

HYPNOSIS, RUMINATION, AND DEPRESSION: *Catalyzing Attention and Mindfulness-Based Treatments*

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Abstract: Over the past 30 years, mental health practitioners, encouraged by rigorous empirical studies and literature and meta-analytic reviews, have increasingly appreciated the ability of hypnosis to modulate attention, imagination, and motivation in the service of therapeutic goals. This article describes how hypnosis can be used as an adjunctive procedure in the treatment of depression and rumination symptoms, in particular. The focus is on attention-based treatments that include rumination-focused cognitive behavioral therapy, cognitive control training, and mindfulness-based cognitive therapy. The authors provide numerous examples of techniques and approaches that can potentially enhance treatment gains, including a hypnotic induction to facilitate mindfulness and to motivate mindfulness practice. Although hypnosis appears to be a promising catalyst of attention and mindfulness, research is required to document the incremental value of adding hypnosis to the treatments reviewed.

Over the past 3 decades, hypnosis has moved into the scientific mainstream. A weighty body of evidence, derived from reviews and meta-analytic studies, has documented the value of hypnosis in treating a gamut of psychological and medical conditions and disorders ranging from acute and chronic pain to obesity. Furthermore, meta-analyses have shown that hypnosis bolsters the effectiveness of psychodynamic and cognitive-behavioral psychotherapies, and researchers and clinicians have documented numerous ways in which hypnosis holds promise as a catalyst for a variety of empirically supported interventions (see Lynn & Kirsch, 2006).

Given the embrace of hypnosis by the psychological community, it is perhaps surprising that, until recently, workers in the field have devoted scant attention to hypnosis in the treatment of depression. Yapko (2006) speculated that ill-informed practitioners have feared

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that hypnosis might “strip away” people’s defenses or promote symptom substitution, and, as a result, clinicians eschewed hypnotic interventions. However, it makes no sense to entertain such misconceptions today in light of what we know about hypnosis, the unlikelihood of symptom substitution, and the pressing need to develop durable non-pharmaceutical treatments for depression. Indeed, depression ranks fourth among diseases worldwide that create the greatest health burden, with as many as 32 million U.S. citizens falling under its dark shadow at one time or another (Kessler et al., 2003).

Fortunately, a viable clinical and empirical case can be made for integrating hypnosis with evidence-based methods for treating depression. Michael Yapko (1992, 2001, 2006) has been an effective champion for using hypnosis to treat depression, arguing persuasively that hypnosis can be combined fruitfully with cognitive-behavioral, interpersonal, and strategic methods. Yapko (2006) contends, and we agree, that hypnosis can augment treatment response because it can: (a) increase expectancies for positive treatment outcome and thereby create hope as an antidote to demoralization; (b) fortify the therapeutic alliance, often integral to treatment success; and (c) narrow attentional focus and foster believed-in-imaginings and positive self-talk that promote accessing personal and interpersonal resources and replacing negative cognitive styles and attributions (i.e., depressogenic thinking; “I’m worthless, what’s the use of trying? It’s all my fault.”) with a more optimistic perspective.

Relatedly, Lynn and Kirsch (2006) observed that negative automatic thoughts that arise when people are depressed can be viewed as spontaneous self-suggestions subject to identification, challenge, and change via therapeutic suggestions (see also Alladin & Alibhai, 2007). Alladin (2006) described a comprehensive treatment for depression using hypnosis to amplify cognitive-behavioral therapy by maximizing concentration, facilitating divergent thinking and experiences, and enhancing access to unconscious processes. Lynn and his colleagues (Lynn, Matthews, Fraioli, Rhue, & Mellinger, 2006) presented an individually tailored cognitive-behavioral treatment—dubbed the “5-Finger Technique”—in which patients, with each finger of the hand, access techniques related to different domains of personal growth (e.g., physical, cognitive, behavioral, spiritual, and acceptance and mindfulness), and therapists use hypnosis to minimize catastrophic thinking and avoidance-based coping strategies (e.g., withdrawal, rumination).

Clearly, the putative advantages hypnosis confers are entirely harmonious with multimodal cognitive-behavioral therapies (CBT) that target maladaptive thinking and behavioral patterns pertinent to depression. However, until recently, the benefits of adding hypnosis to such interventions have been based almost entirely on case studies and clinical observations. In a landmark study, Alladin and Alibhai (2007)

randomly assigned 84 depressed patients to a 16-week regimen of either CBT alone, or CBT supplemented with hypnosis (cognitive hypnotherapy). At the end of treatment, improvement was evident in both groups. However, patients who received hypnosis demonstrated more impressive reductions in depression, anxiety, and hopelessness. Importantly, the gains exhibited were still apparent at 6-month and 12-month follow-ups. Alladin and Alibhai (2007) concluded appropriately that the study met the American Psychological Association criteria for a "probably efficacious" treatment for depression.

In this article, we describe the use of hypnosis in conjunction with interventions for depression specifically geared to treat rumination, broadly defined as the tendency to think repetitively about an emotional topic. Alladin (2006) and Lynn and his colleagues (Lynn & Kirsch, 2006; Lynn et al., 2006) independently suggested that mindfulness could be used in tandem with hypnosis to treat depression but did not focus on applications of hypnosis to treat rumination, as we do in this article. Because hypnosis provides a particularly effective means of controlling and modifying attention, it is ideally suited to augment attention- and mindfulness-based interventions for rumination. The interventions we will describe can be applied to a variety of psychological disorders, ranging from anxiety and eating disorders to substance abuse, in which rumination plays a prominent role (Siegle, 2008).

RUMINATION AND DEPRESSION

Our focus on rumination is by no means arbitrary. Rumination is a key component of depression and can be defined, in this context, as repetitive and passive thinking about the symptoms of depression and the possible causes and consequences of the symptoms (Nolen-Hoeksema, 1991; Smith & Alloy, 2009). Rumination predicts the severity and duration of depressive symptoms as well as episodes of major depression (Just & Alloy, 1997; Nolen-Hoeksema, 2000). Importantly, rumination is linked to high rates of relapse in depressed patients (Hood, 2007). Rumination is a common residual symptom of a depressive episode and, if untreated, increases vulnerability to future episodes (Judd, 1997), marked functional impairments, and increases in usage of health care services (Cornwall & Scott, 1997).

Rumination often engenders mental and often physical paralysis: It dominates attention, generates pessimism and withdrawal from potentially rewarding activities, and precludes effective problem solving (Lyubomirsky & Tkach, 2004). People who ruminate and also experience cognitive distortions, such as the perception that negative experiences are unchangeable, also experience particularly severe depressive episodes (Robinson & Alloy, 2003) and are less responsive to both antidepressant and cognitive-behavioral interventions (Ciesla & Roberts,

2002). Even after researchers statistically control for the influence of other variables, including neuroticism, perfectionism, and pessimism, rumination still exhibits a unique relationship to depression (Spasojevic & Alloy, 2001).

Theories of Rumination

Two influential theories of rumination are especially relevant to our discussion. According to Nolen-Hoeksema's (1991) response-style theory (RST), rumination is a stable, inflexible, and pervasive pattern of thinking that, by its very nature, prolongs depressive mood. The polar opposite of rumination is flexible attention that serves current needs and goals. The therapeutic ramifications of the RST model are obvious: Hypnotic and other approaches that modify attention and enhance mental agility should alleviate depression.

Alloy's (Alloy et al., 2000) model of stress-reactive rumination (SRR) highlights the widely accepted finding that rumination in response to stressful life events increases vulnerability to depression (Robinson & Alloy, 2003). Predictably, people are at risk for depression who believe that stressful or negative life events (e.g., failing an important exam) reflect their unworthiness or who attribute negative events to stable and global causes (e.g., "I'm not intelligent"), which spurs further negative consequences such as deficient task motivation (e.g., "What's the use of studying?") and virtually guarantees failure (e.g., failing the next exam).

Rumination may become an obdurate pattern when it is rewarded (via negative reinforcement) when events that are the content of rumination turn out to have a more positive outcome than anticipated. Relatedly, rumination can lead to avoiding circumstances associated with real or imagined failure, likewise (negatively) reinforcing rumination. Individuals typically react to distressing thoughts by either intentionally suppressing them or indirectly avoiding them via distraction. However, both of these strategies require resistance, which may paradoxically increase negative cognitions and fortify the connection between negative mood and rumination (Wegner, 1997). SRR theory underscores the need for patients to either modify their negative thinking patterns or find a way to disengage from them. Both of these goals can be achieved with the methods we discuss below that specifically target rumination by controlling attention and modifying cognitive and behavioral patterns.

ATTENTION- AND MINDFULNESS-BASED TREATMENTS

Rumination-Focused Cognitive Behavioral Therapy

Rumination-focused cognitive-behavioral therapy (RFCBT) is designed to shift attention from dysfunctional to more adaptive cognitions and

behaviors. RFCBT begins with a functional analysis of rumination. More specifically, clinicians obtain information regarding the functional relations among antecedent conditions (e.g., negative life events), thinking and behavior patterns (e.g., rumination, negative thinking patterns), and consequences (e.g., avoidance of rewarding activities, depression). Researchers have identified two distinct styles or modes of rumination: the helpful and maladaptive (i.e., unhelpful) style (Treyner, Gonzalez, & Nolen-Hoeksema, 2003; Watkins & Moulds, 2005; Watkins & Teasdale, 2004). When rumination is helpful, persistent thoughts are concrete, based on immediate experience, and are goal and solution oriented (e.g., reflecting, pondering). In contrast, unhelpful rumination is analytical, self-evaluative, self-focused, and likely to deepen depression and to deter problem solving.

Clinicians who conduct an RFCBT functional analysis assess the variability of: (a) helpful versus unhelpful rumination (e.g., providing emergency contact information to the babysitter vs. worrying ceaselessly about a child until you return home); (b) behaviors and situations associated with rumination (i.e., procrastination, passivity); and (c) behaviors that counteract rumination (i.e., effective engagement in tasks). From this functional analysis, the therapist encourages the patient to recognize warning signs for potential rumination (e.g., catastrophizing, procrastination), to develop alternative strategies and contingency plans (e.g., task scheduling and assertiveness), and to alter the environmental and behavioral contingencies that maintain rumination (i.e., engage in more self-fulfilling activities).

Overall, the RFCBT model places greater emphasis on modifying attention—the process of thinking (shifting from unhelpful to helpful thinking)—in contrast to modifying or challenging the content of thoughts, as in traditional CBT. In a recent study, researchers (Watkins et al., 2007) determined that RFCBT reduced levels of rumination in 14 patients who met criteria for medication-refractory residual depression to levels exhibited by nondepressed individuals.

Hypnosis and RFCBT

The hypnosis literature is replete with examples of methods that can facilitate RFCBT using imagery exercises and behavioral experiments that facilitate therapeutic movement toward more helpful ways of thinking and acting. During rumination, autobiographical memories are constrained to negative themes and preclude a shift in perspective to neutral and positive thoughts and feelings. To encourage healthy rumination and flexible thinking, therapists can suggest that patients experience alternating waves of pleasant/comforting and neutral thoughts about the self, world, and external objects, no matter how trivial (e.g., I like the shape of my nose) or consequential (e.g., My health is generally good). Alternately, patients can imagine as many

concrete things (e.g., a red barn door, a street curb) as possible in a 2-minute period, with the time period for such imaginings increased on a gradual basis (David Mellinger, personal communication, June 27, 2009). To further promote concrete, nonevaluative thinking (i.e., healthy rumination), practitioners can provide suggestions to avoid thinking about the same thing twice, while not judging whether it is good or bad.

Clinicians can facilitate problem solving with age regression (e.g., suggestions for reliving or reexperiencing past events) to access memories and specific situations when successful problem-solving and goal-directed activity short-circuited rumination. Suggestions or post-hypnotic suggestions can also be given for patients to gain an increasingly vivid and accurate sense of the salient dimensions or features of problems to be solved, along with suggestions to imaginably rehearse different approaches to problems and their consequences. Imaginative rehearsal combined with motivational ego strengthening suggestions can improve self-confidence and bolster self-esteem by helping patients to prepare for challenging situations and to develop a positive internal dialogue (e.g., “You CAN do it!”) as coping strategies are implemented. Imaginative rehearsal can be conducted in the context of hypnotic age progression in which patients envision a future time in which they have resolved their problems and note the steps taken to improve their lives (Lynn & Kirsch, 2006).

Brooding can be addressed with suggestions that foster a deliberate change from a passive to an active problem-solving set and encourage rewarding social and nonsocial activities (e.g., getting previously avoided work done) that break depressive gridlock (Treyner et al., 2003). Patients can first imagine such pleasurable activities as riding a bike, socializing, jogging, or gardening and then engage in one or more of the imagined activities in everyday life. Therapists can suggest that each day patients will be curious about and get a sense of “the next right thing to do” and be able to take appropriate action with determination and resolve. Even severely depressed patients are, more often than not, capable of devising a rudimentary blueprint for living “a day at a time.”

Cognitive Control Training

Cognitive control training (CCT) is a neurobehavioral therapy that can be usefully combined with virtually any cognitive-behavioral approach, including RFCBT, and integrated with hypnotic procedures. CCT differs from conventional psychological treatments in that it targets a biological mechanism—activity in the amygdala and decreased prefrontal cortex activity presumed to underpin rumination—rather than the symptom of rumination itself or behavioral symptoms of depression such as passivity (see Siegle, Ghinassi, & Thase, 2007). To

counteract the decrease in prefrontal functioning that is a marker of unipolar depression (see Siegle et al.), CCT uses attention and working memory exercises.

CCT is grounded in the work of Adrian Wells (2000)—who proposed that a mode of ruminative thinking is active in a variety of mental disorders. Specifically, in this thinking mode—called the cognitive attention syndrome—individuals narrow and redirect their attention to negative thoughts and threats in a repetitive, dysfunctional manner. To alleviate this pattern of thinking, Wells (2008) teaches patients the attention training technique (ATT), a neurobehavioral intervention that involves training in selective attention, rapid attention switching, and divided attention aimed at increasing the ability to flexibly and intentionally deploy attention and mitigate the singular focus on negative thoughts. Patients accomplish this by shifting attention from ruminative thoughts to present-moment awareness of sounds. Research indicates that ATT can successfully treat symptoms of major depression (Papageorgiou & Wells, 2000; Siegle et al., 2007).

According to Wells (2008), at least three competing sounds should be used in the training room (e.g., voice of administrator, tapping by administrator, clock, radio, etc.). Another six sounds should be targeted outside of the training room, or inside, but manipulated to sound distant. For the entire 15-minute practice session, which the therapist sequences, selective attention and rapid attention switching should occupy 6 minutes each (alternating from the three sounds in the room to another three sounds outside of the room), with 3 minutes devoted to divided attention (count all the sounds you can hear at one time). Patients are encouraged to practice at least twice a day for 10 to 15 minutes and often to decide with the therapist, ahead of time, what auditory stimuli they will use. In the first training session, the therapist: (a) reviews the patient's presenting problem and notes details of internal dialogue or key cognitions; (b) presents the rationale for using ATT; (c) checks the credibility of this rationale by soliciting an expectancy rating (e.g., 0 = *not at all helpful*; 100 = *very helpful*); (d) administers the ATT protocol; and (e) elicits feedback and discusses practice outside of the session.

CCT combines ATT with another task (Gronwall, 1977)—the paced auditory serial attention task (PASAT)—designed to activate the prefrontal cortex by using working memory during a mildly stressful task associated with emotional reactivity. In this computer-based task, participants listen to serially presented digits and add them on a continuous basis to tax working memory, with the instruction to get as many items right as possible to exercise executive control. The rate of stimulus presentation is adjusted based on response accuracy to promote continuous performance.

Siegle and his associates (2007) conducted a study of CCT in which the researchers first administered the ATT via computer. Participants listened to environmental stimuli (i.e., bird sounds) presented at random intervals by surround sound equipment. To improve selective attention, initially they focused on only one bird sound. Next, they directed attention to each bird sound and counted the total number of sounds, while staying focused on the computer task instead of automatic ruminative thoughts. After this exercise, the researchers administered the PASAT.

Participants who experienced CCT were able to achieve normalized activity in the prefrontal cortex and amygdala, compared to participants who received no CCT (i.e., treatment as usual). The results suggest that the adjunctive use of CCT is potentially more beneficial than conventional psychological treatments alone, such as CBT.

Hypnosis and CCT

A moment's reflection suggests that it is possible to adapt the general principles of attentional focus, selective attention, and divided attention to less artificial (e.g., computer-generated) everyday stimuli and situations. For example, we first teach patients relaxation during hypnosis, provide them with posthypnotic suggestions and teach self-hypnosis (see Lynn & Kirsch, 2006) to achieve a state of equanimity in "real life." Useful techniques include diaphragmatic breathing, generating calming thoughts, and developing physical cues of gathering physical tension and negative feelings in a closed hand and fist then releasing it unobtrusively. We then provide suggestions for increased attention and concentration in general and then on sounds and sights in the room. Borrowing from ATT, we ask patients to detect different sounds, then to switch attention as rapidly as possible from one sound to another, and finally to count all the sounds they can hear at one time. Visual or physical sensations can be substituted for sounds, which can also be presented via a tape or DVD recording. Additionally, suggestions can be given for patients to count by serial sevens in-between each breath (one breath: 7; two breaths: 14), keeping track of both the breath and the count, as an adaptation of the PASAT. We encourage patients to praise or reward themselves when they derail rumination, and to engage in goal-oriented activity or problem solving if a situation remains unresolved and the focus of lingering rumination.

ACCEPTANCE AND MINDFULNESS

Therapists who implement CCT do not attempt to engage patients in Socratic dialogue or to convince them that their negative thoughts are irrational. Accordingly, CCT is one of a growing number of treatments

that encourage acceptance and mindfulness of moment-to-moment experience. Over the past few decades, acceptance of oneself, other people, circumstances, and the world at large, has been identified as a force for personal change and incorporated into what has been described as the “third wave” of behavioral and cognitive-behavioral approaches (e.g., acceptance and commitment therapy; Hayes, 2004) and self-regulation techniques.

The core value of acceptance, so prized in third-wave approaches, has deep roots in Eastern and Western culture, with its benefits touted in religious texts (e.g., Buddhist Sutras, Bhagavad Gita, New Testament), philosophical tracts (e.g., Aurelius, Epictetus, Kierkegaard, Lao Tzu), and literary works (e.g., Austen, Nabokov, Shakespeare, Tolstoy) across diverse eras and cultures (see Williams & Lynn, in press). In the more contemporary psychological arena, typically humanistic and existential therapists, particularly Carl Rogers, are credited with elaborating acceptance as a mechanism of self-realization and therapeutic change. However, it warrants mention that Milton Erickson, a contemporary of Rogers and a pioneer in clinical hypnosis, placed therapist acceptance of the patient at the vital heart of the pursuit of therapeutic goals, sparking a tradition in the field of hypnosis that continues to this day. Erickson’s approach was a little acknowledged and underappreciated precursor of contemporary acceptance-based interventions that stress the empirically established futility of attempts to pressure patients to simply suppress and to control symptoms such as rumination (Wegner, 1997). Indeed, the cornerstone of Erickson’s utilization approach (Erickson, 1959) is the demonstration of acceptance and respect for the patient’s subjective reality and responses. From this base of radical acceptance, Erickson used highly permissive suggestions, subtly primed therapeutic responses, noticed and capitalized on small changes in the direction of valued actions, and gently guided the patient’s associations and stream of awareness (see Lynn & Hallquist, 2004). We provide an example of this approach in a sample mindfulness induction presented below. There is a clear parallel between “nondirective” hypnosis and mindfulness-based cognitive therapy we review below in which the therapist fully acknowledges and accepts the patient’s moment-to-moment experiences.

Mindfulness-Based Cognitive Therapy

Acceptance is a core ingredient of mindfulness-based approaches to rumination that have recently acquired a foundation of research support and can be artfully combined with hypnotic techniques. Mindfulness refers to purposeful, nonjudgmental attention to the unfolding of experience on a moment-to-moment basis (Kabat-Zinn, 1990/2005). As applied to rumination, mindfulness can blunt and redirect well-established negative thinking patterns.

Indeed, the goal of mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) is to train patients to “disengage from dysphoria-activated depressogenic thinking” (Teasdale et al., 2000, p. 615).

Although MBCT incorporates many cognitive techniques, it differs from more conventional therapies in that it emphasizes acceptance rather than change and makes no attempt to alter the *content* of negative thoughts. Instead, MBCT promotes a shift in the patient’s *relation* to negative thoughts by teaching participants to observe thoughts and feelings from a “decentered” perspective as ephemeral, objective events in the mind, as opposed to reflections of the self or “facts” that are necessarily true (Safran & Segal, 1990). Decentering prevents transient dysphoric moods from escalating to more persistent and negative affect instigated by rumination (Broderick, 2005). Importantly, mindfulness trains individuals “to switch out of habitual, relatively automatic, patterns of reaction into a more intentional, considered choice of response” (Teasdale, Segal, & Williams, 2003, p. 159); an emphasis that can also be seen in Yapko’s writings (e.g., Yapko, 1992, 2001). MBCT’s focus on increasing mindfulness is thought to improve participants’ abilities to consistently recognize and attenuate incipient dysphoric mood states and rumination: Mindful individuals are able to shift into a “being mode” of mind, in which they are able to observe their stream of consciousness without becoming entangled in negative thoughts or increasing their intrusions through failed attempts at suppressing them (Wenzlaff & Luxton, 2003).

MBCT consists of eight weekly, class-based sessions, which are 2½ hours in length, and one all-day practice between the sixth and seventh classes. MBCT principles and techniques taught in MBCT can also be applied on an individual basis. Between sessions, participants are expected to practice MBCT skills for approximately 1 hour a day. Through both formal and informal meditation practices, MBCT participants seek to develop their capacity for intentional, nonjudgmental awareness of the present moment. Formal practices involve mindfulness meditation exercises such as focusing attention on the breath or successively focusing attention on each part of the body (see the body scan approach in the sample induction below), walking and stretching mindfully, and doing yoga. Informal practice encourages mindfulness during everyday activities, particularly at times of emotional distress or during activities that are commonly performed on “auto-pilot” such as driving or taking a shower. Participants are instructed to note when their mind has wandered, briefly to acknowledge the contents of the mind, and then nonjudgmentally to redirect their focus to the object of attention (e.g., the breath). Participants eventually learn to extend mindfulness to a broad range of experiences (Williams, Duggan, Crane, & Fennell, 2006).

Cognitive therapy techniques in MBCT include education about the symptoms of depression, the role of negative thoughts, and the process through which rumination can fuel depression. Participants are encouraged to identify and increase their engagement in activities that improve their mood and increase their energy. MBCT also seeks to enhance participants' abilities to identify patterns of emotional response and rumination that act as warning signals of potential relapse. Finally, participants develop a crisis plan that details their warning signs of relapse and the actions they will take to prevent the onset of depression.

Among individuals with a history of three or more previous major depressive episodes, randomized clinical trials support the efficacy of MBCT for preventing depressive relapse, and research shows that MBCT is as effective as maintenance antidepressant medication for preventing relapse (Kuyken et al., 2008). When compared to maintenance antidepressants, MBCT produced superior outcomes regarding residual depressive symptoms and quality of life (Kuyken et al.). A number of smaller, nonrandomized outcome trials suggest that MBCT can be effective for decreasing symptoms of depression in patients who are currently depressed (Kenny & Williams, 2007) or in partial remission (Kingston, Dooley, Bates, Lawlor, & Malone, 2007). Further, studies have shown that MBCT decreases rumination in response to sad moods, and that these changes are mediated by increases in mindfulness (Raes, Dewulf, Van Heeringen, & Williams, 2009). Importantly, MBCT now meets the criteria for a "well-established" treatment.

Hypnosis and MBCT

The idea that suggestion can radically alter and heighten awareness and destabilize entrenched thought patterns has long been recognized in Buddhism. In Buddhist tradition, there are eight Jhanas, or states of intense samadhi (concentrated meditative absorption), which one uses or develops to supercharge and empower meditative experience, and specifically to explore, to cultivate, and even to exploit—for positive purposes such as heightened loving kindness—higher states of consciousness. These states or levels of consciousness (e.g., pleasant sensations, joy, contentment, complete peacefulness, infinity of consciousness) are "entered" through resolves, which are intentional affirmations and self-statements. The resolves can be thought of as self-suggestions to remove hindrances to meditative practice and enlightenment including sensual desire/craving, aversion, worry and restlessness, sloth and torpor, and excessive doubt or skepticism (Lama Surya Das, personal communication, June 21, 2009). Just as it is possible to suggest that a patient enter a state of hypnosis, it is possible to suggest that a patient experience enhanced attention/concentration and mindfulness, as we illustrate in the sample induction that follows.

The induction combines elements of a MBCT body scan with imagery of a special place, commonly used in clinical applications of hypnosis (Lynn & Kirsch, 2006). The first two paragraphs are adapted from Hayes, Strosahl, and Wilson (1999):

You have been you your whole life. Whether you think of something that happened last year, or last minute, it was always you who were noticing, you who were aware, you who are aware today. Notice now how your experience and your awareness are constantly changing. Perhaps you are aware of sounds in the room that you did not notice a few minutes ago. Perhaps some of your muscles are more relaxed than they were when I started speaking to you. Your body may be tired or rested. Are you rested now and comfortable, a bit tired, or are you alert and attentive? Moods come and they go, your thoughts are constantly changing. Even as I have spoken, things have changed, most of which you are not aware of, but some of which you may be aware of now, like the gradual slowing down of your breathing, or has it sped up ever so slightly? Even as I speak, things change, if ever so subtly. But there are some changes you may be aware of now, like the gradual slowing down of your breathing, or has it sped up ever so slightly?

And as you notice shifts—subtle though they may be—in your thoughts, sensations, perceptions, feelings—you notice that you are the one noticing, witnessing. You are more than your body, more than your roles, your emotions, your thoughts, these things are the content of your life, while you are the arena . . . the space in which they unfold. You will always be there. What you think at any given moment is not the measure of who you are, or your life. Just notice the experiences in all aspects of your life, notice how they come, they go, as your breathing rises and falls . . . be aware of so many things, stay in contact with whatever arises, and let your awareness flow with each suggestion you receive, and know who you are will remain secure . . . let thoughts come, and let thoughts go, let feelings come, let them go, just be aware, and notice how your awareness changes from time to time, as you experience the suggestions, just be aware, moment to moment of your experience during hypnosis, bring this mindfulness to your experience of hypnosis and after our session today, letting the experiences come and go, flowing with them, paying attention to them, but not attached to them. Just notice, observe, and be aware, of your ever-changing, moment-to-moment experience, as you enjoy your hypnosis with compassion for yourself if your attention wanders. Just bring it back to your experience.

Continue to be aware of your moment-to-moment experience . . . and each time you exhale, you can feel yourself becoming more and more aware . . . more and more aware, and your strong intention to be mindful of all your experiences, your powerful resolve. Choose to be mindful, to pay attention to how your attention is sometimes more focused than at other times. Feel yourself becoming more and more aware, more centered within yourself, more balanced, more and more deeply aware . . . open to all your experiences, knowing they will come and go. Be aware of your body. Just begin to feel your awareness spreading . . . aware of

all of your experiences, let your thoughts come, and let them drift away, like clouds in the wind . . . dissipating . . . breaking up . . . more and more . . . and then reforming into something new and different . . . new thoughts and feelings, you feel more and more in tune . . . perhaps even more secure, balanced, and centered, as you become so deeply involved in hypnosis . . . I will give you suggestions to be aware of different parts of your body. After you focus on each part, take an easy breath and as you exhale, release your awareness of that part of your body, and let your awareness flow with my suggestions to the next part of your body. Start with awareness of your toes . . . yes, that's right, your right toe . . . and your left toe. More and more aware . . . dialed into your experiences . . . more and more . . . more and more. And let your feet become the object of your attention . . . more and more the object of your thoughts . . . as you feel attuned, in the moment, aware and in the moment, in touch in the moment, deeper and deeper. . . . Now your ankles and your calves. Perhaps you can begin to be aware of a sense of warmth in your ankles or your calves . . . or perhaps it is a cool feeling . . . or even no feeling at all. Becoming aware of whatever it is that you are experiencing in your ankles and calves. Living in the flow. Let the beacon of your awareness spread to your thighs . . . your thighs can be the subject of your attention. . . . And notice your pelvis. . . . Now pay attention to your stomach. Can you focus your attention on it completely, or does your mind wander . . . can you notice how it feels now, or a bit later? And let your awareness move to your chest. Can you notice the muscles in your chest . . . feel your awareness come alive as you notice different things in the present moment . . . your body and mind so aware and attuned. And now center your attention on your back and your shoulders. Do they feel at ease as your body relaxes? Or perhaps you are aware of something else. Just flow with your awareness, with your experience of the moment.

Focus on your arms, down to your hands and your fingers. Focus on the feelings in your arms and hands. Focus on your right upper arm . . . right lower arm . . . your right hand . . . and fingers . . . do your fingers feel more heavy than light, or more light than heavy . . . aware . . . more and more attuned . . . just as completely in the moment as you can be. And now your left upper arm, left lower arm, your left hand . . . and fingers . . . pay attention, notice whatever you can. Stay tuned.

What can you notice when you zoom in on the muscles of your neck? . . . Just go there . . . are the muscles heavy and relaxed? Or do you feel something else? What is it you notice? And now pay attention to your jaw muscles. Be aware of all the rest of the muscles in your face . . . your mouth . . . nose . . . eyes . . . eyebrows . . . eyelids . . . forehead . . . all the muscles at ease . . . or is it something else you are aware of?

You can bring your moment-to-moment awareness to what you imagine. For now, you might like to imagine being somewhere very special. I like to imagine lying on a quiet beach on a warm sunny day, with a beautiful blue sky and just a few billowy clouds floating by . . . I can imagine feeling a soft gentle breeze . . . smelling the salt sea air . . . but you can imagine being anywhere you like. It might be someplace you've been . . . or someplace you'd like to be. Or just a place in your imagination.

It doesn't matter . . . all that matters is that you tune your mindfulness to this place. Wherever it is, it is . . . someplace where you can just be you . . . where you can feel just what you feel, moment to moment, accepting yourself, with compassion for yourself, with deep understanding and empathy. And you can imagine yourself actually being there . . . seeing, in your mind's eye, the things that you would see if you were actually there now . . . feeling the things you would feel . . . moment to moment . . . hearing the sounds you would hear . . . smelling the smells, moment to moment.

And while you are mindful of this place, I am going to count from one to ten. And with each count you can drift more and more fully into a deep state of mindfulness . . . more and more . . . able to experience whatever you experience. One . . . drift, drift and deeper . . . two . . . more and more centered, and balanced . . . three . . . four . . . deeper and deeper . . . five . . . half way there . . . six . . . seven . . . even deeper than before . . . so deep that you can be mindful of whatever you experience . . . eight . . . nine . . . ten . . . very deep now . . . very deep . . . completely at one with yourself . . . as completely mindful as you would like to be.

To cultivate acceptance and mindfulness and to decrease avoidance of thoughts and experiences, clinicians can pepper suggestions into inductions like the one above or even create separate inductions based on the following facets of acceptance (Williams & Lynn, in press): (a) nonjudgment (i.e., conscious abstention from categorizing experiences as good or bad, right or wrong; just because you feel bad, doesn't mean you *are* bad); (b) tolerance (i.e., remain present and experience whatever is occurring in the moment, even if sad or angry; do not become discouraged if attention inevitably wanders); (c) willingness (i.e., consciously choose to be mindful and accepting of experience); (d) nonattachment (i.e., accept what cannot be changed, know limits of ability to control outcomes); and (e) nonavoidance (i.e., develop courage to confront life's challenges; experiences are impermanent, be aware of change).

Hypnotic metaphors such as the following, which emphasize the evanescent or temporary nature of thoughts, including ruminative thoughts, can be employed to facilitate a decentered perspective: Imagine that your thoughts are written on signs carried by parading soldiers (Hayes, 1987). Notice that thoughts "continually dissolve like a parade of characters marching across a stage" (Rinpoche, 1981, p. 53).

Treat your thoughts as clouds. Imagine your thoughts printed on them and allow them to occupy their own space as they pass by. . . . Imagine that each of your intrusive thoughts is a nonstop passenger train passing through a station. There is no point in trying to stop it or trying to climb aboard. Just be a bystander and watch your thoughts pass through. (Wells, 2005, p. 349)

Observe your thoughts as if they were leaves floating on a river, watching them from the shore as they pass by, rather than swimming

with the thoughts and getting caught up in the currents. These metaphors reinforce the idea that ruminations are mental events that “occur within the self, but are not the self.” That is, we are not what we think, but we are the arena in which our thoughts take place, as expressed in the above induction (Williams, Hallquist, Barnes, Cole, & Lynn, in press). The following hypnotic suggestions and approaches also promote decentering and mindfulness:

1. To interrupt intense self-focused ruminations (e.g., I, I, I; me, me, me-oriented thoughts), think about anything that does not involve the self as the main subject (e.g., dogs, the sky, big ears, a door knob).
2. Watch the breath rather than think about it; should ruminative thoughts occur, parse the mental flotsam and jetsam into discrete sentences (“I am a terrible person”), repeat them to the self and state, “That’s just a sentence I observe myself thinking, is there anything I need to do?” Count such “mental sentences,” note whether they are attached to particular thoughts or self-criticism without lingering on any particular mental content and then return to breath awareness or awareness of sounds or physical sensations for several minutes.
3. Mentally replay key ruminative thoughts (e.g., “It’s terrible I’m so depressed and can’t get anything done”) and hear them as if broadcast by radio, until you are ready to turn the mental channel on the radio to another station.
4. Label emotions, thoughts, and body sensations as they arise, while “letting them pass.” When you find yourself caught up in the content of your rumination and the emotions associated with this, shift your attention by labeling your experience (e.g., “thinking,” “thinking,” “anxiety,” “anxiety”) and then simply return your focus to the breath. Alternatively, as per Linehan (1993), observe the parade of thoughts without becoming absorbed in any of them. Imagine that the mind is a conveyor belt. Thoughts, feelings that come down the belt are observed, labeled and categorized.
5. Be mindful at certain times of the day at specific intervals, notice the ebb and flow of experience when engaging in particular activities such as eating meals and in “high risk situations” when confronting or contemplating events typically associated with rumination.

Perhaps the most difficult challenge in administering MBCT is motivating participants to follow the treatment protocol. MBCT requires intensive home practice that many participants struggle to perform on a consistent basis. Indeed, Segal and colleagues (2002) originally designed MBCT for individuals in remission because it was thought that meditation would prove too difficult for patients deeply entangled in rumination. In our experience, the approach described above, especially developing mindfulness inductions with motivational suggestions, can mitigate, if not eliminate, impediments to mindfulness practice.

CONCLUSIONS

A variety of cognitive behavioral, attention, and mindfulness techniques can be combined in what we expect will prove to be a potent package for treating rumination. The union of hypnosis and mindfulness/attention-control techniques, at face, seems to be a natural marriage with excellent prospects. Of course, empirical work will be necessary to evaluate the integration of these techniques and traditions in the treatment of rumination. However, given the ability of hypnotic techniques to modulate attention, imagination, and motivation, we have reason to be optimistic that future investigations will document the ability of hypnosis to improve therapy outcomes, to promote the generalization of treatment effects, to improve treatment compliance, and, hopefully, to reduce or eliminate the need for pharmaceutical interventions.

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Hypnose, Rumination und Depression: Katalyse von Aufmerksamkeits- und Achtsamkeits-basierten Therapieansätzen

Steven Jay Lynn, Sean Barnes, Amanda Deming und Michelle Accardi
Zusammenfassung: Über die letzten 30 Jahre hinweg haben Praktiker, ermutigt durch strenge empirische Studien sowie Literatur- und metaanalytische

Übersichten, zunehmend die Fähigkeit von Hypnose anerkannt, Aufmerksamkeits-, Imaginations- und Motivationsprozesse im Dienste therapeutischer Zielsetzungen zu modulieren. Dieser Artikel beschreibt wie Hypnose als Zusatzprozedur bei der Behandlung von depressiven und ruminativen Symptomen eingesetzt werden kann. Der Schwerpunkt liegt dabei auf aufmerksamkeitsbasierten Therapien, die die ruminationsfokussierte kognitiv-behaviorale Therapie einschließen. Die Autoren liefern zahlreiche Beispiele für Techniken und Ansätze, die therapeutischen Fortschritt herbeiführen können, darunter eine Induktion, die Achtsamkeit zu fördert und praktisch einübt. Obgleich Hypnose Aufmerksamkeit und Achtsamkeit zu befördern scheint, ist weitere Forschung notwendig, um ihren zusätzlichen Nutzen zu dokumentieren.

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L'hypnose, la rumination et la dépression: Catalyser les traitements fondés sur l'attention et la concentration

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Résumé: Au cours des 30 dernières années, les thérapeutes de la santé mentale, encouragés par des études empiriques, par des analyses documentaires et par des méta-analyses rigoureuses, ont de plus en plus apprécié la capacité de l'hypnose de moduler l'attention, l'imagination et la motivation aux fins d'objectifs thérapeutiques. Cet article décrit comment l'hypnose peut être utilisée comme procédure adjuvante, particulièrement dans le traitement des symptômes de la dépression et de la rumination. Cette procédure porte sur les traitements fondés sur l'attention, et comprend la thérapie cognitivo-comportementale axée sur la rumination, l'apprentissage du contrôle cognitif et la thérapie cognitive basée sur la concentration. Les auteurs fournissent de nombreux exemples de techniques et de méthodes susceptibles de faire progresser le traitement, y compris une induction hypnotique visant à faciliter la concentration et à encourager la pratique de celle-ci. Bien que l'hypnose semble être un catalyseur prometteur d'attention et de concentration, de plus amples recherches sont nécessaires pour déterminer la valeur supplémentaire de l'ajout de l'hypnose aux traitements étudiés.

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Hipnosis, ruminación, y depresión: Tratamientos basados en catalizar la atención y presencia mental (mindfulness)

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Resumen: Durante los últimos 30 años, profesionales de la salud mental, alentados por rigurosos estudios empíricos, literatura especializada y reseñas meta-analíticas, han apreciado cada vez más la capacidad de la hipnosis para modular la atención, imaginación y motivación en el servicio de objetivos terapéuticos. Este artículo describe cómo la hipnosis se puede utilizar como un procedimiento auxiliar en el tratamiento de la depresión,

en particular los síntomas de ruminación. Nos enfocamos en tratamientos basados en la atención que incluyen terapia cognitivo- conductual basada en la ruminación, entrenamiento de control cognitivo, y terapia cognitiva basada en la presencia mental (mindfulness). Los autores proporcionan numerosos ejemplos de técnicas y métodos que potencialmente pueden aumentar los beneficios del tratamiento, incluyendo una inducción hipnótica para facilitar mindfulness y motivar su práctica. Aunque la hipnosis parece ser un catalizador prometedor de atención y mindfulness, se necesita investigación que documente el valor incremental de añadir hipnosis a los tratamientos mencionados.

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