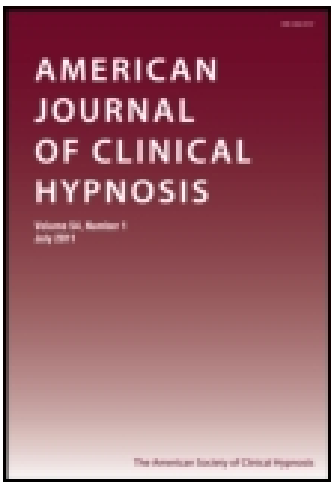

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Hypnotic Intervention for Ambiguity As a Depressive Risk Factor

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In the face of ambiguous life events, depressed individuals are more likely to make negative and depressing interpretations than nondepressed individuals. Fundamental to the success of cognitive-behavioral treatments, one of the most empirically supported treatments for depression is teaching the client to recognize and self-correct so-called cognitive distortions. To facilitate that learning process, clients can learn to better recognize and tolerate ambiguity inherent in many situations, and thereby diminish the drive to form subjective interpretations (either negative or positive) when more objective evidence is unavailable. This article describes ambiguity as a risk factor for depression and details a strategy employing hypnosis for teaching the skills of both recognizing and tolerating ambiguity.

Overview

Ernest Hilgard once described hypnosis as "believed-in imagination" (personal communication, 1988). That is an astute framing, capturing both the flesh and spirit of hypnosis. To go a step further, though, one could also say that anyone's view of life is similarly a product of believed-in imagination. For one person to form from the ambiguous stimulus of life a belief that "life is wondrous and joyful" while another forms the belief that "life is a miserable burden to endure" represents two different believed-in imaginations that have specific and measurable consequences for each individual.

The body of literature describing the relationship between the quality of one's beliefs and one's mood is substantial: It is well established that the positive, optimistic person is less likely to suffer depression. Likewise, such a person will also benefit: 1) *physically* by likely suffering less serious illness and higher rates of recovery; 2) in terms of *productivity*, having higher levels of focus, persistence and frustration tolerance; and 3) in terms of greater *sociability* and likeability, enjoying the many health and mood benefits associated with having more close and positive relationships

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(Peterson, 2000; Seligman, 1989,1990; Yapko, 1997,1999, 2001a).

The overlap between depression as a problem and hypnosis as a means for addressing it centers on the believed-in imaginations of the depressed client. Believing "life is unfair," "I'm no good," or "I'll never be able to do that," are just a very few of the many self-limiting and even self-injurious beliefs that depressed individuals may form and come to hold as true. Thus, it is no coincidence that cognitive-behavioral therapies, which challenge depressed individuals to learn how to identify and self-correct their cognitive distortions and behave more effectively, have been shown to be highly effective approaches (Clarkin, Pilkonis, & Magrude, 1996; Greenberger & Padesky, 1995).

A variety of therapeutic efficacy studies have been published attesting to the added value of hypnosis to established treatments, especially cognitive-behavioral approaches (Lynn, Kirsch, Barabasz, Cardena, & Patterson, 2000; Schoenberger, 2000). No formal studies have yet been done specific to the use of hypnosis with depressed populations. Depression is a global term, however. In fact, depression is comprised of many different components, including cognitive patterns (such as attributional style), behavioral patterns (such as avoidant coping styles) and relational patterns (such as hypercriticalness). Many of these components have been addressed successfully with hypnosis (Kirsch, 1996; Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997). In fact, much of what is presented in this article could be characterized as cognitive-behavioral therapy performed within a hypnotic and strategic framework (Yapko, 1992,1995, 2001b).

Ambiguity, Making Meaning, and Depressive Risk

Ambiguity may well be the most powerful and pervasive risk factor for depression of all known risk factors. Ambiguity in this context refers to the lack of clear meaning associated with one's various life experiences. Events occur, we observe them occur, but what we most often don't know is what, if anything, they mean. The great majority of events in life do not have a clear and inherent meaning, leaving each of us the task of having to establish for ourselves our own subjective interpretation of what the meaning or significance is of the event. Similarly, a particular person's symptoms invite inferences from clinicians; for example, "I think you're depressed because your thinking is distorted and you need to learn to identify and self-correct your cognitive distortions," or "I think your depression is caused by too low a concentration of serotonin in your brain." Depression, like almost any problem, can be interpreted and treated from many viewpoints.

In response to any life event, however minor or major, the formation of an idiosyncratic meaning represents the heart of a belief system, whether self-reinforced ("I believe it no matter what others might think") or culturally reinforced ("Any true American would believe this"). Beliefs are multidimensional, encompassing feelings, physiology, and behavior, as well as the obvious cognitive components, and all will need to be addressed in a comprehensive intervention.

To diagnose a depression is not the same as declaring that it has a specific meaning. Aaron Beck was right to have questioned decades ago whether instead of depression being the outgrowth of some deeper intrapsychic conflict, depression might itself be the problem and the symptoms of depression the most appropriate targets for

treatment (Beck, Rush, Shaw, & Emery, 1979). This provided a foundation for a clever "divide and conquer" strategy that works quite well, as efficacy studies indicate. Now, decades later, we can recognize that each of the treatments that has been deemed "empirically supported" for treating depression is short-term and focuses on the dual goals of skill-building and symptom resolution (Depression Guideline Panel, 1993; Schulberg, Katon, Simon, & Rush, 1998).

Cognitive therapy (CT) in particular has flourished as perhaps the most well studied and most systematic form of psychotherapy (Dobson, 1989). Aaron Beck and Albert Ellis in particular spawned a revolution in the field of psychotherapy by shifting the focus away from what someone thinks (the content) to how someone thinks (the process). Whether assessing the specific cognitive distortions in the context of Beck's Cognitive Therapy, or the irrational thoughts in the context of Ellis' Rational Emotive Behavioral Therapy (REBT), an underlying mechanism for the development of depression is the inability to distinguish inferences from facts (Sacco & Beck, 1995; Ellis, 1997).

Why are there cognitive distortions or irrational thoughts to have to correct in CT or REBT? Why can't people willingly and with self-awareness sidestep the vulnerability of their own beliefs? Consider as an example a so-called cognitive distortion, "jumping to conclusions," the error of reaching a conclusion despite the lack of supportive evidence. Why jump to conclusions, if not merely to have a conclusion? But the salient question is, why have the need for a conclusion? What is it about ambiguity that is so uncomfortable and compelling in the force it generates to reach a conclusion, even at the risk of reaching an incorrect and potentially depressing one?

Recognizing and Tolerating Ambiguity as Therapeutic Goals in Hypnosis

For as long as an individual is unable to tolerate uncertainty, he or she will be motivated to continue forming meanings about life experience with little or no insight into the interpretive process, and thus suffer the mood consequences when they are negatively distorted yet accepted as "true." Thus, one of the most basic goals in treating therapy clients in general, and depressed clients in particular, is to teach them how to recognize and tolerate ambiguity. It is a therapeutic goal that even precedes identifying specific cognitive distortions or irrational beliefs in the client. Before teaching someone to avoid jumping to conclusions (or personalizing, thinking dichotomously, or forming any other cognitive distortion), that person would have to become more comfortable with no conclusions; that is, reduce the drive to have an answer. By addressing the issue of ambiguity in therapy, and making it a primary target of a specific hypnotic intervention, the larger goals of therapy, such as teaching skills in rational thinking, are well facilitated (Seligman, 1990).

The primary therapeutic goals, therefore, are to: 1) learn how to quickly recognize ambiguity in situations; 2) be on guard against one's own tendency to interpret such events in some patterned and hurtful way that may not be objectively true; and 3) develop a tolerance for ambiguity that permits comfort with not knowing. Not knowing what's "right" or what's "true" in a given context can either be empowering or victimizing, depending on one's perspective. Not knowing can be an empowering spur

to finding out.

The positive value of cognitive therapy in particular has been well documented in the literature, and is clearly a treatment of choice for depression (Depression Guideline Panel, 1993). Cognitive skills can be learned more easily with hypnosis as a vehicle of experiential learning, and can be more easily learned when the basic human need to believe something, anything, can be reduced (Beck, 1976; Kirsch, 1993; Kirsch, Montgomery & Sapirstein, 1995; Schoenberger, 1996; Yapko, 1992,1997, 2001b). Furthermore, hypnosis can provide anxiety reduction, lowered agitation, and reduced ruminations. Hypnosis can thus be a means for demonstrating to the client that his or her symptoms are malleable, helping to build the positive expectancy that is crucial to recovery from depression (Seligman, 1990; Beck, 1997; Yapko, 1992).

Structuring Hypnosis Sessions for Recognizing and Tolerating Ambiguity

Table 1 below outlines a generic, process-oriented structure (developed and used with depressed clients in the author's clinical practice) for a formal hypnosis session designed to encourage recognizing and tolerating ambiguity.

In calling this strategy's structure "generic," not only will the content of the clinician's verbalizations vary according to the unique attributes of each individual client, but the steps themselves may vary according to what needs more or less amplification in the client's experience. One client might respond better to direct suggestions for greater comfort with uncertainty, while another client may better respond to metaphors about brilliant people who are adept at publicly stating "I don't know" in response to questions supposedly in their area of expertise. As always, it is a matter of clinical judgment as to what a particular client is likely to respond to best. The more feedback from the client a clinician uses in formulating an approach, the

Table 1: A Generic Structure For Hypnotically Facilitating Recognizing and Tolerating Ambiguity

- Orient Client to Hypnosis
- Induction Process
  -Build a response set regarding uncertainty
- Introduce the Process of Inference
  -Suggestions/metaphors regarding inferences
- Introduce the Value of Knowing
  -Suggestions/metaphors regarding "knowing"
- Introduce the Value of Not Knowing
  -Suggestions/metaphors regarding "not knowing"
- Reframing "Not Knowing" as Desirable in Some Contexts
  -Suggestions for identifying when "not knowing' is desirable
- Posthypnotic Suggestions for Integration
- Closure
- Disengagement

more likely the interaction can be tailored appropriately (Yapko, 1990, 1995).

Describing the Strategy

Every hypnosis session has an identifiable structure, just as every psychotherapy session has a structure. From first greeting the client to saying goodbye at session's end, there is a sequence for how a session progresses. Sequences will vary, of course, with the goals and methods of specific sessions, but there are sequences nonetheless. It can be helpful to have structured sequences for conducting hypnosis sessions, a progression of ideas and suggestions that move the client in the direction of the session's goals.

The first step is to *orient the client to hypnosis.* Any time formal (overt) hypnosis is to be employed there needs to be a statement (or two or three) that encourages the client to prepare him or herself for the hypnotic process to begin. A common tactic is to simply ask, " Have you experienced hypnosis before?" or to suggest he or she "Find a comfortable position to sit in" as a means for getting the client "on the track" of thinking about and preparing for hypnosis.

The *induction process* is whatever means a clinician uses to absorb and direct the client's attention. Inductions can be structured (e.g., countdowns) or conversational ("Can you recall how good it feels to close your eyes and get absorbed in relaxing images?"). The chief function of an induction is to facilitate some degree of dissociation in the client, so the actual method employed is a secondary consideration. The primary consideration is the client's ability to relate well to it and get absorbed in it, whatever it is.

The *building of a response set* is the means for establishing a momentum in client responsiveness. To expect the client, following an induction, to instantly be able to relate to and absorb new ideas isn't usually realistic. Most clients need time to progressively develop their hypnotic responsiveness over the course of a session, and the goal of this step is to deliberately assist in that process. An example of the most commonly used response set is the so-called "yes set," a means for building agreement and receptivity in the client to further suggestions. The client may be offered a series of truisms (i.e., suggestions so obviously true there is no legitimate basis for rejecting them) that he or she naturally will agree with, establishing a momentum in the direction of more easily agreeing with whatever else the clinician might say. In the context of this strategy where the goal is to increase awareness and acceptance of uncertainty, a response set might include such suggestions as, "There are many different things I could say intending to help you relax... and I don't know which of them would be the most valuable in helping you get deeply comfortable... and you don't know exactly what I'm going to talk about that will be helpful to you... and you don't know quite yet how you'll come to think differently about yourself... and you don't really know at just what moment you'll find yourself so wonderfully comfortable with the possibilities you'll discover here." In each suggestion, uncertainty is amplified but also associated to positive possibilities.

Hopefully receptivity is now well established and the clinician can *introduce the process of inference* to the client. Direct and/or indirect suggestions can be employed in the service of getting across the concept that ambiguity invites inferences. Suggestions to illustrate the process (in personal and/or impersonal terms according to

client responsiveness) are used to teach the client that forming inferences is normal (thereby depathologizing the client) but self-monitoring will be necessary because they are not always accurate. For example, one might say, "I'm sure you've had the experience of calling someone... getting his or her answering machine... and leaving a message... and when the person doesn't call back in a time frame you think reasonable... you might wonder what it means... whether the person is busy... whether the answering machine worked properly... whether the person is avoiding you for some reason... or any of many possible reasons... and how do you know what the real reason is? ...But it's human nature to speculate about what things that happen mean... and the real skill is knowing when you're speculating... and when you have evidence to affirm your interpretation... after all... you don't want to react to something on the basis of an incorrect interpretation."

Introducing the value of knowing is a validation of the human need to believe, the human need to understand. Another step in depathologizing the client, the goal at this stage is to affirm to the client that scientific and social progress originates in the desire to know, but the distinction between truly knowing versus merely imagining can begin to emerge. So, following the above example of no return phone call, one could say, "...and all the speculations about why the person didn't call back... are normal... and reflect our desire to make sense out of things that don't seem to make much sense... and whether you want to understand something like why someone doesn't call back, or something much more complex like how the universe works... it's one of human beings' greatest strengths... that they strive to understand... and make sense of the things that go on around us..."

In the next step, *the value of not knowing is introduced.* The goal at this stage is to depathologize "not knowing." Suggestions are offered to highlight that there are unanswerable questions in life that no amount of analysis will ever answer, and that not having an answer is not only acceptable, but may at times be the best possible outcome. The client, hopefully, begins to absorb the notion that "not knowing" is often preferable to "knowing" something that is merely made up. In line with the phone call example, one could continue by saying, "... and the fact that you can generate so many different explanations for why someone doesn't call back... gives you an opportunity to realize you don't know why he or she didn't call back... you can make lots of guesses... but you really don't know for sure... and when you don't know how to explain something... it's perfectly alright to say you don't know... after all, no one really expects you to know why someone else doesn't return a phone call... it's a gift of honesty and clear thinking when someone says, "I don't know" instead of making up an answer that might well be wrong... there are so many times in life you'd rather be given no answer than a wrong one."

In the next step involving *reframing*, the client is taught a strategy, an internal mechanism of sorts that he or she can use to discriminate what is known from what is inferred. Such a strategy might be something as simple as the direct suggestion, "Before you reach a conclusion, any conclusion ...ask yourself, 'How do I know?' and if your answer is 'I just feel it's so' or 'I just think so'... then know you are forming a conclusion with no apparent objective data... that doesn't mean you are wrong, necessarily, but it increases the chances considerably... so, you can remind yourself to go the next step and ask yourself, 'Are there any objective data to support this?', and maybe there will be or maybe there won't be, but you'll notice the quality of your ideas and conclusions

getting better and better over time."

The function of the *posthypnotic suggestion* is to associate new learning to desired contexts. Posthypnotic suggestions are a routine part of hypnotic intervention, for without them, new learning would be unlikely to generalize to the relevant contexts of the client's life. So, a clinician might offer a posthypnotic suggestion such as, "And each time throughout the day you encounter a situation where the meaning isn't clear to you, or can even anticipate such an event before it happens, you can recognize there are many different ways to interpret the event... and you can instantly remind yourself you don't know what it means just yet... but can entertain a variety of interpretations... and can ask yourself directly how you will know which one - if any - it is... and it will lead you to look deeper and you can do so comfortably... knowing you can look for evidence for your views if it exists... and comfortably knowing you can adopt any perspective that might feel good to you... when one interpretation is merely as plausible as another."

A session's *closure* can be suggested permissively, encouraging the client to "do whatever processing you need or want to do to bring this session to a comfortable close." *Disengagement* can also be done permissively, encouraging the client to "reorient yourself at a gradual rate that is comfortable for you, and when you're ready to fully reorient you can do so and allow your eyes to open."

Summary

As the rates of depression continue to rise, and more research attests to the therapeutic value of skill-building approaches in the treatment process, clinicians will need to have more varied and effective means for teaching such skills. Hypnosis has been shown to be an effective vehicle for catalyzing therapeutic interventions. In the treatment of depression in particular, hypnosis holds great potential as a means of helping suffering clients feel less victimized and more empowered to better manage their symptoms, and to more easily learn the skills known to reduce depression and even prevent later episodes.

One of the primary skills one can teach depressed clients is how to recognize and tolerate ambiguity in order to reduce the probability of noncritically accepting one's depressogenic thoughts and beliefs. A generic hypnosis strategy for achieving this treatment goal was presented with sample verbalizations.

Depression is the most common mood disorder that clinicians are asked to treat. The hopelessness and helplessness of depression are powerful forces that serve to maintain depression's grip on individual sufferers. There is much that mental health professionals can do to raise the general awareness level in both their clients and their colleagues that hopelessness and helplessness are more about perceptions than facts.

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