

Cognitive hypnotherapy for psychological management of depression in palliative care

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Abstract: The prevalence of psychiatric disorders in palliative care is well documented, yet they often remain undetected and untreated, adding further to the burden of suffering on patients who are already facing severe physical and psychosocial problems. This article will focus on depression as it represents one of the most common psychiatric disorders treated by psychiatrists and psychotherapists in palliative care. Although depression in palliative care can be treated successfully with antidepressant medication and psychotherapy, a significant number of depressives do not respond to either medication or existing psychotherapies. This is not surprising considering depression is a complex disorder. Moreover, the presentation of depression in palliative care is compounded by the severity of the underlying medical conditions. It is thus important for clinicians to continue to develop more effective treatments for depression in palliative care. This article describes cognitive hypnotherapy (CH), an evidence-based multimodal treatment for depression which can be applied to a wide range of depressed patients in palliative care. CH, however, does not represent a finished product; it is a work in progress to be empirically validated and refined by advances in cancer and clinical depression.

Keywords: Psychiatric disorders; palliative care; cognitive hypnotherapy (CH)

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Introduction

Psychiatric disorders, particularly clinical depression, often remain undetected and untreated in palliative care. This adds considerable stress on patients who are already burdened with severe physical and psychosocial problems. It is estimated that up to one-quarter of patients with cancer develop depression (1). Among the terminally ill cancer patients, Breitbart *et al.* (2) found approximately 17% to be clinically depressed. There is also growing evidence that depression is associated with shorter survival times in cancer patients (3). Moreover, depression exacerbates cancer-related pain, causes functional impairment, reduces acceptance of chemotherapy, raises the levels of helplessness and hopelessness, and increases the desire for hastened death among terminally ill cancer patients (3). Furthermore,

antidepressants are overprescribed in oncology (4) and a significant number of patients do not respond to antidepressants. Similarly, the efficacy of supportive psychotherapy in reducing distress and depression in palliative care is questioned (5). These findings underscore the need for an early diagnosis of clinical depression and the pressing need to develop more efficacious and innovative treatments for depression in palliative care. Palliative care is the total care of patients whose disease is resistant, nonresponsive, or failed reasonable medical treatments. Thus the goal of palliative care is to achieve the best possible quality of life both for the patients and their families.

According to World Health Organization (6), palliative care is the total care of patients whose disease is not responsive to curative treatment. The focus of care is on pain and symptom's relief, and the alleviation of psychological, social and spiritual suffering. In other words,

the goal of palliative care is to achieve the best possible quality of life for patients and their families.

This article describes cognitive hypnotherapy (CH), an evidence-based sub-modality of contemporary hypnotherapy for depression that combines cognitive behavior therapy (CBT) with hypnosis (7). There is strong empirical evidence for the association of hypnosis with CBT in the treatment of a multiplicity of medical and psychological disorders. A meta-analysis of eighteen studies of CH with various emotional disorders clearly demonstrated that the addition of hypnosis to CBT substantially enhances treatment outcome (8). More recently, the additive effect of CH has been demonstrated with anxiety disorders (9), acute stress disorder (10), bulimia nervosa (11), chronic pain (12,13), depression (14), insomnia (15), migraine headache (16), posttraumatic stress disorder (17), psychosomatic disorders (18), and somatoform disorders (19,20). CH is also recognized as an integrative model of psychotherapy (19,21,22). Alladin (23-26) has provided the scientific rationale and a working model for combining CBT with hypnosis in the treatment of clinical depression.

CH, as an integrative psychotherapy, has not been used widely in palliative care. To date the author is not aware of any published CH trial with depression in palliative care or other stages of cancer. The common practice has been the utilization of either CBT or hypnotherapy independently, although at times, techniques from each therapeutic approach overlap (e.g., relaxation training, imagery training, etc.). Similarly, the effectiveness of either CBT or hypnotherapy in oncology has been studied separately. Weisman and Worden (27) were the first investigators to systematically study the effect of psychological treatment on patients with cancer. They found both CBT and consultation therapy (problem identification, ventilation, and problem solving) to be equally effective in relieving emotional distress and improving psychosocial problem solving in newly diagnosed cancer patients. This study sparked a series of investigations into the effectiveness of psychological interventions in different stages of cancer. Despite some methodological flaws with these studies, they provided strong evidence for the effectiveness of psychological therapy in oncology. The most significant finding was that cancer patients with greater distress benefited most from psychological therapy (28,29). These findings suggest that patients with severe symptoms and greater emotional distress are more likely to seek out and benefit from psychological therapy.

Studies on the application of CBT with terminal illness have been sparse. Linn, Linn and Harris (30) examined the impact of a mixture of non-directive and cognitive-behavioral strategies on adjustment of men with terminal cancer with life expectancy of 3–12 months. After three months of therapy, the treated patients were less depressed, had higher self-esteem and increased internal locus of control compared to untreated controls. Savard *et al.* (31) specifically examined the effect of individual CBT (8-weekly sessions + 3 booster sessions) on women with metastatic breast cancer (N=45); randomly assigned to either CBT or waiting-list control. At the end of treatment, the CBT group significantly decreased the scores on the Hamilton Depression Rating Scale (HDRS) compared to the control group. The treatment group also presented significant reduction in anxiety, fatigue, and insomnia, and these effects continued at 3- and 6-month follow-ups. More recently, several CBT trials were targeted at patients in palliative care. For example, Greer and his colleagues (32) randomly assigned 105 patients from a hospice to either individual CBT or counseling (average of 6.6 sessions). The CBT group produced 76% of decrease on the Hamilton Anxiety and Depression Scale (HADS) compared to 56% of decrease in the counseling group.

Several meta-analyses also support the effectiveness of CBT as an adjunctive therapy both in the early and late stages of cancer (28). Studies targeted at the treatment of anxiety and/or depression showed an overall effect size of 0.42 when treated patients were compared with untreated controls. Shear and Maguire also examined the results of the 10 most reliable designs and they found the effect size to be 0.36. Then they looked at 20 of the trials that had data on the outcome of depression. They found the effect size for treated patients compared with untreated controls to be 0.36 as well. The trial also examined the effect of CBT (four studies) on patients suffering important psychological distress or at risk of emotional disturbance. The effect size was 0.94 for anxiety and 0.85 for depression. These large effect sizes indicate that the average patient in the treatment conditions did better than 80% of patients in the untreated control conditions (33). The meta-analysis also discovered that group therapy was as effective as individual therapy and short but intensive interventions by highly trained therapists were more effective than protracted ones delivered by staff who had received less psychological training (33).

Clinical trials of CBT in advanced cancer have been less extensive. In a recent meta-analysis of CBT for depression in somatic disease, Beltman *et al.* (34) found larger effect size

for patients with depressive disorder (0.83) than in patients with depressive symptoms (0.49). From these studies it is concluded that depressed and psychologically disturbed cancer patients (I) are open to psychological intervention; (II) show good response to psychological treatment, particularly CBT; and (III) they respond better to intensive short-term therapy delivered by trained therapists. The application of CH to palliative care is predicated on these findings. CH, by virtue of its multimodality, represents a structured and an intensive form of short-term therapy, usually practiced by experienced therapists.

Hypnosis, as an anxiety and/or pain management technique, has been used in oncology since time immemorial. Despite the long history, hypnosis has not been subjected to extensive clinical trials as CBT, especially in the management of depression in palliative care. However, hypnosis has been found to be effective in the management of pain and other symptoms in severe chronic diseases (35). In palliative care, as part of the multidisciplinary therapy, hypnosis is recommended as an adjunctive therapy for decreasing pain, relieving symptoms, and improving the quality of life (36). As the effort of palliative care, is to provide patients with relief from physical and psychological symptoms such as pain, anxiety, and depression (37,38), hypnosis is well suited for this population. More specifically, in advanced cancer and in palliative care, clinical hypnosis (I) reduces daily background pain and symptoms intensity; (II) improves the quality of life for many patients; and (III) enhances the ability of patients to use self-hypnosis to create experience of peace, serenity and wellbeing, which can last for several hours, days or months (39,40). Although the physiological and neuro-psychological mechanisms, of how hypnosis controls biological and emotional responses are not fully understood, recent brain imaging studies have clearly demonstrated that hypnosis influences all of the cortical areas and neurophysiological processes that underlie pain and emotional regulation (41-44). In summary, it would appear hypnosis is important as a powerful adjunctive therapy in advanced cancer and palliative care to reduce pain and suffering and to enhance the quality of life.

The dearth of clinical trials of hypnosis in palliative care, especially with depression, represents one of the major weaknesses of hypnotic treatment. This is one of the major reasons for integrating hypnosis with CBT in the treatment of depression. Alladin (45), from his review of the literature on CBT and hypnosis, concluded that each treatment approach was lacking in several ways. For example, CBT does not improve unconscious cognitive

restructuring; instead, its main focus is on cognitive restructuring via conscious reasoning and Socratic dialogue. Hypnotherapy, on the other hand, has usually focused on unconscious restructuring or reframing, paying less attention to conscious restructuring of dysfunctional cognitions. Alladin argued that the shortcomings of each of these therapies could be compensated by integrating procedures from both therapies. More specifically, CH uses hypnosis to amplify CBT by maximizing concentration, facilitating divergent thinking and experiences, and enhancing access to unconscious processes. As discussed before, there is important evidence that the integration of CBT with hypnosis increases the effect size for a variety of emotional disorders. In reference to these conclusions, it is not unreasonable to predict that the combination of hypnosis with CBT is likely to increase the treatment outcome in palliative care. This article represents an attempt to apply CH in the management of depression in palliative care. It is hoped that this publication will encourage more therapists to use CH for the psychological management of clinical depression in palliative care patients. It is also hoped that the treatment protocol described here will be subjected to replication, refinement and empirical validation.

Components of CH

CH for clinical depression generally involves 16 weekly sessions or spread over 4 to 6 months. In palliative care the amount of sessions and the therapy vary, in relation to patient's clinical needs, distress, and severity of presenting symptoms. The components of CH are briefly described in the next sections. Since most of the literature on depression in palliative care is related to adult cancer patients, this paper draws largely on experience with adult patients.

Clinical assessments

Before applying CH with a depressed person in palliative care, it is central for the therapist to study a detailed clinical history to confirm the diagnosis of clinical depression and identify the essential medical, physical, psychological, social and spiritual aspects of the patient's behaviors. The most well-organized method to obtain all these information within the context of CH is to use the case formulation approach described by Alladin (19). The case formulation approach is highly idiographic as it allows the clinician to translate and tailor nomothetic (general) treatment protocol to the individual (idiographic) depressed patient (46,47).

Within the case formulation framework, clinical work in palliative care becomes systematic and hypothesis-driven, rather than being truncated by a hit-and-miss approach to therapy.

CBT

As revised before, CBT is found to be effective in the treatment of clinical depression in different stages of cancer. CBT is therefore increasingly used in advanced cancer and in palliative care (33,48). CBT uses a structured and collaborative approach to help depressed patients identify, monitor, and restructure their dysfunctional thoughts and behaviors that are maladaptive or damaging (49,50). CBT includes a range of both cognitive and behavioral techniques such as relaxation, guided imagery, visualization, guided discovery and stress management. In the context of CH, these strategies are combined with hypnotherapy. Although there is a lack of research on the use of CBT in palliative care settings, CBT is effective for many of the psychological issues that are prevalent in palliative care including, depression, anxiety, pain management, and insomnia.

Advanced cancer refers to a broad range of patients (I) with short life expectancy ranging from 6 months to 6 years; (II) some experiencing severe debilitating symptoms while others may be asymptomatic; and (III) some are informed of their prognosis while others may not be aware of it or do not want to know (33). It is thus inevitable that patients with advanced cancer are likely to show wide variation in their psychological response to their illness. Moreover, different forms of cancer, and even different subtype of the same disease, can subsume different prognoses. It is therefore difficult to generalize about the relationship between coping and advanced disease. However, fighting spirit and emotional expressiveness are found to be associated with better psychological adjustment (51), while avoidance strategies are associated with poor social functioning (52) in women with advanced breast cancer. These findings are supported by a recent review of studies of positive attitude in advanced disease, which concluded that positive attitude, self-efficacy, and active problem-solving are associated with better emotional adjustment, whereas avoidant coping strategies were found to be maladaptive (53). Some of the CH strategies described in this article are driven by these findings.

CBT is based on the concept 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 successfully with life's challenges (50). The primary goal of CBT in depression is to teach depressed persons various techniques that will allow them to examine and modify their depressogenic beliefs and behaviors. According to the cognitive model it is not the cancer itself that causes the depression, it is the patient's interpretation of the physical effects of the disease. For example, Rabkin *et al.* (54) found that 76% of patients with advanced cancer never experienced clinical depression during their last months of life. While other patients interpret their symptoms of advanced cancer as (I) a sign of permanent loss; (II) a reminder that they will never return to their old self; and (III) a sign of laziness as they have lost the ability to carry out normal activities. Although there is some truth in these beliefs, these attributions usually imply a loss of self-worth. Therefore some patients with advanced cancer feel like "non-persons" and they perceive themselves to be treated as if they are already dead. Thus raising self-esteem of the patient with advanced disease can be one of the most useful contributions to psychotherapy. CBT is used to help the depressed palliative care patients examine and refute their negative views of the self, the world (including others) and the future. This case from Burns (55) illustrates how to refute "all-or-nothing thinking" and sense of "unworthiness" ("I'm a failure."). A patient in her mid forties with disseminated lung cancer, who had to give up her daily activities that meant a great deal to her sense of pride and identity because of weakness from chemotherapy concluded: "I'm useless"; "I'm a failure"; and "I'm worthless". Burns helped her realize that although her illness had reduced her activities and productivities significantly, she was still contributing to herself and to her family in numerous small ways. Then she saw these little activities as being very important and precious to herself and her family. She also realized that her personal self-worth was constant and steady and not related to achievement or success. She came to the understanding that we are born worthy and that we don't need to earn it and therefore as humans we are precious whether we are strong, weak or healthy. This CBT approach restored her self-esteem and improved her affect.

As CBT methods are fully described in numerous excellent books (56), they are not elaborated on here. For a detailed explanation of sequential progression of CBT within CH framework, see Alladin (19,45). The CBT component of CH can be extended over 4 to 6 sessions, depending on patient's need and the severity of the presenting symptoms.

Hypnotherapy

Four to six sessions of CH is dedicated to hypnotherapy. This module of CH is presented to increase the psychological cure of depression in advanced cancer or palliative care (19,26,45). To accomplish these goals, the hypnotherapy sessions focus on (I) relaxation training; (II) generating somatosensory changes; (III) demonstration of the power of the mind; (IV) expansion of awareness; (V) ego-strengthening; (VI) self-hypnosis training; and (VII) post-hypnotic suggestions.

Relaxation training

As the most of depressed persons (50% to 76%) experience high levels of anxiety (57), relaxation training is considered a significant constituent of CH. In palliative care the anxiety is often related to the disease and in some cases by fear of dying. Different hypnotic induction techniques can be applied to induce relaxation- the opposite of anxiety. The author uses the Relaxation with Counting Method adapted from Gibbons (45,58) for inducing and deepening the hypnotic trance as this technique can be simply used for self-hypnosis training. In the CH trial for depression reported by Alladin and Alibhai (14), most patients shown that they felt the relaxation experience empowering as it gave them the confidence to shut out anxious experiences in their lives. The ability to relax is particularly helpful to patients in palliative care as it helps them achieve comfort at the end of life (39,58). Brugnoli (40) noted that anxiety is often untreated in palliative care. Although benzodiazepines can effectively reduce anxiety symptoms, their long-term benefits are not established (59). Hypnosis and self-hypnosis provides a prompt, cost-effective, and a safe adjuvant or alternative to medication for the therapy of anxiety-related conditions in palliative care (40,60).

Producing somato-sensory changes

The most effective way to modify an experience is to produce a new experience. Hypnosis is a powerful process for inducing syncretic cognition (26), which comprises a matrix of cognitive, somatic, perceptual, physiological, visceral, and kinaesthetic changes. Hypnotic amplification and the modulation of syncretic cognition (e.g., feeling relaxed, sense of calm, sense of comfort, warmth, heaviness, floating, etc.) provide depressed patients, particularly those in palliative care, dramatic proof that they can adjust their depressive affect and negative experience. According to DePiano and Salzberg (61) the induction of positive involvement is partly responsible for the rapid and

deep behavioural, emotional, cognitive and physiological variations observed in hypnotized patients.

Demonstration of the power of mind

To further ratify depressed patients' belief in the effectiveness of hypnosis, eye and body catalepsy are induced in hypnosis. The catalepsies demonstrate to the patients that they have the capability to produce somato-sensory variations in their body by applying the power of their mind. The utility of this procedure is well illustrated by the case of Bob, a 55-year-old electronic engineer, with a past of chronic major depressive disorder, who was skeptical about hypnosis (26). Bob thought that his depression was a biochemical disorder, hereditary from his father, who suffered with anxiety and depression during his adult life. Bob did not show good reaction to antidepressant medication, and he was convinced that CBT would support him. 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" (26). Five sessions of hypnosis were needed to teach Bob acquire a positive image of hypnosis. 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 important improvement and indicated to the therapist that he likes coming to therapy and he looks forward to his "fascinating sessions" (26).

This case exemplifies the exceptional potential of hypnosis to produce dramatic cognitive, emotional and somato-sensory changes in depressed patients.

Amplification and expression of affect

The variety of emotions experienced by depressives is severely constricted due to their constant rumination with their symptoms and the consequences of their symptoms (62,63). These ruminative tendencies are more apparent in palliative care because of the nature of their terminal illness. Nevertheless, this does not mean that depressives do not have several feelings; it means "patients are dimly aware of the emotional undercurrent in interactions with others" (64). Hypnosis provides depressed palliative patients a powerful vehicle to produce, intensify and express a

variability of negative and positive feelings and knowledge. The Enhancing Affective Experience and Its Expression technique established by Brown and Fromm (64) can be successfully used with depressed persons to (I) transport their underlying emotions into awareness; (II) produce awareness of a wide range of feelings; (III) improve positive affect; and (IV) intensify the “discovered” choice of affect and emotions. The following script shows how underlying emotions can be brought into awareness, amplified and verbally described:

As you continue to relax, you may become aware of a specific feeling...This 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?

Once the patient is able to describe the feeling, the next step is to intensify 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 that feeling...you will begin to experience it 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... and notice the feeling growing stronger and stronger.

The aptitude to vacillate between different feelings and emotions disrupts the depressive sequence and counteract the depressive affect.

Ego-strengthening

Bandura (65) has demonstrated experimental evidence that self-efficacy, the expectancy and self-assurance of being able to cope positively with various circumstances, improves treatment outcome. Persons with a sense of high self-efficacy have a habit of perceive themselves as being in control. If depressives can be helped to understanding themselves as self-efficacious, then they are expected to perceive themselves as being in control. The most common technique for increasing self-efficacy inside the hypnotherapeutic setting is to provide ego-strengthening suggestions. The principles behind ego-strengthening are to eradicate anxiety, self-doubts, and self-recriminations, and to progressively restore patients' confidence in themselves and their skill to cope with their difficulties (66). Thus, ego-strengthening suggestions consist of generalized supportive suggestions to growth patient's confidence, coping abilities, positive self-image and interpersonal skills. Hartland (66) trusts patients need to feel confident and strong enough to work with their symptoms. However, when working with depressed palliative patients it is important to craft the ego-strengthening suggestions in such a way that they appear credible and logical. For

instance, rather than stating “*every day you will feel better*”, it is prudent to suggest: “*as a result of this treatment and as a result of you listening to your self-hypnosis CD every day, you will begin to feel more relaxed and comfortable*.” This set of suggestions not only sounds logical, but feeling better becomes contingent on continuing with the therapy and listening to the self-hypnosis CD daily (19).

Posthypnotic suggestions

Depressed persons have the predisposition to ruminate with negative self-suggestions, mostly when subjected to a stressful 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, or posthypnotic suggestions (PHS) that can become amount of the depressive cycle. To counter such dysfunctional cognitions (NSH), behaviours, emotional response and self-affirmations (negative PHS), PHS are offered routinely in hypnosis toward the end of each hypnotherapy session. Here are some examples of PHS provided by Alladin (26) for countering NSH in depression:

- ❖ *While you are in a hurtful condition, 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 feel more comfortable, you will feel better;*
- ❖ *As you get involved in doing things, you will be motivated to do more things.*

PHS helps as a powerful means for growing perceived self-efficacy. Clarke and Jackson (67) have provided evidence that PHS increase the consequence of in vivo exposure among agoraphobics. They believe PHS acts as a form of higher-order conditioning.

Self-hypnosis training

The self-hypnosis constituent of CH is designed to produce positive affect, counter NSH and simplify skills learned in the therapy sessions to existent conditions. At end of the first hypnotherapy session, each patient is routinely provided with an audio CD of the session. The script of the CD comprises hypnotic induction, relaxation training, ego-strengthening suggestions, and post-hypnotic suggestions. As part of their daily job, the patients are stimulated to listen to their CD as this offers continuity of therapy between sessions and produces the background for learning self-hypnosis. The ultimate goal of CH is to help the depressed patient create self-reliance. Alman (68) and Yapko (69) believe, by learning self-hypnosis, patients

can achieve independence, personal control, and self-correcting behaviors that give them a sense of control over their challenging lives. These interpretations were confirmed in the studies reported by Alladin and Alibhai (14) and Dobbin, Maxwell and Elton (70). In the latter study, Dobbin *et al.* (70) examined the efficacy of self-hypnosis in the managing of depressive symptoms in depressed patients from primary care setting. Patients who were provided self-hypnosis CDs exhibited important decrease in self-reported depressive symptoms and 50 of 58 patients who took part in the study indicated self-hypnosis over medication for the management of their depressive symptoms.

Cognitive restructuring under hypnosis

When the depressed patient has had some knowledge with CBT and hypnosis, the aims of the following sessions are to incorporate cognitive and hypnotic approaches. In the course of CBT, sometimes patients report the inability to identify cognitions preceding their depressive affect (71). Cognitive model of depression assumes the primacy of affect. In the absence of conscious cognitive distortions, cognitive restructuring is not viable. This characterizes a major limitation of CBT that can be simply resolved by integrating hypnosis with it (45,71). Hypnosis provides a multiplicity of hypnotic approaches for accessing and restructuring conscious, semi-conscious (automatic) and unconscious cognitive distortions and negative self-schemas. These hypnotic approaches can be opportunely contextualized and defined under (I) regression to recent activating event; (II) editing and deleting the unconscious file; and (III) symbolic imagery techniques (71).

Regression to recent activating event

This method is utilized for accessing maladaptive thoughts correlated to a recent experience that activated depressive affect, which the patient cannot recall. This scenario is quite common among depressed patients in palliative care. To access the non-conscious/forgotten depressive trigger, while in hypnosis, the patient is given suggestions to recall the condition that caused the recent upset, e.g., “Can you remember the situation that made you feel depressed last Tuesday?” Once the situation is identified, the patient is trained to remember the emotional and behavioral reactions associated with that condition, and then to become aware of the interconnected dysfunctional thoughts: *“Remember the feelings and the emotions that you experienced. Remember the physical and body sensations that you felt.* After a short silence:

What was your behavioral reaction? And what kind of negative thoughts were going through your mind?” Following, 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 damaged 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 reaction. This process is repeated until a set of damaged cognitions associated to a specific condition is considered to be positively reframed. This procedure was used effectively by Alladin (26) to treat Rita, a 39-year-old mother and housewife, with a 10-year history of recurrent major depressive disorder, who felt anxious in some social circumstances and was inhibited about sexual activities, but was unable to identify the underlying maladaptive cognitions. Hypnotic regression helped her to bridge the association between her affect and her cognitions. Once the connection between her affect and her maladaptive cognitions were established, her “adult ego lenses” were used to reframe the faulty cognitions.

Editing and deleting the unconscious file

This technique consists of two stages: (I) carrying out the adult “strong ego state” and (II) figuratively rewriting a set of maladaptive involvement. To bring out the “strong ego state”, while in hypnosis, following ego-strengthening suggestions and intensification of positive affect, the patient is instructed to become aware of the “good feelings” and then directed to focus on personal achievements and successes (i.e., the “strong ego state”). Once this is achieved, the patient is trained to imagine opening an old computer file containing outdated behaviors, 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 behaviors, and negative feelings. By figuratively deleting and editing the file, the person is able to diminish cognitive distortions, thinking, self-blame 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 search and restructure negative self-schemas in hypnosis.

Symbolic imagery techniques

Depression can be activated, aggravated or maintained by either conscious or unconscious “emotional garbage” such as inappropriate anger, self-doubts, guilt, fears, and self-blame. The “emotional garbage” is more apparent in depressed patients who are at the last stage of their

life. Several hypnotherapeutic techniques can be used to reframe patient's past experiences that cause these erroneous feelings. Alladin (19,45,71,72) has studied four symbolic imagery techniques for dealing with guiltiness and self-blame, including *The Door of Forgiveness* (73), *Dumping the "Rubbish"* (74), *Room and Fire* (74) and *The Red Balloon Technique* (72). For example, the *Room and Fire* (74) technique uses the image of a fireplace for burning unwanted garbage. During hypnosis, the patient is asked to visualize going down in the elevator from the tenth floor of a hotel to the basement. In the basement there is a very cosy room with a large stone fireplace with a fire burning. The patient is asked to imagine throwing into the fire "*Things you may not wish to keep ... such as fears, doubts, anxieties, hostilities, resentments, and guilts...one at a time, feeling a sense of release as they are transformed into ashes.*" (74).

Attention switching and positive mood induction

As mentioned before, depressives are inclined to ruminate with catastrophic thoughts and negative images (62,63). Such negative rumination or brooding can amplify the depressive affect, further kindle the depressive neuropathways, and thus perpetuate the depressive loop. This process is known to impede therapeutic progress (75,76). To counter negative ruminations, depressed patients are instructed to practice Attention Switching and to prevent the kindling of depressive neuropathways, the Positive Mood Induction technique is recommended.

Attention switching

To break the harmful ruminative cycle, depressives are trained to shift attention away from damaging cognitions and to focus more on positive skills (45). Patient is advised to make a list of 10 to 15 enjoyable life experiences and to "practice holding each experience in your mind for about 30 seconds". This process is experienced at least three times a day and the patient is encouraged 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 satisfying items from your list". By applying this method, the depressed patient acquires to substitute NSH by positive self-hypnosis. Yapko (77) has argued that since depressives use NSH to create their experience of the depressive reality, they can similarly learn to use positive self-hypnosis to generate an understanding of anti-depressive reality.

Positive mood induction

Just as the brain can be kindled to produce depressive neuropathways through conscious negative focusing (78), the brain can also be kindled to improve anti-depressive or joyful ways by focusing on positive metaphors (79). There is extensive empirical evidence that directed cognition can produce neuronal modifications in the brain and that positive affect can enhance adaptive behavior and cognitive flexibility (45). In this theoretical and experiential context, Alladin (25,26,45) has developed the *Positive Mood Induction* technique to counter depressive neuropathways and to develop antidepressive neurocircuitry.

The Positive Mood Induction technique consists of five steps: (I) education; (II) making list of positive experiences (same as for Attention Switching); (III) positive mood induction; (IV) posthypnotic suggestions; and (V) home practice. To instruct the patient, the therapist develops a scientific rationale for developing antidepressive neuropathways. When in deep trance, the patient is instructed to focus on a positive skill from the Attention Switching list, which is then improved with support from the therapist. The practice is repeated with at least three positive experiences from the list of pleasant skills. Post-hypnotic suggestions are provided that the patient, with practice, will be able regress completely when working with the list on his/her own. Apart from providing a systematic approach for developing antidepressive neurocircuitry, the method also strengthens the brain to withstand depressive symptoms, thus preventing recurrence of depressive episodes.

Active interactive training

While interacting with their internal or external environment, depressives are inclined to involuntarily dissociate rather than actively interact with pertinent internal or external information. This dissociative proclivity is further compounded in palliative care patients because of their worry with the consequences of their serious physical illness, fear of death and the distress caused by side-effects of drug treatment. The Active Interacting Training is planned to help breakdown the "dissociative" behaviors by establish "association" with more pertinent information or experience. The training involves four steps. First, the depressed patient is encouraged to differentiate between "active interaction" and "passive dissociation" and to become aware of these involuntary processes. Active interaction needs being alert and mindful of received

information (conceptual reality), whereas involuntary or passive dissociation is the tendency to become anchored to “inner reality” (negative schemas and associated syncretic feelings), which prevents reality testing or appraisal of conceptual reality. Second, patient actively attempts to inhibit the “disassociation” (once the patient becomes aware of this process occurring) by switching attention away from the “bad anchors” (negative inner reality). Three, patient actively attends to pertinent internal or external cues (conceptual reality) by switching off from the “disassociation”. A pattern of approaches, including “grounding” or “anchoring” techniques (80-82), have been described in the literature for learning to directly counteract dissociative habits. What this group of methods has in common is that they all comprise education to direct one’s attention to the immediate present (81). In other words, patient acquires to actively engage in higher-order executive processes (breaking away from involuntary thinking).

Recent neuroimaging studies have revealed depressed patients to manifest (I) hyperactivity in the limbic regions that are significant for perceiving emotional characteristics of information and (II) hypoactivity in areas of the prefrontal cortex that exert inhibitory control over those limbic regions (83). CBT appears to affect cortical roles (84,85), that is, it bolsters higher-order executive functioning centred in the prefrontal cortex (86). As Active Interactive Training is a cognitive behavioral technique, it is not unreasonable to accept that it may be generating similar cortical modifications to CBT. Edgette and Edgette (87) have also described several methods for developing adaptive dissociation. They have put forward the view that a patient with expected maladaptive dissociation can equally be trained to endorse adaptive dissociation, which would counter maladaptive dissociation, arrest sense of pessimism and sense of helplessness, and help the patient become detached from toxic self-talk.

Mindfulness training

Depression includes withdrawing or turning away from negative experience to avoid emotional pain (88). 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 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 supports the depressed person

becomes less distressed by unpleasant experience and hence less reactive to adverse event in the present moment. Teasdale *et al.* (89) have provided empirical evidence that mindfulness-based CBT reduces relapses in depression.

Mindfulness can be easily integrated with hypnotherapy in the management of depression (90-92). Mindfulness-based CH is well-suited for the psychological management of clinical depression in palliative care. Inside the CH context, mindfulness training is introduced at the late part of the cure protocol. The author finds the following consecutive training of mindfulness helpful to the depressed patients: (I) education; (II) training; and (III) hypnotherapy. The learning component of mindfulness consists of providing the depressed patient knowledge about the danger factors involved in the exacerbation and relapse of depression, the diverse approaches used for relapse prevention, and the simplicity and efficacy of mindfulness training. After the patient approves the 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 temporary conditions that “come and go just like a cloud, but the sky stays the same”. Mindfulness training includes informal mindfulness training consisting of the Body Scan Meditation exercise adapted from Segal, Williams and Teasdale (93). The exercise concentrates on teaching depressed patients to become aware of their breathing and the feeling in diverse parts of the body. The aim of this training is to support depressed patients focus on the present moment and learn to appreciate that feelings are momentary states and not permanent state. For a exhaustive script of the Body Scan Meditation, refer to Alladin (19).

Alladin (26) and Lynn *et al.* (91,92) recommend using hypnosis to catalyze mindfulness-based approaches. For example, Alladin (26) uses hypnosis to combine and increase the education and the meditation components of mindfulness training. Lynn *et al.* (92) use hypnotic suggestions to provide the basic information for practicing mindfulness. They also mention using hypnotic and posthypnotic suggestions to reassure patients to (I) practice mindfulness on a regular basis; (II) not to be discouraged when attention wanders off during training; (III) learn to accept what cannot be changed; (IV) not to personally identify with feelings as they arise; (V) learn to tolerate troublesome feelings; and (VI) appreciate that troublesome feelings and thoughts are not permanent.

Conclusions

CH offers a multiplicity of hypnotic and cognitive-behavioral methods for the psychological management of clinical depression in palliative care. From this array of approaches, the therapist can choose the best-fit intervention for any individual depressed patient. The number of sessions and the sequence of CH are determined by the clinical necessities of each patient. CH also offers advanced techniques for developing antidepressive neurocircuitry and mindfulness-based hypnotherapy for treating depression. Even though there is some empirical evidence for the effectiveness of CH, further studies, especially in palliative care, are required before CH can achieve the APA status of well-established treatment for depression. Conducting this kind of research is needed if clinical hypnosis were to be established as a bona fide psychotherapy. On the other hand, as the treatment approach to CH in palliative care is highly idiographic, the scope of therapist's resourcefulness should not be curtailed by evidence-based practice.

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Footnote

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