Hypnosis and Transference in the Treatment of Depression

SUSANNA CAROLUSSON, M.Sc., lic. psychologist, lic. psychotherapist works in private practise with psychotherapy and hypnosis. She is responsible for the SSCEH advanced psychotherapy education, as a director and teacher. She is an often invited guest lecturer at the University in Gothenburg. She also works as a consultant for leadership training, stress management, group relations and assessments for the Ericsson Company (Business Radio, not Milton)

ABSTRACT

Depressive clients often have an extremely negative self-image and their symptoms can be very persistent. My rationale for using hypnosis with the depressive client is that by focusing the attention on defensive functions and resources beyond the depression and being ready to contain unbearable emotions causing the depression, a confirmation of the client as a whole person becomes possible. Because of distrust and negative transference, trance inductions must be extraordinarily idiosyncratic and sometimes indirectly communicated or postponed.The case presentations illustrate some typical transferential communications, how they can be handled and some possible conclusions.

ZUSAMMENFASSUNG

Depressive Patienten haben oft ein extrem negatives Selbstbild und ihre Symptome sind sehr hartnäckig. Meine Begründung für den Gebrauch von hypnose bei depressiven Patienten ist, daß durch Fokussierung der Aufmerksamkeit auf Abwehrfunktionen und Ressourcen außerhalb der Depression und das Ertragen der starken Emotionen eine Bestätigung des gesamten Persönlichkeit des Klienten ermöglicht wird. Aufgrund von Mißtrauen und negativer Übertragung müssen die Tranceinduktionen oft sehr idiosynkratisch, indirekt und subtil sein. Die Fallbeispiele illustrieren einige typische übertragungsspezifische Kommunikationen, zeigen auf, wie damit umgegangen werden kann und welche Schlüsse daraus gezogen werden können.

SAMMANFATTNING

Depressiva klienter har ofta en extremt negativ självbild och symptomen kan vara mycket ihållande. Om man vill använda hypnos med depressiva klienter, är det nödvändigt att uppmärksamma försvarsfunktioner och resurser bortom depressionen och vara beredd att härbärgera de outhärdliga känslor som orsakar depressionen. Därigenom kan klienten bekräftas som en hel person. P.g.a. bristande tillit och negativ överföring behöver trance-induktioner skräddarsys, kommuniceras indirekt och ibland skjutas upp. Fallbeskrivningarna visar hur överföringen tar sig uttryck i kommunikationen, hur detta kan hanteras och vilka slutsatser man kan dra.

KEY WORDS: Depression, Hypnosis, Negative self-image, Transference.

INTRODUCTION

When I studied hypnosis in the late seventies one of the few traditional contra-indications for hypnosis was depression. I believe the reason was that the depressed state is extremely passive and introverted, very similar to the common apprehension of conventional hypnosis. The depressed client doesn't need more of the same, but the opposite; extroverted activation.

However, hypnosis as an introverted state is only partly true, because in clinical hypnosis, the expe-riences are communicated to a therapist and used in a dialogue. And even if the images are suicidal, an experienced psychotherapist can use them constructively.

And is hypnosis a passive state? I claim it is not, because hypnosis as it is used in psychotherapy, e.g. hypnotic ego state therapy, guided imagery etc., eventually engages and activates the client in the therapeutic task.

Milton Erickson has contributed brilliantly as a role model on the art of finding and utilising the most unexpected resources in clients, who have got stuck in their old patterns. Erickson's work is most known through his adepts, e.g. Steven de Shazer, who wrote ”Most of the ideas for 'unusual interventions' ...in fact came from the clients themselves! Fortunately, we were cleverly listening when they told us what to do” (de Shazer, 1994).

One of our first authorities in the Swedish hypnosis education was Joseph Shorr. He wrote: "When depression lifts, imagery returns." (Shorr, 1974). Does this statement mean that as long as there is depression, images are not available? No, according to my clinical experience, images are never lost, but are often as depressing as the rest of the depressed client's feelings and lack of motivation. This is a challenge for any psychotherapist and it is my opinion that without an understanding of transference phenomena, hypnosis will be of no or little avail in the therapy with a depressive client. On condition that transference phenomena are given proper attention, my experience is that hypnosis and imagery can be of great help in a psychotherapeutic working relationship.

On diagnosing depression

Depression is a diagnostic concept, which means something to the person using it. In order to make an academic discussion possible several attempts to define ”depression” have been made. The diagnostic and statistical manual of mental disorders, DSM, is one of these attempts. The diagnostic categories in DSM-IV are deducted from how clients present themselves in order to receive the diagnosis, according to experienced psychiatrists.

In DSM-IV you will find the criteria for depression under Mood disorders and Depressive syndromes. Criteria are defined as: Feeling sad or empty most of the day, most days; no engagement in activities; change in appetite and /or weight; sleep disturbances; loss of energy; loss of concentration and decisiveness; and also suicidal thoughts, plans or attempts (APA, 1994).

In psychotherapy, a diagnosis is too shallow without at least a hypothesis on aetiology. In my clinical experience, I have found evidence for the psychodynamic hypothesis that early relations influence self-image, coping and defensive operations later in life. Martin Seligman's experiment with dogs is one of several convincing publications on the immense impact of earlier experiences upon later coping mechanisms. The dogs had been exposed to pain and restrained from stopping or escaping the pain. When finally released, they did not use the chance to escape! Seligman's observations was that human depression had similar qualities, and after having interviewed a selection of psychiatric patients with the diagnosis of depression, he draw the conclusion that most of them seemed to suffer from ”learned helplessness” (Seligman, 1975).

Depressive behaviour and mood sometimes cover repressed trauma and associated guilt feelings. Bowlby (1980) discussed the high correlation between loss of a parent figure, by death or separation, and neurotic or psychotic depressive disorders in adult life. ”…we have considered evidence that suggests that those who have lost a parent by death during childhood or adolescence are at greater risk than others of developing psychiatric disorder and, more especially, of becoming seriously suicidal and/or psychotically depressed”. According to Bowlby, losses can be traumatic separations as well as death, and the loss affects the perception of self and others: ”the depressed person not only wishes to see the other as perfect but in actually doing so is regressing to a childhood condition in which, it is contended, a child is incapable of seeing his parents in any other light (...) the depressed person has to direct all criticism away from his attachment figure, perhaps towards himself, because his aggressive tendencies are excessive.”

This biased perception is described in a coherent theory on dissociated and repressed trauma behind clinical chronic depression by Emmy Gut (1989). In a discussion on the difference between depression, mourning and anxiety, she wrote: ”Being depressed signals that in some way we are lacking in awareness of what causes us distress or what can be done about it”. ”Being unable to become aware of anger or contempt or to express such feelings, presents a normal cause for depressed reactions. (...) The depressed response may serve to maintain denial instead of facilitating intensified information processing leading to insight”. ”Amnesia and a multitude of other cognitive and emotional disturbances are at times the result of exposure during the formative years to incest or other sexual abuse, particularly if this exposure is ignored or denied by attachment figures. The origins of these patterns being hidden creates powerful cause for overt chronic depression or for any variety of

avoided depression".

So, as a complement to the DSM diagnosis, which takes in account only the symptoms, a psychodynamic perspective also suggests an aetiology of learned self-image and defence mechanisms, which gives us a useful model for treatment planning and for understanding transference phenomena as they occur.

Transference and countertransference in therapy with the depressed

In psychoanalytic theory, clients are showing therapists their story of trust and distrust; their introjected drama of early relationships; their hopes and fears, and they are doing it by repeating these dramas with the therapist, by transference. It is a complicated task for the therapist to react correctly to these patterns of communication, because the normal human reaction would be to take an expected role from the client's inner scenario, and then act as expected (counter-transference). Thus the client becomes the director of the scenario, repeating a self-fulfilling prophecy.

In order to avoid the trap of repetition, therapists must discriminate between clients' therapeutic needs and clients' habits of testing others through repeating earlier relational patterns of a destructive nature.

Emmy Gut wrote: "one of the many features of the relationship with their parents that depression-prone people repeat in interaction with their therapists is their getting caught in a conflict between, on the one hand, wanting to judge the therapist objectively and, on the other, wanting to leave well enough alone, idealize the therapist, and take the entire blame for anything that doesn't feel right in the therapy" (Gut, 1989).

In "Psychoanalytic Diagnosis", McWilliams wrote: (Depressive clients) "attach quickly to the therapist (...) work hard to be good (...) tend to idealize the clinician." And further: "Depressive clients are subject to the chronic belief that the therapist's concern and respect would vanish if he or she really knew them. This belief can persist over months and years". Eventually the depressive client starts trusting the therapist enough to exhibit the deeper distrust. McWilliams described this excellently: "As depressive patients progress in therapy they project their hostile attitudes less and experience them more directly in the form of anger and criticism toward the therapist. At this point in treatment, their negativity often takes the form of communications that they do not really expect to be helped and that nothing the therapist is doing is making a difference." Her advice is: "It is important to tolerate this phase of treatment without taking their criticisms too personally." This is not an easy task. Common countertransference reactions working with depressive clients are, according to McWilliams: "from benign affection to omnipotent rescue fantasies (...) the therapeutic fantasies is that one can be God" or "One feels demoralized, incompetent, blundering, hopeless, and in gene-ral 'not good enough' to help the client." (McWil-liams, 1994)

Bowlby has discussed the depressive persons habitual stereotype ways of interpreting information and events in a negative pessimistic manner. After some time in therapy, the client's self-image may change: "instead of his remaining a doormat, he rebels". Bowlby also described typical patterns of transference: "he can have little confidence that he will receive kindness or comfort from relatives or others. Not only that, but he may well believe that he will receive, instead, blame and punishment (...) extremely hesitant in responding to offers of help; and he will be apt to misinterpret a potential comforter's approaches. Criticism and rejection, or a predatory intent, will be seen where none is meant" (Bowlby, 1980).

From my clinical experience I have acquired the belief that every client has an unconscious script for what he needs from a therapist in order to change bad, old patterns, and my experience is that severely depressed clients need long term therapy. I am convinced that these clients are sensitive to the therapist's ability to understand this and to the therapist's ability to endure anxiety, despair and helplessness.

The depressive client, as soon as he feels there is hope for help, will intensify the repetitive transference and thus test the therapist's ability to withstand the authority and power of early relations. These transferential scripts are often of the kind that will tempt the therapist to behave like those people from the past, who failed to respect and explicitly confirm the strength of the clients despair, needs, terror and shame.

Hypnosis and the depressive client

20 years ago, when I started studying hypnosis, we were taught that when it came to depression, hypnosis was

contraindicated.

When searching for the reason why hypnosis should be avoided with the depressed clients, I find very little material that gives a coherent explanation supporting such an opinion.

In a chapter on the decision to employ hypnosis, Meyer (1992) listed some negative indicators, e.g.: masochistic self-defeating pattern and severe characterologic depression. In the same book, in a chapter on depression, he presented a rationale for employing hypnosis with the depressed: ”to motivate and energize such clients, reduce phobic anxiety, and facilitate cognitive restructuring. It may also be used as an adjunct for clients with suicidal ideation and those suffering from bereavement.” Hypnotic interventions in cognitive-behavioural therapy are describ-ed in detail, e.g. with the purpose to restructure nihi-listic cognitions. The hypnotherapy approaches described are quite technical and the transferential influences on the therapy are hardly mentioned.

Daniel Brown and Erica Fromm have discussed low motivation as a possible contraindication, but they also claimed that low motivation can be a manifestation of deep despair. The specific roots of a given client's despair may be the initial evaluative task to uncover, with or without hypnosis. The authors are more explicit when warning against using hypnosis with manic-depressive illness: ”any psychological intervention, is useless during a manic or a major depressive episode.” ”However, hypnosis can be employed during remissions, although with great caution. The interpersonal difficulties of patients with manic-depressive illness make hypnotizing them technically complicated (...) The naive use of hypnosis with such people may all too readily play into their unrealistic expectations.”

The authors also warn against potential dangers with certain diagnoses, such as ”compulsion neurosis, multiple personality, alcoholism and substance abuse, posttraumatic stress disorders, and in some psychotic and most border-line patients”...”in these cases it should be employed only by a highly skilled expert, using the right approach at the right time.” (Brown and Fromm, 1986).

From my clinical experience, I have realised that depressive clients on the psychotic level of personality organisation may lack the ego-strength required to cooperate in imagery. They might even lack communication abilities on a verbal level and be stuck in a primary process language (imagery), making their personal symbols represent their only means of communication. The psychotic client can be understood as a person being overwhelmed by images. These images sometimes intrude upon the reality perception; therefore there is no need for inducing hypnosis. These clients already are in a trance state more than wished for. But a psychotherapist who is well trained in using imagery and hypnosis will probably be more creative in communicating on an imaginary level, than a therapist without such experience.

The issue of imaginary communication on the psychotic level is well elaborated in a book on imagery and psychotherapy (Horowitz, 1983).

Contraindications for hypnosis should perhaps not be focussed on diagnoses and symptoms. Maybe an interactive perspective on contraindications is all we need? Such a perspective has been indicated by Wormnes, Hillestad and Wikström in a Scandinavian book on hypnosis. They claimed that: ”If hypnosis is practised by a well trained and experienced therapist with a psychotherapeutic background and education, we can't see any contraindications against the method, except for those we can find in ordinary psychotherapy practise and psychological theory.” (Wormnes et al. 1992).

A psychological theory includes the possibility of dynamic (functional and interactional) aspects of symptoms and these aspects as they are described by Nancy McWilliams have certain implications for the practise of hypnosis and psychotherapy. McWilliams discussed psychoanalysis and the benefits of the lying down position: ”Freud (…)quickly learned that there were serendipitous benefits to this innovation”(...)”The supine posture relaxes people, inducing a more flowing kind of consciousness, now understood as a mild trance, comparable to that evoked in light hypnosis”.

But the depressive patient's eagerness to please the therapist demands that he can check the therapist's reactions. This need to observe can be very urgent and in conflict with the introspective trance state. McWilliams wrote: ”Their (the most disturbed depressive patients) presumptions of their unlovability and terrors of rejection are so profound and ego syntonic that without the freedom to scrutinize the therapist's face

and invalidate their worst fears, they will be too anxious to talk freely." (McWilliams, 1994)

Conclusively, one contra-indication for hypnosis may be when the negative transference is immense and gains on being dealt with verbally and directly in the therapeutic relationship. The therapist will have to listen carefully to the client, in order to know.

Case 1,
illustrating the early transference

A client contacted me for guided imagery after having listened to my giving a lecture on hypnosis. She was in a process of doing a good introspective work on her own, but had come to an impasse, empowered by helplessness. She only asked for a few hours with me. She had previously had years of helpful psychotherapy and wanted to manage her life without another long period of therapy. She apparently had the required motivation and ego strength for a short time-limited therapy. She experienced an intense regression to early memories, relived them from a child's as well as from her empathetic adult perspective, felt relieved and strengthened, made some constructive decisions and felt confident after only a few sessions!

We reserved a follow up session and we made the agreement that she could cancel in case she felt no need of that session. She cancelled it and I believed this was one of those cases that could be regarded as "a few hours successful cure".

A year later she came back with the same request – a few hours just to get the courage and strength to be in charge of her own life. I agreed. This time however, she used her preliminary follow up, entering my office in a suicidal state. We continued psychotherapy and she experienced me as rejective. Actually I liked her and knowing her background I understood that her unconscious script was to show me her self-image of being a detestable three year old girl, who now repeated and enacted a destructive relationship. In this phase, hypnosis was postponed and imagery was used only metaphorically.

An example of the metaphoric use of imagery is, when after some time the client told me she had experienced herself as either a black devil or a white saint, but now she was ordinary grey. I said: "Yes, that's development: first you can only discriminate black from white in order to survive, then you become safer and discover the huge field in between, experiencing that as grey. Then you will realise that nothing is really grey, but have all the colours of the rainbow."

The strong transferential situation gave me material enough to react upon with empathy and understanding. As she gradually understood her reactions as transferential, she started trusting me. Then she told me why she had not used her follow up session the previous year: The improvements had not lasted and she didn't want me to know she (!) had failed!

Case discussion

The case illustrates how hypnosis sometimes must be apprehended or modified, in order to take care of the distrust inherent in the depressive client. Had I, on her second therapy with me, insisted on traditional hypnotic work (which was successful a year earlier), I would have resembled her relative, who was more attentive to her own needs, than with the child's.

There was no immediate need of any hypnosis – she merely needed my accepting her feelings, as they gradually differentiated from suicidal, to love and hate and finally to nuances.

She blamed herself for having had a relapse after our first short therapy. From my clinical experience, I believe there is a pattern: To blame themselves is typical of depressed clients, unlike the narcissistic or borderline characters, who would rather blame a failure on the therapist.

If you are able to handle the transference and countertransference, the client may trust you enough to be

refractory, show dissatisfaction and testing your patience. I regard it as a good sign, when the client seems determined not to be compliant, but to be honest. The depressive client already knows too well how to follow instructions, and needs something else from therapy. Therefor the therapeutic imagery must often be conducted in a conversational, Ericksonian and very idiosyncratic style.

As a client, described in the third case below, said to me: "I don't want you to tell me how to do. I could easily be a perfect patient and hypnotic subject, but I have been role-playing all my life and I don't want to waste my time here, repeating the compliant pattern."

Case 2,
illustrating the tendency to comply

A depressed client of mine, who in hypnotic trance discovered memories of severe and sadistic sexual abuse, after two years of painful therapy told me: "I have been complaining so much lately, you must be getting tired of me".

I asked her what made her think I disapproved of her complaining - did I appear that way to her? "No, but therapists need to achieve."

I had to agree. We like to achieve and I asked her how she had got the idea that therapeutic success excludes complaining – especially when there are so obvious reasons to feel sad.

She referred to her previous therapist, who had become impatient with her, when she after six months of hypnosis and a few terrifying remembrances of abuse, did not react as cured by these crucial insights. Her therapist had told her to stop complaining and start looking forward, enjoying life!

She left that therapist, feeling the huge discrepancy between her self-image and her therapist's ideal image of her.

Case discussion

I draw the following conclusions from this case:

Therapist's high expectations of success with hypnosis, sometimes can blur their empathy. The therapist's urge to achieve inhibits the depressive client. If you chose to learn and use hypnosis in order to achieve and be efficient, you should be extra watchful of your own countertransference. A "quick and effective" treatment can be rewarding to your career, but can leave the depressed client in an old pattern: eager to please, eager to be loved, not for what she is, but for how well she can act as a good patient.

Consequently, if your client starts trusting you and invites you into the search for her real self, she might oppose anything you suggest, just because you made suggestions. She may not yet know how to listen inside, how to reflect, how to know her needs, she may however feel that following your directives makes her feel stuck in an old pattern.

So, although you might know that your hypnotic methods are excellent, it is your respect for the oppositional part of the client that makes possible a working relationship.

Ego state therapy is a form of therapy, which takes into account different and often contradictory states of mind and behaviours in clients. Knowing the theory and practise of ego state therapy is of great help in using hypnosis in an activating style. The two most comprehensive and recently published text-books on the subject are written by Phillips and Frederick (1997) and Watkins H. & Watkins J. (1997).

My last case is chosen, because it illustrates how ego state hypnosis can be introduced in a conversational manner and it also illustrates some transferential phenomena and my responses to them.

Case 3, Bob

By the time of writing this, Bob has worked on his depression for 4 years with me. He asked for hypnosis and I soon realised that I had to work very non-di-rective, inducing trance in a conversational style only. Initially

presenting himself in a rigid, polite and resigned appearance, hypnotherapy resolved feelings of envy, revenge, terror and shame. Bob had been neglec-ted and had suffered from traumatic separations. Both parents had told him never to expect any happiness or success in life, convincing him he was worthless.

At six years of age Bob had been raped by a male relative, and his interpretation was that he deserved it as a punishment. He had accepted to play sex games with the man and when doing that, they were overheard by the women nearby. Bob knew this was his fault. So he deserved the subsequent rape.

We spent years of working through these recovered memories. It was painful and Bob was periodically considering suicide as a relief, but also hoping therapy would help.

Imagery was helpful: eventually he found a wise man in a hut – whom Bob regarded as a symbol for Love and Creativity. He elaborated upon his primitive hate as he identified himself with a dangerous and lonely crocodile subsequently transforming into a (less primitive) hyena. He found himself in earlier lives, repeating the traumas of being punished and sentenced to death, while trying to save innocent boys from abuse.

Bob eventually became more integrated and the most convincing sign of progress according to himself was the deep love he was able to feel towards his sons. He described his residual problems as a dissociative barrier between the feelings of love, which were esoteric and not anchored in his body and on the other hand his every-day ego and body, which felt false, playing traditional, compliant roles. He still had depressive periods, staying home from work, drinking, unable to do anything, but he had started considering these periods as less destructive, sometimes even constructive.

Bob's goal was to integrate his diverse parts into a creative self, being able to enjoy life.

He came up with a hypnotic image, which illustrated his problem: There was a part of him, the boy, who was still captured and suffocating in a wooden chest. Bob felt that he probably had to experience that boy's pain or he would never be free.

I was hesitant. What kind of request was this? A repetitive pattern of being a suffering victim or something that could lead to a relief? I invited Bob to reflect with me upon the possibility of learned helplessness, the habitual pattern of suffering and the possibility that more suffering would preserve his victim position.

But, unlike the masochistic character as described by McWilliams (1994), Bob did not insist upon suffering, but considered this hypothesis seriously, not knowing the answer.

Neither did I, but I chose to respect his urge to go through the wooden chest experience and I asked him if he wanted me to help him find that state of mind.

Bob answered: "You can't ask me such a question. You know I don't want to, that I am terrified to face what it is like."

I laughed. "This is your dilemma in a nutshell. You ask for help, you have chosen me as your therapist because I use hypnosis, and you have convinced me of the necessity to experience the captured boys terror. Then you tell me not to ask you to find the boy's state of feeling. So, I can't use any of my hypnotic and deepening techniques and stuff like that, because that makes you feel resistant." Bob smiled and agreed.

I continued: "OK, that little boy, he is captured, terrified and an obstacle to your creativity. Right?"

"Yes."

"And he is stuck in that chest. Right?"

Bob closes his eyes. "Yes."

"There. In that chest. How does he feel in there?"

"Terrible. I have tried to reach that feeling at home. I imagined you to be outside the chest, saving me if I was about to die. I do trust you, but I feared you would die from a heart attack and I would not be rescued."

I moved my chair closer to Bob. "Well now I am sitting here very close to you. .... I don't know whether the little boy knows I am here."

"I can almost feel it.." (Not addressing my presence, but the boy's pain).

After a silence, obviously distressed: "………It is impossible to stay in my body, in such pains. I now can feel leaving my body."

"And that is an old feeling?"

"Yes, you cannot stay in that state - you fall to pieces."

I confirmed his experience with my theory, that he probably would have become fragmented (psychotic), had

he not left his body (dissociated).

The next session Bob told me that he had been closer to the trauma than ever before, that the chest had to do with the rape and that something important was going on, although he could not tell exactly what.

Bob said the boy felt exhausted. He had gone through so much pain and he really needed a rest. I welcomed this as a progress, because the boy had not been willing to rest in my room before. Bob found out that the boy had been opposing success and health. Any progress Bob made, made the boy fear he would be left behind and never confirmed.

I used the opportunity to reach the boy: “Do you think the hut could be a nice place for the little Bob’s rest?“

“Oh yes!“

“And the wise man, is he there?“

“Yes he is there, but not literally. He is there somehow and that is good enough.“

After a long silence he concluded: “I feel something is different.“

The following session Bob told me that the little boy had been a real nuisance to him and had made him so obstinate that he, Bob, had stayed home from work all week. Bob asked me to take care of the boy until next session, so that he himself could have some rest.

I accepted.

The following session Bob informed me that when he had left the boy with me, the boy had felt abandoned. The boy believed that I wanted him to be normal, to play and have fun, but he knew he could not enjoy anything, until I had fully understood how injured he really was. Before being happy, he had to show his anger and vengeance.

Case discussion and general tips

Hypnosis or imagery with the depressive client often can be induced only or preferably in a conversational mode; asking questions and deepening the experience only by nondirective focusing strategies.

I have found ego state therapy worthwhile with clients like Bob. Most depressive clients have a reasonable (often adult) part that cognitively understands that the self-blame resides in a victimised part, sometimes experienced as the child. Bob’s adult part agreed with me that children always try to survive the way they believe possible and they are not to blame for the abuses or traumata.

The problem is that for many clients the adult part often has no idea as how to reach the child part, who is empowered by self-blame and convinced that he is an exception to the rule; Bob’s child part did experience himself as being innately evil.

Sometimes I ask the adult part to imagine he is a parent or a teacher or a psychotherapist to that child part. The client may find out how to approach the child, and a good therapy can be exerted in a light trance, with the client as his own therapist.

But with some clients the response may be that the child is mute or says, “Go to hell, don’t touch me!“ Or this reaction may be directed towards the therapist, as a negative transference.

The suicidal client usually has no idea of how to continue and is helplessly empowered by this uncooperative child.

Bob, like many depressive clients, could not feel any empathy with his oppositional and revengeful child part until after three years of therapy.

In such cases I may ask the client for permission to pretend the child is in therapy with me and the client is like a parent, just watching my attempts to reach the child. Clients who have the experience of being neglected or abandoned when they really needed consolation, probably enjoy my efforts to communicate with this hopeless child. I ask the client to give the child a position in my room (as a hallucination), thus making him engage in the imagery. Then I turn to the child telling him why he is there, why he is important, why his knowledge is needed and that his feelings, whatever they are, can be understood.

I ask my client to tell me the child’s reaction to this and we continue from whatever that reaction is. If the child is still mute, I continue guessing aloud about the child’s feelings. I tell the child how I would feel being in

his shoes and I try to convey my respect for his suspiciousness to me.

Since depression often includes suicidal drives, and since I work in my own private practise, I allow myself to be quite flexible with depressive clients. I accept phone calls between hours in the acute phases, as long as I feel they are not used as transferential means of testing the power of suicidal anxiety, which would make me a victim rather than a therapist. This is another aspect of the importance of understanding transference when working with depressive clients, but to develop this issue goes beyond the purpose of this article.

CONCLUSION

I introduced my article with a quote from Joseph Shorr: "With the lifting of depression, imagery returns".

Does that mean that depressed people don't have images? No, but in the depressed state of mind, they often don't find anything worth the effort, imagery included. The depressive client has a pessimistic image of himself and his prognosis, which makes him protect you from his real suffering, as illustrated in my first case example.

By helping the client to explore his images as well as his distrust, my conclusion is that:

The facilitating of imagery can assist you in explo-ring, understanding and dissolving the depression. The therapist is helped by being aware of the severe pain underlying depressive symptoms, sometimes causing dissociative defences. The therapeutic process often demands from the therapist a deep understanding of certain transferential phenomena, typical of the depressive patient: distrust, hopelessness and opposition.

Afterword

After reading my paper and allowing it to be published, "Bob" had some personal comments addres-sed to the readers.

His first comment was about love. My article as well as other professional writings he had read, miss to express the crucial importance of love. Had he not felt an atmosphere of "love in this room", Bob would not have gained any progress. He suggests that love is more important than any technique used.

Bob's second comment was about my trust in him. Had I been afraid of the intensity of his depression and anxiety, he would have given up hope. Bob gave me an explicit example of how I could have discouraged him. His initiative to contact me in the first place, was due to having encountered some encouraging literature on hypnotherapy, thus hoping I would assist him to find the state of mind that could add the missing link: hope, memories, earlier life experiences, trust, or whatever necessary for healing. My first hypnosis inductions with Bob raised all his resistances and he exhibited a total block. Had I then dismissed hypnosis as not appropriate for his problems or explained his resistance as "low hynotizability", he would have interpreted that as another personal failure and left me, discouraged.

Bob is still consulting me and he is much more integrated and self-confident than before.

References

American Psychiatric Association. 1994. *DSM-IV Diagnostic and statistical manual of mental disorders.*

ARIETI, S. & BEMPORAD, J. 1978. *Severe and mild depression: the psychotherapeutic approach.* N.Y. Basic Books. London: Tavistock Publ. 1980.

BOWLBY, J. 1980. *Sadness and depression.* London: Hogarth Press.

BROWN, D. & FROMM, E. 1986. *Hypnotherapy and hypnoanalysis.* London: Lawrence Erlbaum Ass. Publ.

DE SHAZER, S. (1994) *Essential, Non-Essential: Vive la Differèrence.* In J. Zeig (Ed.) Ericksonian Methods – the essence of the story. New York: Brunner/Mazel Publ.

GUT, E. 1989. *Productive and unproductive depression. Success or failure of a vital process.* London: Routledge.

HILLESTAD B., & WIKSTRÖM, P-O. 1992. *Hypnos i teori, metodik och terapi.* Natur & Kultur.

HOROWITZ, M. 1983. *Image formation and psychotherapy.* New York, London: Jason, Aronson Inc.

MCWILLIAMS, N. 1994. *Psychoanalytic diagnosis. Understanding personality structure in the clinical process.* London: The Guilford Press.

MEYER, R. 1992. *Clinical Hypnosis, techniques and applications.* New York: Lexington Books.

PHILLIPS, M. & FREDERICK, C. 1997. *Healing the divided self - clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditons.* London: Norton.

SELIGMAN, M. 1975. *Helplessness: On depression, development and death.* S. Francisco: W. H. Freeman.

SHORR, J. 1994. *Psychotherapy through imagery.* Los Angeles: Institute for Psycho-Imagination Therapy.

WATKINS H. & WATKINS J. 1997. *Ego States. Theory and Therapy.* New York / London: Norton & Co. Wormnes.