Hypnosis in Treating Symptoms and Risk Factors of Major Depression

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Abstract

This article summarizes aspects of effective psychotherapy for major depression and describes how hypnosis can further enhance therapeutic effectiveness. Hypnosis is helpful in reducing common symptoms of major depression such as agitation and rumination and thereby may decrease a client' sense of helplessness and hopelessness. Hypnosis is also effective in facilitating the learning of new skills, a core component of all empirically supported treatments for major depression. The acquisition of such skills have also been shown to not only reduce depression, but also the likelihood of relapses, thus simultaneously addressing issues of risk factors and prevention.

Overview

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

The primary purposes of this article are twofold: First, to highlight some of what we already know about the nature of major depression (i.e., Major Depressive Disorder) and what works in its treatment, and second, to draw attention to how clinical hypnosis can further enhance aspects of the treatment process. This article

considers hypnosis as part of a psychotherapy regimen for major depression only, and does not address either medication issues or other forms of depression (such as bipolar disorder, depressed phase), although concepts and techniques might apply to Dysthymic Disorder, an enduring depression, as well. When psychotherapy is clinically indicated, whether in combination with antidepressant medications or as a sole intervention, hypnosis may sometimes be deemed an appropriate means for facilitating the therapeutic goals. Given the reach of depression into our pockets, our personal relationships, our communities, and our very lives, addressing this complex disorder in a variety of timely and effective ways is an especially urgent challenge we as health care professionals face.

Some of What We Know About Major Depression

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

Major depression has many contributing factors, not a single cause. The three primary domains of the contributing factors are biological, psychological, and social. Hence, the so-called "biopsychosocial model" predominates (Cronkite & Moos, 1995; Thase & Glick, 1995).

Depression has many underlying risk factors and a variety of co-morbid conditions likely to be associated with it (Stevens, Merikangas & Merikangas, 1995). In fact, numerous medical (e.g., cancer, heart disease) and psychological conditions (e.g., anxiety disorders, substance abuse disorders) are found to commonly co-exist with depression, requiring sharp differential diagnosis and multi-faceted treatment planning (American Psychiatric Association, 1994).

Depression can be successfully managed in the majority of sufferers with medication and/or psychotherapy (Schulberg, Katon, Simon & Rush, 1998). While no one antidepressant has been shown to be superior in rates of effectiveness to another, therapeutic efficacy studies show some psychotherapies (specified below) outperform others in treating depression (Schulberg & Rush, 1994).

Medication has some treatment advantages, such as a generally faster rate of symptom remission and greater effectiveness in treating the vegetative symptoms, e.g., sleep and appetite disturbances (DeBattista & Schatzberg, 1995). Medication also has some disadvantages, including uncertain dosing and effectiveness, potentially negative side-effects, habituation and "poop-out" (i.e., the drug may eventually stop

working), and higher initial rates of relapse (Altamura & Percudani, 1993; Dubovsky, 1997).

Psychotherapy also has some treatment advantages and disadvantages. The therapies which enjoy the greatest empirical support are cognitive, behavioral and interpersonal approaches (Depression Guideline Panel, 1993). The advantages include therapy's focus on skill-building and the associated reduced relapse rate, the value of the therapeutic relationship, the greater degree of personal empowerment, and the potential to not just perform a "mop-up" of pre-existing problems but to instead teach the skills of prevention (Seligman, 1990; Yapko, 1999). The disadvantages of psychotherapy include the greater reliance on the level of clinician competence (i.e., experience and judgment), the greater time lag between the initiation of treatment and the remission of symptoms compared to medications, the lesser effect in reducing vegetative symptoms, and the potential detrimental side-effects of client exposure to a clinician's particular theoretical or philosophical stance (Mondimore,1993; Thase & Howland, 1995).

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

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

Some of What We Know About Treating Depression With Psychotherapy

A number of important insights about major depression and suggestions for its treatment were articulated in the depression treatment guidelines developed by the United States Agency for Health Care Policy and Reseach (AHCPR), now the Agency for Healthcare Quality and Research (AHQR) (Depression Guideline Panel, 1993):

1) Three psychotherapies were shown to have the greatest amount of empirical support: Cognitive, behavioral and interpersonal psychotherapies. These are identified as the psychotherapies of choice, and any or all can be applied according to the client's symptom profile (not the clinician's preferred orientation);

2) Psychotherapy should be an active process in the way it is conducted, involving active exchanges between clinician and client which would typically involve providing psychoeducation, the development of skill-building strategies, the use of homework assignments, and the use of the therapy relationship as both a foundation and a vehicle for exploring relevant ideas and perspectives; 3) Therapy should not only focus on problem-solving, but the teaching of problem-solving skills, especially as they relate to symptom resolution, the guidelines' suggested focus of treatment; 4) Effective therapy need not have a historical focus. According to the treatment guidelines, the most effective therapies are goal-oriented, skill-building approaches. None of them focus on attaining extensive historical data to explain the origins of depression. Rather, they focus on developing solutions to problems and coping skills for managing symptoms. Hypnosis is especially amenable to each of these psychotherapeutic applications, since it, too, is an active and directive means of intervention. The same indications and contraindications as articulated in the treatment guidelines (Depression Guideline Panel, 1993) prevail when applying hypnosis, particularly the recommendation that clinicians adapt their approach according to the patient's symptom profile rather than a specific theoretical allegiance.

Treatment Guidelines and Depressive Risk Factors

In performing the extensive review of clinical and research literature in order to prepare the depression treatment guidelines, the panel formed the conclusion that trying to find a specific origin for an individual's depression was unnecessary in promoting recovery. This sharply distinguishes what might be termed an event-driven perspective (the view that depression has its origin in specific historical events that must be identified

and "worked through") from what could be called a process-driven perspective (the view that depression has its roots in ongoing ways of erroneously or negatively interpreting or managing various life experiences). Recognizing that depression arises for many reasons of a process-driven nature accentuates the realization that by the time depression strikes most individuals, one or more risk factors (such as perceptual style, cognitive style, and level of social and problem-solving skills) had already been well in place (Seligman, 1989).

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

Is Clinical Hypnosis an Empirically Supported Treatment For Depression?

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

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

been attempted to either validate or invalidate that conventional wisdom.

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

Hypnosis has been evaluated for its therapeutic merits in a number of relevant arenas. Research shows that treatments which also employ hypnosis compared to the same treatments not employing hypnosis have a significantly more favorable outcome (Kirsch, Montgomery & Sapirstein, 1995; Lynn, Kirsch, Barabasz, Cardena & Patterson, 2000; Schoenberger, 2000). However, it is admittedly an extrapolation of available data to suggest that hypnosis can enhance treatment results for depression in particular. Undoubtedly, this is a valid concern to those who want therapeutic efficacy data specific to the value of hypnosis in treating major depression. Until such research data become available, we can rely on the strong clinical evidence that indicates that when it is integrated with other established therapies, hypnosis can be helpful in addressing and resolving many of the most troublesome components (i.e., patterns and risk factors) of depression.

Some of What We Know About Applying Hypnosis in Psychotherapy

There is substantial evidence that psychotherapy for the treatment of depression can be highly effective (Antonuccio, Danton & DeNelsky,1995). Wherever psychotherapy may be well applied, so can the use of clinical hypnosis, since the two share the underlying mechanisms of communication and influence and are fundamentally inseparable (Spanos & Coe, 1992; Yapko, 1990,1995).

Hypnosis encompasses a wide variety of concepts and methods that share a commondenominator of appreciating that people often have more abilities than they may consciously realize. Hypnosis

can help make those abilities more well-defined and readily accessible. By considering those psychotherapies that have already received empirical support for being efficacious for depression (i.e., cognitive, behavioral and interpersonal therapies), we can better appreciate where hypnosis might help to further amplify their therapeutic components, such as their collective focus on process over content (i.e., considering how someone thinks, behaves or relates rather than what they think or do) and their emphasis on active participation in treatment.

Hypnosis and Building Realistic Expectancy

One of the strongest factors contributing to the viability of hypnosis as an intervention tool is termed "expectancy" (Coe, 1993; Kirsch, 2000). Expectancy refers to that quality of the client's belief system that leads him or her to believe that the procedure implemented by the clinician will produce a therapeutic result. Positive expectancy for treatment involves multiple perceptions: The clinician is seen as credible and benevolent, the procedure seems to have a plausible perhaps even compelling rationale, and the therapy context itself seems to support its application. Thus, by the client being instructed in the value and the methods of hypnosis, whether directly or indirectly, an expectation is established that the associated procedures will have some potentially therapeutic benefit, increasing the likelihood of them actually doing so (Barber, 1991; Zeig, 1980).

Expectancy is an especially critical issue in the treatment of major depression. Cognitive theory in particular has viewed depression as existing on a three point foundation of negative expectations, negative interpretation of events, and negative self-evaluation (Beck, Rush, Shaw & Emery, 1979). An individual's negative expectancy for life experience is a cognitive pattern and risk factor which has been associated with difficulties not only in the realm of mood, but also in poorer physical health, poorer social adjustment, and diminished productivity. Furthermore, negative expectancy has been associated to lowered treatment success rates (Seligman, 1989, 1990). At the extreme, negative expectancy in the form of a pervasive sense of hopelessness can be associated with suicidality (Beck, Brown, Berchick, Stewart & Steer, 1990). Establishing positive expectancy in a variety of specific contexts may be a necessary ingredient in effective treatment (Yapko, 1988, 1992, 1993, in 2001). Age progression in hypnosis as a vehicle for concretely establishing a positive and motivating view of the future may be helpful in this regard (Torem, 1987, 1992; Yapko, 1988, 1990, 1992).

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

Examples of Depressive Symptoms and Risk Factors as Intervention Targets

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

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

Targeting insomnia with hypnosis has special importance because it is both a symptom and risk factor. For reasons currently unknown, there is a correlation between insomnia and later relapses. If someone suffers a depressive episode and experiences a sleep disturbance, if the sleep disturbance remits when the depressive episode ends, the person is statistically at a lower risk for later relapses. If, however, the depression lifts and the person's disturbed sleep does <u>not</u> return to normal, the person is at a higher statistical risk for later relapses (Kravitz & Newman, 1995). Thus, assessing the client's sleep is important for clinicians to do. Actively intervening with

hypnosis to enhance sleep (through suggestions both for relaxation and diminished rumination) might well have a profound impact on both the course of depression as well as the risk for later relapses. Research in this area is clearly needed.

The relationship between insomnia and fatigue, another frequent symptom of depression, seems obvious. When someone sleeps poorly, how can he or she feel an adequate level of energy? Furthermore, if someone has a global cognitive style that may lead him or her to see all problems as piled together in an insurmountable mountain of woes, how can he or she feel energized to want to move through them? Thus, addressing insomnia and simultaneously addressing any global thinking that may contribute to a sense of being overwhelmed and exhausted (just by thinking of all the problems to be faced) become vital aspects of treatment. How many people become depressed simply from unrelenting fatigue: an on-going sense of never getting caught up, always having too much to do and not enough time to do it, routinely feeling sleep and fun deprived, and regularly living from frantic moment to frantic moment (Bell, 1997)? Thus, fatigue is not only a depressive symptom, but may reflect both a depressogenic patterning of perception and behavior which are likely risk factors for later depressive episodes as well. Helping people learn to "slow down," curtail their ruminations, establish stronger boundaries between their work and personal lives, and better separate problem-solving time from sleep time are all worthwhile goals to address in treatment. These are life skills that may be learned with clinicians serving as teachers or guides.

Hypnosis can be an effective vehicle for teaching such skills, even if just teaching basic relaxation skills, perhaps even outperforming sleep medications. As one prominent sleep and depression researcher wrote, "...using deep muscle relaxation and other forms of progressive relaxation strategies may help individuals to fall asleep more quickly... controlled studies suggest effects as strong as, and with greater durability than, those observed with sedative hypnotics" (Thase, 2000, pp. 49-50). The quality of the symptoms a client presents can point the clinician in the direction he or she might go if the client is to be sufficiently empowered to get some control back and reduce or eliminate symptoms. *For as long as a client feels victimized by his or her symptoms, recovery from depression is extremely unlikely* (Cohen, 1994).

The goals of therapy include not only reducing or eliminating symptoms, but also reducing or

eliminating associated risk factors for further episodes. Depression is often described in the literature as a "recurrent disease," and relapse statistics confirm an ever higher probability of later episodes the more episodes one has (Glass, 1999). Using the previous example of insomnia as a target, insomnia is the symptom. But, unless the individual's ruminative coping style is altered, and unless the person's global cognitive style is addressed by teaching better compartmentalization (boundary) skills (e.g., to separate problem-solving time from sleep time), the mere teaching of relaxation skills is unlikely to be of enough help to the person to overcome depression.

Patterns of client experience that underlie symptom structures might include:

1) Cognitive style (Is the person's style of thought abstract or concrete? Global or linear? What is his or her attributional style?)

2) Response style (Is the person more self or other-directed? Open or guarded?)

3) Attentional style (Is he or she more focused or diffuse? Focused on saliency or irrelevance?) ; and

4) Perceptual style (Does the person tend to focus more on similarities or differences between experiences? Does he or she tend to magnify or diminish perceptions?) (Yapko, 1988,1997).

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

Risk factors for depression may be addressed singly or in combination. The therapeutic goal is to introduce

variability and accuracy into the pattern according to situational cues. Thus, instead of the person interpreting events in a rigid, consistent manner (e.g., routinely taking things personally, even when they're not personal), the person would learn to distinguish when it is and isn't personal, and how to respond to specific contexts flexibly and appropriately (Yapko, 2001).

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

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

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

Conclusion

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

living better, they are more likely to recover (Lewinsohn, Munos, Youngren & Zeiss, 1986; Schulberg & Rush, 1994).

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

In the following companion paper, one such intervention strategy for empowering depressed clients is presented. It aims to disrupt the process by which people can become caught up in their own depressogenic beliefs.

References

Altamura, A. & Percudani, M. (1993). "The use of antidepressants for long-term treatment of recurrent depression: Rationale, current methodologies, and future directions." *Journal of Clinical Psychiatry, 54* (8, supplement), 1-23.

American Psychiatric Association. (1994). *Diagnostic and statistical maual (4th edition).* Washington, D.C.: American Psychiatric Association.

Antonuccio, D, Danton, W., &. DeNelsky, G. (1995). "Psychotherapy versus medication for depression: Challenging the conventional wisdom with data." *Professional Psychology: Research and Practice, 26,*6,574-585.

Azar, B. (April, 1997). "Environment is key to serotonin levels." *APA Monitor, 28,* 4, 26-29.

Barber, J. (1991). "The locksmith model: Accessing hypnotic responsiveness." In S. Lynn & J. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 241-274. New York: Guilford.

Beck, A., Brown, G., Berchick, R., Stewart, B., & Steer, R. (1990). "Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients." *American Journal of Psychiatry*, 147, 190-195.

Beck, A., Rush, A., Shaw, B., & & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford.

Bell, A. (1997). *The quickening*. New Orleans: Paper Chase Press.

Coe, W. (1993). "Expectations and hypnotherapy." In J. Rhue, S. Lynn, & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp.73-93). Washinbgton, D.C.: American Psychological Association.

Cohen, D. (1994). *Out of the blue: Depression and human nature.* New York: Norton.

Crasilneck , H. & Hall, J. (1985). *Clinical hypnosis: Principles and applications* (2nd ed.). New York: Grune & Stratton.

Crawford, H. & Barabasz, A. (1993). "Phobias and intense fears;Facilitating their treatment with hypnosis."In J. Rhue, S. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp.311-338). Washington, D.C.: American Psychological Association.

Cronkite, R. & Moos, R. (1995). "Life context,coping processes, and depression." In E. Beckham and W. Leber (Eds.) *Handbook of depression* (pp.569-587). New York: Guilford.

DeBattista,C. & Schatzberg, A.(1995). "Somatic therapy." In I. Glick (Ed.), *Treating depression* (pp.153-181). San Francisco: Jossey-Bass.

DeBattista,C. & Schatzberg, A.(1995). "Somatic therapy." In I. Glick (Ed.), *Treating depression* (pp.153-181). San Francisco: Jossey-Bass.

Depression Guideline Panel (1993). "Clinical Practice Guideline Number 5: Depression in Primary care. Volume 2: Treatment of Major Depression." Rockville, Md: U.S. Dept. of Health and Human Services, Agency for Health Care Policy and Research. AHCPR publication 93-0550.

Dubovsky, S. (1997). Mind-body deceptions: *The psychosomatics of everyday life.* New York: Norton.

Glass, R. (January 6,1999). "Treating depression as a recurrent or chronic disease." *Journal of the American Medical Association*, 281, 1, 83-4.

Kaelber, C., Moul, D. & Farmer, M. (1995). "Epidemiology of depression." in E. Beckham and W. Leber (Eds.), *Handbook of depression* (pp.3-35). New York: Guilford.

Kirsch, I., Montgomery, G., & Sapirstein, G. (1995). "Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis." *Journal of Consulting and Clinical Psychology,* 63, 214-220.

Kirsch, I. (January/April, 2000). "The response set theory of hypnosis." *American Journal of Clinical Hypnosis,* 42, 3-4, 274-293.

Kravitz, H. & Newman, A. (1995). "Medical diagnostic procedures for depression: An update from a decade of promise." In E. Beckham & W. Leber (Eds.), *Handbook of depression* (pp.302-326. New York: Guilford.

Lewinsohn, P., Munos, R., Youngren, M., & Zeiss, A. (1986). *Control your depression.* New York: Prentice Hall.

Lynch, D. (October, 1999). "Empowering the patient: Hypnosis in the management of cancer, surgical disease and chronic pain." *American Journal of Clinical Hypnosis,* 42, 2 122-131.

Lynn, S., Kirsch, I. Barabasz, A., Cardena, E. & Patterson, D. (April, 2000). "Hypnosis as an empirically supported clinical intervention: The state of the evidence and a look to the future." *International Journal of Clinical and Experimental Hypnosis,* 48, 2, 239-259.

Mondimore, F. (1993). Depression: *The mood disease.* Baltimore: The Johns Hopkins University Press.

Montgomery, G., DuHamel, K., & Redd, W. (2000). "A meta-analysis of hypnotically induced analgesia: How effective is hypnosis?" *International Journal of Clinical and Experimental Hypnosis*, 48, 2, 134-149.

Moore, K. & Burrows, G. (1991). "Hypnosis in the treatment of obsessive-compulsive disorder." *Australian Journal of Clinical and Experimental Hypnosis,* 19, 63-75.

National Institute of Mental Health (June 1, 1999). "Depression: The invisible disease." Available on the World Wide Web: http://www.nimh.nih.gov/publicat/invisible.ctm.

Sacco, W. & Beck, A. (1995). "Cognitive theory and therapy." In E. Beckham & W. Leber (Eds.), *Handbook of psychotherapy* (pp.329-351). New York: Guilford.

Schoenberger, N. (April, 2000). "Research on hypnosis as an adjunct to cognitive-behavioral psychotherapy." *International Journal of Clinical and Experimental Hypnosis,* 48, 2, 154- 169.

Schoenberger, N. Kirsch, I. Gearan, P., Montgomery, G., & Pastyrnak , S. (1997). "Hypnotic enhancement of a cognitive behavioral treatment for public speaking anxiety." *Behavior Therapy,* 28, 127-140.

Sacco, W. & Beck, A. (1995). "Cognitive theory and therapy." In E. Beckham & W. Leber (Eds.), *Handbook of psychotherapy* (pp.329-351). New York: Guilford.

Schulberg, H. & Rush, A. (January, 1994). "Clinical practice guidelines for managing major depression in primary care practice: Implications for psychologists." *American Psychologist,* 49, 1, 34-41.

Schulberg, H., Katon, W., Simon, G. & Rush, A. (December, 1998). "Treating major depression in primary care practice." *Archives of General Psychiatry,* 55, 1121-1127.

Schwartz, J. (1996). *Brain lock*. New York: Regan Books.

Seligman, M. (1989). "Explanatory style: Predicting depression, achievement, and health." In M. Yapko (Ed.), *Brief therapy approaches to treating anxiety and depression* (pp.5-32). New York: Brunner/Mazel.

Seligman, M. (1990). *Learned optimism*. New York: Alfred A. Knopf.

Siever, L. with Frucht, W. (1997). *The new view of self.* New York: Macmillan.

Spanos, N. & Coe, W. (1992). "A social-psychological approach to hypnosis." In E. Fromm & M. Nash (Eds.), C*ontemporary hypnosis research* (pp.102-130). New York: Guilford.

Spiegel, H. & Spiegel, D. (1978). Trance and treatment: *Clinical uses of hypnosis.* New York: Basic Books.

Thase, M. (2000). "Treatment issues related to sleep and depression." *Journal of Clinical Psychiatry*, 61,(suppl. 11): 46-50.

Thase, M & Glick, I. (1995). "Combined treatment." In I. Glick (Ed.), *Treating depression* (pp.183-208). San Francisco: Jossey Bass.

Thase, M. & Howland, R. (1995). "Biological processes in depression: An updated review and integration." In E. Beckham & W. Leber (Eds.), *Handbook of depression* (pp.213-279). New York: Guilford.

Torem, M. (1988). "Hypnosis in the treatment of depression." In W. Wester (Ed.), *Clinical hypnosis: A case management approach* (p.288-301). Cincinnati, OH: Behavioral Science Center.

Torem, M. (1992). "Back from the future: A powerful age progression technique." *American Journal of Clinical Hypnosis*, 35, 2:81-88.

Weissbourd, R. (1996). The vulnerable child: *What really hurts America's children and what we can do about it.* Reading, PA.: Addison-Wesley

Weissman, M., Bland, R., Canino, G., et. al (July 24/31, 1996). "Cross-national epidemiology of major depression and bipolar disorder." *Journal of the American Medical Association,* 276, 4, 293-299.

Yapko, M. (1988). *When living hurts: Directives for treating depression.* New York: Brunner/Mazel.

Yapko, M. (1990). *Trancework: An introduction to the practice of clinical hypnosis* (2nd ed.). New York: Brunner/Mazel.

Yapko, M. (1992). *Hypnosis and the treatment of depressions.* New York: Brunner/Mazel.

Yapko, M. (1993). "Hypnosis and depression." In J. Rhue, S. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp.339-355). Washington, D.C.: American Psychological Association.

Yapko, M. (1995). *Essentials of hypnosis.* New York: Brunner/Mazel.

Yapko, M. (1997). *Breaking the patterns of depression.* New York: Doubleday.

Yapko, M. (1999). *Hand-me-down blues:* How to stop depression from spreading in families. New York: St. Martins Griffin.

Yapko, M. (2001). *Treating depression with hypnosis: Integrating cognitive-behavioral and strategic approaches.* Philadelphia, PA.: Brunner/Routledge.

Zeig, J. (Ed.) (1980). *A teaching seminar with Milton H. Erickson, M.D.* New York: Brunner/Mazel.

Biography

Michael D Yapko, PhD, is a clinical psychologist and marriage and family therapist residing in Fallbrook, California. He is internationally recognized for his work in advancing clinical hypnosis and outcome-focused psychotherapy, routinely teaching to professional audiences all over the world. To date, he has been invited to present his ideas and methods to colleagues in 30 countries across six continents, and all over the United States. His workshops are well known for being practical as well as enjoyable.

Dr. Yapko has had a special interest for nearly three decades in the intricacies of brief therapy, and the clinical applications of hypnosis and directive methods. He is the author of ten books and editor of three others, as well as numerous book chapters and articles on the subjects of hypnosis and the use of strategic psychotherapies. These include his widely used classic text, Trancework: An Introduction to the Practice of Clinical Hypnosis (3rd edition), the award-winning books Treating Depression With Hypnosis: Integrating Cognitive-Behavioral and Strategic Approaches (2001) and Hypnosis and Treating Depression: Applications in Clinical Practice (2006), as well as Essentials of Hypnosis, and Hypnosis and the Treatment of Depressions. His works have been translated into nine languages. More information about Dr. Yapko's publications can be found on his website: www.yapko.com.

Dr Yapko is a member of the American Psychological Association, a clinical member of the American Association for Marriage and Family Therapy, a member of the International Society of Hypnosis, and a Fellow of the American Society of Clinical Hypnosis. He is a recipient of The Milton H Erickson Award of Scientific Excellence for Writing in Hypnosis, and the 2003 Pierre Janet Award for Clinical Excellence from the International Society of Hypnosis, a lifetime achievement award honouring his many contributions to the field. He also received The Milton H Erickson Foundation Lifetime Achievement Award for Outstanding Contributions to the Field of Psychotherapy.

By Michael D. Yapko