply confused after the incident. She incorrectly concluded that "men are bad; I will never let them come near me." Once these core maladaptive cognitions were identified, the *Circle of Life Technique* was used to help her come to

the understanding that not all men are bad. The *Circle of Life Technique* (Alladin, 2008) is a strategy commonly used in CBT to counter all-or-nothing thinking. The therapist draws a large circle on a board or sheet of paper and fills it with large dots, each dot representing an activity. Then the therapist asks the patient: "As you can see from the number of dots, we do hundreds of things daily. Do you know of anyone who does *everything* well?" (Usually the answer is "No.") "Do you know of anyone who does *everything* badly?" (Again, the usual answer is "No.") Then the therapist points out, "Therefore, no one is *all* good or bad. We are all a mixture of good and bad." She was also encouraged in hypnosis to give herself permission to break the promise that she will never let a man touch her. Breaking the promise was deemed acceptable to her as she realized that the original promise was made by a frightened 7-year-old child who was confused and in a state of shock.

Editing and Deleting Unconscious Files

Another method for cognitive restructuring in hypnosis involves the computer metaphor of editing and deleting old files. This method is particularly appealing to children and adolescents. When the patient is in hypnosis, the patient is first instructed to become aware of the "good feelings" (after ego strengthening and amplification of positive feelings) and then directed to focus on personal achievements and successes (adult ego state). Here attempts are made to get the patient to focus on higher order skills of cognition, judgment, and reality testing. Once this is achieved, the patient is ready to work on modifying old learning and past experiences.

To begin, the patient in hypnosis is instructed to imagine opening an old computer file containing old beliefs or outdated behaviors or feelings that require editing or deletion. At the outset of the session, it is usually decided which file the patient would be working on during the hypnosis session. Once the patient is able to access the specific file, he or she is instructed to edit or delete it, paying particular attention to dysfunctional cognitions, maladaptive behaviors, and negative feelings "in the file." By metaphorically editing the file, the patient is able to mitigate cognitive distortions, magical thinking, self-blaming, and other self-defeating mental scripts (i.e., NSH). Other hypnotic uncovering or restructuring procedures (such as an affect bridge, age regression, age progression, and dream induction) can also be used to explore and restructure negative self-schemas.

SYMBOLIC IMAGERY TECHNIQUES

Symbolic imagery techniques are used for the reframing and discarding of "emotional garbage," such as inappropriate guilt, anger, fears, doubts, or anxieties that may be triggering, exacerbating, or

maintaining depressive affect. Various hypnotherapeutic techniques can be used to reframe the patient's past experiences that cause guilt or regret. Four symbolic imagery techniques for relieving unconscious guilt and self-blame are briefly described below. These techniques are typically used with depressed patients in the late phase of treatment, when the patient is sufficiently versed in both CBT and hypnotherapy. It is also advisable to use these techniques when the patient is in a fairly deep experience of hypnosis.

The Door of Forgiveness

This technique was devised by Watkins (1990) to help patients find their own self-forgiveness. The patient is asked to imagine walking down a corridor at the end of which is the door of forgiveness. While walking down the corridor, the patient notices several doors on either side of the corridor that he or she must pass before reaching the door of forgiveness. Some of these doors may appear familiar or meaningful to the patient. The patient is encouraged to open each door in turn and to describe to the therapist what he or she observes inside the room. The idea is for the patient to resolve any experiences or relationships from the past that cause guilt before reaching the door of forgiveness. Often when a patient enters through a door, an emotional abreaction may occur. The therapist does not provide any interpretation nor act as forgiver. The therapist's role is to provide direction and support.

Dumping the "Rubbish"

Stanton (1990) used the image of laundry for helping his depressed patients wash away their unwanted rubbish, such as fears, doubts, anxieties, and guilt. The patient is asked to imagine (a) going into an old-fashioned laundry room, consisting of a sink; (b) filling the sink with water; (c) opening a trap door from the head and dumping all the rubbish into the water; (d) seeing the water become black; and, (e) pulling the plug from the sink to let the inky water go down the drain.

Room and Fire

This technique utilizes the image of a fireplace for burning unwanted garbage (Stanton, 1990). The patient is asked to imagine going down in an elevator from the 10th floor of a hotel to the basement. In the basement there is a cozy room with a fire burning in a large stone fireplace. 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, p. 313).

The Red Balloon Technique

Hammond (1990) finds the hot air balloon metaphor for getting rid of unwanted negative emotions (such as guilt and anger) useful with depressed patients. The patient is asked to imagine walking up the hill with a large, burdensome, heavy backpack. As the patient imagines climbing up the hill, the backpack gets heavier and heavier. The patient imagines coming across a moored hot air balloon with a gondola underneath, containing a large basket. Next the patient imagines unloading all the excessive and unwanted objects from the backpack into the large basket in the gondola. The patient then climbs into the gondola, releases the balloon and it flies away. The patient wants to fly higher but because of the heavy load in the gondola, the balloon cannot climb higher. The patient imagines throwing out the burdensome load and, as the load lightens, the balloon rises higher up. The patient feels a sense of lightness and relief for having unloaded all the unwanted garbage.

POSITIVE MOOD INDUCTION

Nolen-Hoeksema (2004) and Papageorgiou and Wells (2004) found depressives to be preoccupied with repetitive catastrophic thoughts and negative images called ruminations. Ruminations can easily become obsessional in nature and further kindle the depressive neuro-pathways, thus impeding therapeutic progress (Monroe & Harkness, 2005; Post, 1992). To counter negative ruminations and to prevent the kindling of the depressive neuro-pathways, the positive mood induction technique may be used.

Just as the brain can be kindled to produce depressive neuro-pathways through conscious negative focusing (Schwartz, Fair, Salt, Mandel, & Klerman, 1976), the brain can also be kindled to develop antidepressive or "happy" neuro-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 associated positive affect can enhance adaptive behavior and cognitive flexibility (see Alladin, 2007). Within this theoretical and empirical context, Alladin (1994, 2006a, 2007) devised the positive mood induction technique to counter negative ruminations and depressive neuro-pathways and kindle antidepressive neuro-pathways.

The positive mood induction technique consists of five steps: (a) education; (b) making a list of positive experiences; (c) suggestions for a positive mood; (d) posthypnotic suggestions; and (e) home practice. To educate the patient, the therapist provides a scientific rationale for developing antidepressive neuro-pathways. Then the patient is advised to make a list of 10 to 15 pleasant or positive experiences. When in hypnosis,

the patient is instructed to focus on one of the positive experiences from his or her list, which is then amplified with suggestions from the therapist. (The technique is similar to the enhancing affective experience and its expression method described earlier.) However, to develop antidepressive pathways, more emphasis is placed on producing somatosensory changes and concomitant physiological changes. The procedure is repeated with at least three positive experiences from the patient's list. Posthypnotic suggestions are provided that the patient will be able to reexperience positive mood when practicing at home with the list.

To consolidate the positive mood induction technique, the patient is encouraged to practice with the list of positive experiences at home three or more times a day. Moreover, the patient is instructed to put negative or "undesirable" experiences (negative ruminations) "out of your mind and replace them with one of the pleasant items from your list." Apart from providing a systematic approach for developing antidepressive neuropathways, the positive mood induction technique fortifies the brain to withstand depressive symptoms, thus reducing the vulnerability to relapse and recurrence of future depressive episodes. The negative ruminative cycle can be further regulated by utilizing the attention switching exercises (see Alladin, 2007, pp. 164–171).

BEHAVIORAL ACTIVATION AND SOCIAL SKILLS TRAINING

As CH adopts a multimodal approach to treating depression, it also addresses behavioral and social concerns, especially when these concerns are identified in the case formulation. Lewinsohn and Gotlib (1995) proposed the behavioral theory of depression, which maintains that life stress can lead to depression by reducing positive reinforcers in a person's life. Lack of positive reinforcers causes social withdrawal, which leads to further reduction in positive reinforcers, resulting in more withdrawal, and thus self-perpetuating the cycle of depression. Alladin (2007, pp. 172–181) described several behavioral, physical, and hypnotherapeutic methods for reducing avoidance and inactive behaviors. The behavioral methods include weekly activity schedule (engages depressed patient in planned daily activities that increases access to reinforcement) and behavioral activation training (helps patients change their behaviors 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 provides depressed patients an efficient means for countering avoidant behaviors. In addition, regular physical exercise is considered a cheap and effective physical treatment for depression

(Patterson, 2002). Physical exercise has the capacity to prevent mental illness, to foster positive emotions, and to buffer individuals against the stresses of life (Mutrie & Faulkner, 2004). Meta-analyses, randomized controlled trials, and large-scale epidemiological surveys have provided consistent evidence that physical activity makes people feel better (Biddle, Fox, & Boutcher, 2000). Based on these findings, the National Health Service in the United Kingdom has listed exercise on their Web site as one of the recommended treatments for depression (National Health Service, 2009). Patterson (2002) recommends either aerobic (such as running or swimming) or nonaerobic (such as yoga, tai chi, and walking) exercises for depression.

Hypnotherapeutic strategies such as forward projection, imaginal rehearsal, ego strengthening, and posthypnotic suggestions can be used to reduce avoidant behaviors, to augment behavioral activities, and to increase the motivation to exercise regularly. Torem (2006) offered a specific hypnotic age progression strategy called *back from the future* for helping depressed patients counter symptoms of hopelessness. This hypnotic technique encourages the depressed patient to "travel to a specific time in the future," which is hypnotically enhanced by getting all the senses involved. The experience is further enhanced by ego-strengthening suggestions and instructions:

. . . to store these positive feelings, images, and sense of accomplishment and to internalize them consciously and unconsciously. Patients are told that these positive images, sensations, and feelings are a special gift that they can take with them on their trip "back from the future" into the present, and that these gifts will guide them on conscious and subconscious levels in their journey of healing and recovery. Then, the patient is guided back into present time. (Torem, p. 104)

By utilizing forward projection, imaginal rehearsal, and ego strengthening, the therapist is able to help the depressed patient increase his or her motivation and commitment to participate in behavioral and physical activities.

Youngren and Lewinsohn (1980) provided evidence that a lack of social skills may cause and maintain depression in some patients. If the case formulation identified a lack of social skills to be exacerbating or maintaining the depressive affect, then the problem should be addressed directly in therapy. There are many approaches to improving social skills in depressed patients, including training, instruction, modeling, rehearsal, role-playing, and homework assignments. Social skills training can be enhanced by hypnosis via forward projection, imaginal rehearsal, ego strengthening, and posthypnotic suggestions as described above.

SUMMARY

Cognitive hypnotherapy provides a variety of treatment interventions for depression from which a therapist can choose the “best-fit” strategies for a particular depressed client. CH, which is based on the circular feedback model of depression (CFMD), embraces the rationale for combining CBT with hypnotherapy in the management of depression. A case formulation approach guides the clinician to select the most effective and efficient treatment strategies for his or her patient. However, the number of sessions and the sequence of the stages of CH are determined by the clinical needs of each individual patient. Although there is some empirical evidence for the effectiveness of CH (Alladin & Alibhai, 2007), further studies are required before it can achieve the APA status of a well-established treatment for depression. As CH for depression provides a template for studying the additive effect of hypnotherapy as an adjunctive therapy, CH can be applied to other psychological and medical disorders. Only through evidence-based research can hypnotherapy be integrated into the flow of mainstream psychotherapies.

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Evidenzbasierte Hypnotherapie bei Depression

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Zusammenfassung: Kognitive Hypnotherapie (KH) stellt eine umfassende evidenzbasierte Hypnotherapieform bei klinischer Depression dar. Dieser Artikel beschreibt die Hauptkomponenten von KH, welche Hypnose und kognitive Verhaltenstherapie vereint. Dabei bietet die letztgenannte eine effektive Leittheorie für die Assimilation empirisch gestützter Therapieformen. KH erfüllt die Kriterien für ein assimilatives Modell der Psychotherapie, welches als effektives Modell der Psychotherapie-Integration gilt. Die wichtigsten Komponenten der KH bei Depression werden ausreichend detailliert beschrieben, um so Replikation, Bestätigung und Validierung zu ermöglichen. KH bei Depression kann als Vorlage angesehen werden, die Kliniker und Forscher einsetzen können, um zusätzliche Effekte von Hypnose bei der Behandlung weiterer psychologischer oder medizinischer Störungen zu untersuchen. Es wird zu evidenzbasierter Hypnotherapie und Forschung angeregt; solche Anstrengungen werden notwendig sein, um klinische Hypnose in die Hauptströmung der Psychotherapie zu integrieren.

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L'hypnothérapie fondée sur l'expérience clinique dans le traitement de la dépression

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Résumé: L'hypnothérapie cognitive (HC) est une méthode exhaustive fondée sur l'expérience clinique pour traiter la dépression. Cet article décrit les principales composantes de l'HC, laquelle intègre l'hypnose et la thérapie cognitivo-comportementale, alors que celle-ci fournit une théorie de base efficace dans l'assimilation de techniques de traitement empiriquement obtenues, dérivées de divers modèles théoriques de psychothérapie et de psychopathologie. L'HC satisfait aux critères d'un modèle assimilatif de psychothérapie, lequel est considéré comme un exemple efficace d'intégration psychothérapeutique. Les principales composantes de l'HC pour traiter la dépression y sont suffisamment détaillées pour permettre la répétition, la vérification et la validation des techniques présentées. L'HC fournit un modèle de traitement que les cliniciens et les chercheurs peuvent utiliser pour étudier les effets additifs de l'hypnose dans la gestion d'autres troubles psychologiques ou médicaux. L'hypnothérapie et la recherche fondées sur l'expérience y sont encouragées; ce mouvement est en effet nécessaire pour que l'hypnose puisse être intégrée à la psychothérapie traditionnelle.

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Hipnoterapia basada en evidencia para la depresión

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Resumen: La hipnoterapia cognitiva (HC) es una hipnoterapia completa basada en evidencia la para la depresión clínica. Este artículo describe los principales componentes de la HC, que integra la hipnosis con la terapia cognitivo-conductual, que proporciona una teoría eficaz para la asimilación de técnicas de tratamiento con apoyo empírico derivadas de diversos modelos teóricos de la psicoterapia y la psicopatología. La HC cumple los criterios de un modelo de asimilación de psicoterapia, es decir un modelo eficaz de integración de psicoterapia. Describo los principales componentes de CH para la depresión con suficiente detalle para permitir la replicación, verificación y validación de las técnicas delineadas. La HC para la depresión proporciona una plantilla que los clínicos y los investigadores pueden utilizar para estudiar los efectos acumulativos de la hipnosis en el tratamiento de otros trastornos psicológicos o médicos. Se alientan hipnoterapias e investigación basadas en la evidencia; tal movimiento es necesario si la hipnosis clínica quiere integrarse a la psicoterapia convencional.

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