INTERVIEW WITH MICHAEL YAPKO, PhD

This interview was conducted by Nancy Iacono and Carolyn Manning, following Dr Yapko's workshop and keynote address at the 26th Australian Society of Hypnosis Annual Conference.

NI: When did you first become interested in hypnosis?

MY: As an undergraduate at the University of Michigan I excelled in psychology and had quite a bit of clinical experience early on. It was a very psycho-analytic school and consequently, because of the reverence for Sigmund Freud, the official attitude of the Department was 'don't study hypnosis, hypnosis is bad'. So when I had the first opportunity to, I studied hypnosis. When I was first exposed to hypnosis is was a very traditional, very authoritarian approach. Yet it was evident to me that, with a shift in therapist demeanour, there were some pretty interesting phenomena that you could elicit in people's experience. It's a long story actually, how I personally became involved in hypnosis, but anyway, at the outset, it just grabbed my attention as having some interesting potentials that wouldn't be realised in other ways.

NI: Can you tell me about the evolution of your private practice?

MY: I think that it became increasingly apparent to me that as I developed my practice, the kinds of things that I had learned as part of my clinical training were theoretically sophisticated, philosophically elaborate and utterly useless. In terms of

clinical practice, the kinds of things that real-life clients wanted were very different than the kinds of things I learned about and so my practice over the years has ultimately become more brief, more focused, more solution oriented, less interested in explanations for people's problems and much more interested in helping people move into the future with more tools, more skills and awareness on what it takes to live well. I would describe myself as an extremely pragmatic person; I don't get impressed by theoreticians; I don't get impressed by elaborate philosophies. As far as I can tell, most of what it takes to live well is pretty simple. It's just that, so often, people's backgrounds don't lead them to develop the kinds of skills that they really need to live well. My practice now is a very cognitive behavioural orientation mixed with a host of strategic, hypnotic, solution oriented methods.

CM: When did you first use brief therapy as an adjunct to hypnosis?

MY: I discovered that people generally don't come for long term therapy and they often want their problems resolved in a hurry. When I was getting started 20 years ago there was very little in the way of brief therapy, there was very little in the way of strategic therapy. It was an up-hill battle because brief therapy was somehow viewed as superficial while long term therapy was somehow viewed as profound. The accusation was, that if you were doing brief therapy then you were not really doing 'real' therapy. Yet, the task of clinicians has become more and more to produce specific results in specified periods of time, to become more accountable. Brief therapy has now come into its own and is more the norm, and it's interesting to be a part of it.

CM: Do you think the public perceptions of hypnosis have influenced clients' expectations?

MY: I know few fields that are more poorly represented to the general public than the field of hypnosis. Consequently, people typically have one of two polar responses to hypnosis. At one extreme, they are afraid of it and afraid of being controlled and manipulated and losing consciousness and all the other myths that get perpetrated – or perpetuated by stage artists or hypnotists who are lacking any depth of knowledge of their own methods. At the other extreme are people who attribute magical qualities to hypnosis. I think it's unfortunate that even to this day if you walk into a room of 25 people and you say the word 'hypnosis' 23 of them will roll their eyes and say, "Who cares?". I have just submitted a new book proposal for publication called 'The Power of Focus' that will, hopefully, get accepted and provide a deeper and more realistic perception of what the value of hypnosis really is. I don't know of anyone who's done that. The literature on hypnosis has been growing steadily in quality and relevance and yet the general public does not have any means for gaining access to the science part of hypnosis and they get misled by the art part of hypnosis. I'd like it to be the other way around; I'd like to walk into a group of 25 people and say, "Hypnosis", and 23 of them go, "Great".

NI: What do you believe are the major causes of depression in the 1990's, and how has the incidence of depression in western society evolved?

MY: Well, depression is a very complex disorder and there are many causes for depression. The primary causes fall into three general categories: biological influences; sociological influences; and psychological influences. I think that the rising rates of depression in western societies clearly indicate that there is something about the way our culture is structured that places people at a higher risk for depression. That observation is further validated by the fact that longitudinally, as societies westernise, their rates of depression, correspondingly go up. I tend to look at culture as being the greatest broad stroke influence and then individual socialisation. The latter shapes a person's psychological makeup. So if we look at the social forces that are leading to higher rates of depression, I'd say that there are quite a few. I'll name a few of the key ones. I think that the breakdown of the traditional nuclear family has given people a sense of missing the stability that they sorely need. I think that geographic mobility and the fact that people are constantly moving, getting themselves separated from their communities and their families creates a sense of isolation. I think the fact that there are more people dying of loneliness now in this terribly overcrowded planet of ours is a shame. The emphasis over the last couple of decades of glorifying the self has led to people being less empathetic, less sensitive and less socially skilled. Consequently, their relationships suffer, which is unfortunate because we know that relationships serve as a buffer against illness of all sorts, including physical and emotional disorders.

NI: You're noted for your unconventional view, that hypnosis can be used effectively and safely with clients suffering from depression. Would you comment on this?

MY: Oh, it's not unconventional any more. I suppose it was by the standards of some individuals but I don't believe that anybody's under the illusion any more that you can sit in an office with someone and adopt a position of neutrality such that you don't influence them. So, if you were to analyse transcripts of cognitive therapy, cognitive behavioural therapy, interpersonal therapy – these are the three leading modalities that longitudinal data indicate are the most efficient in the treatment of depression – you cannot help but notice that each of these therapies have common denominators involving suggestion, education, directing people to evolve new skills. From that vantage point, hypnosis is so obviously valuable as a teaching tool that I find it mystifying that it was ever separated from the larger therapeutic process.

NI: Are some people more prone to depression than others, and what are the predisposing factors?

MY: Yes, some people are more prone to depression than others. At the basic level there are marked gender differences. Women are two to three times more likely as men to be diagnosed as depressed. Certain life philosophies, also certain belief systems, certain ways of information processing do put people at risk. We know that people who

are socially unskilled, who are less capable of forming long term and satisfying attachments are at a higher risk of depression. We know people who are not good problem solvers and [not] good critical thinkers are at higher risk. When people are exposed to various problems in life that all of us face, some of us clearly move through them more easily than do others. So there are those kinds of individual history factors as well as larger cultural factors which influence depression in an individual.

NI: Do you believe that an individual's attributional style can predispose them to depression?

MY: Yes, a person's attributional style is their characteristic explanatory style for interpreting and responding to life events. Most life events are fairly ambiguous. Somebody calls you up, for example, you're not home, they leave a message on your answering machine, they do not get a return phone call right away and they're left wondering, "Why didn't this person call me back? Maybe she's mad at me. Maybe she doesn't like me any more", and their explanations, their attributions, can actually set them off to feel rejected and hurt and abandoned. But, they're doing that inside their head. It may have nothing to do with reality; the reality is that you have not even got home yet to get the message. They're already off and running with the rejection and abandonment hypothesis. So, there is, in essence, a characteristic way that depressed people tend to explain life events, particularly negative life events. What is known in the lay literature as the three P's of depressogenic attributions: Personalisation, people taking things personally that really aren't personal; the second P is Permanence, the person believing that bad times/hard times are going to endure forever; and the third P is Pervasiveness, the person globally believing it's going to ruin their entire life. As long as people react to negative circumstances with those kinds of attributions they are at a high risk for depression.

NI: How does an individual's attributional style evolve from childhood into adulthood?

MY: It is quite clear from literature that there's a very high correlation between the attributional styles of parents and the attributional styles of their children. When you're growing up, you are exposed to the explanations and observations of the people around you and it, in essence, gives you a blueprint as to how to interpret life experience. So, when you hear your dad angrily put down an entire group of people, you learn to think globally, that all of those people must be bad. If you hear your mother tell you that you didn't eat the lunch she prepared for you because you must not really love her, you start to think that people do things to hurt you personally. These are everyday life events and the perceptions and reactions of the people closest to you – namely, your family – influence the development of your attributional style. Your attributional style is largely but not entirely the product of learning from your interactions with significant others.

NI: Do you believe that there are cross-cultural differences in the manifestation of depression across societies?

MY: The evidence is abundantly clear that there are differing manifestations from culture to culture. There are still some cultures on this planet, primitive by our standards, where depression is nearly non-existent and then there are cultures at the other end of the spectrum where depression is rampant. Not only prevalence differs, but also the styles. In some cultures the depression manifests primarily as a mood disorder, in other cultures it manifests primarily as a physical problem, where the people will have a much higher incidence of psychophysiological disorders.

CM: What are your views on repressed memory syndrome and the use of age regression techniques in uncovering repressed memories?

MY: I jumped into this controversy in a big way when I published my book 'Suggestions of Abuse: True and False Memories of Childhood Sexual Trauma.' I wrote a book that I thought was very commonsense, that abuse happens, so do false allegations, some of the memories are true, some of the memories are false, and no-one really knows how to tell the difference. In that book, I provided a set of guidelines about working with people and working with people's memories. It has been made abundantly clear, through four decades of literature in the world of hypnosis, that hypnosis as a tool of psychological archaeology is not completely reliable. It's not inherently unreliable but it's not inherently reliable either. The idea of using hypnosis or any suggestive method to specifically try and uncover memories is a process fraught with danger and I would discourage it. You see, how do we know that there is a repressed memory there that we need to uncover? The problem is, can we infer a history of abuse that's been repressed on the basis of symptoms? The answer is, "No." Can you spot an abuse survivor from the way they walk, talk, sit, act or their symptom cluster? "No." And so, in order for a therapist to want to use age regression to uncover presumably repressed memories, it means that they have already arrived at the preconceived notion that there are these repressed memories to get at, and that is the danger. As soon as the therapist infers a history of abuse and then uses any technique to try and get at the memories, they are in danger of creating the very problems that they're attempting to treat.

CM: How would you respond to a client who wants to have hypnosis to uncover memories which they may have no conscious recollection of?

MY: My response is to first of all say, "No, that is not an appropriate use of hypnosis." More importantly, I then want to move into the educational phase of the process, to let the person know why what they're asking for is something that actually places themselves at great risk. By starting with the presupposition that there are memories to be uncovered, when you do hypnosis, lo and behold, up come these memories and then, of course, you don't know whether they're confabulations or authentic memories. It's very important to me that the client be educated and be made to understand that they can probably find somebody somewhere, some untrained, unskilled or ignorant

hypnotist to accommodate their wishes, but they're not doing themselves any favours by pursuing that path. My message to clients very simply, in a crystallised form, is "tolerate the ambiguity and get better anyway."

CM: ***Research using meta-analysis suggests that cognitive behavioural therapy is the treatment of choice when treating depression. I am just wondering what your views [are] of the therapists who employ, say, long term psychotherapy for treating depression and the legal implications, if there are any?***

MY: Well, you know, in late 1993, the United States Government issued treatment guidelines for the treatment of depression, to try to minimise idiosyncratic and unusual forms of treatment, given that we know so much about what does, in fact, work well in treating depression. These treatment guidelines, I think, represent a basic definition of 'standard care,' from the legal standpoint, which is a necessary part of defining what constitutes malpractice in any law suit. What malpractice is all about is not meeting the established standard of care. Well, I think we have a variety of approaches that are each effective in their own ways. Interpersonal therapy has shown itself to be equally effective as cognitive behavioural therapy. So it really depends on, of course, the kind of problems that people come in with. So it still remains a matter of clinical judgement, but it does suggest, from the long term efficacy studies, that those therapists who are still continuing to use psychodynamic approaches and long term therapies based on psychodynamic formulations are going to have a more difficult time justifying their methods when the preponderance of efficacy studies indicate so clearly that psychodynamic approaches are the weakest approaches in the treatment of depression. I think that as clinicians, hopefully, get more familiar with the literature and the treatment guidelines reach more and more practitioners, they will start to rethink what they're doing and, hopefully, take advantage of the fact that there is solid research that indicates what does work.

CM: ***Does this leave clinicians open to litigation like medical practitioners who mismanage clients' medical treatment?***

MY: It has happened, but it's exceedingly rare. There was not long ago, in fact, one law suit that was successfully waged by someone who presented for therapy for depression. This was in one of the New England states – I won't specify which – and the client was in therapy with a psychologist for six months. The psychologist never once offered antidepressant medication, even as an option, and following six months of treatment the fellow was no better off, decided to drop out of treatment, pursued treatment with another practitioner who promptly placed this person on antidepressant medications and within one month their depressive symptoms lifted, so much so that this person was more than a little angry with the first therapist and filed a law suit claiming that this therapist had not acted competently by not even offering antidepressant medication as a therapeutic alternative and successfully waged the case.

NI: Again, this is going back to your work on depression. In your keynote address today, you talked about helping clients make options for the future. How can a therapist help clients to choose options for the future responsibly?

MY: To choose options responsibly one would have to have a better than average understanding of the relationship between cause and effect, to understand the likely and even perhaps inevitable consequences of any course of action that you take. I can safely predict that if I insult you in some way that you will be pretty unhappy about that. What you see in people's behaviour over and over again is that they just react and they don't regulate their own experience by anticipating the consequences very well, and then when they face what, to my way of thinking, could have and should have been predicated as negative consequences, then all of a sudden they are hurt and despairing and in anguish about it. To me, it's like somebody who has been smoking cigarettes for 25 years thinking that they were very clever, and then when they discover they have lung cancer, all of a sudden they're hurting and despairing. I'm a strong fan of prevention – so from my standpoint, when somebody is making serious decisions, when they're addressing issues like, "Should I get a divorce?", "Should I move to another city?", "Should I move out of my parents' house?", "Should I continue in therapy?", "Should I go on antidepressant medication?", "Should I whatever?", they need to have the ability to weigh options and gather relevant information and weigh the information systematically and understand the implications of the choices that they're making. Of course, this viewpoint is very unpopular with people who say, "Oh, be spontaneous," but, I'm a strong fan of planning for as much as planning is possible. I'm also acutely aware, as some wise individual once pointed out, that life is what happens to you when you had other plans. But at the same time, when you look at people who are very successful and live well, it isn't accidental; there is deliberateness to the way that they approach things that I appreciate. So, to me, it is an inevitable starting point in therapy, to establish some realistic and relevant and worthwhile therapeutic goals and to do that means understanding the implications of those goals and what it's going to look like and what it's going to feel like and what the up side will be and what the down side will be and how to make the decisions intelligently and how to carry through when they're difficult to maintain. That, to me, is what responsibility is about. It is recognising and accepting the consequences of the courses of action you choose.

CM: On a lighter note, are you an 'X File' fan?

MY: On a scale of 1 to 10 of how much I like that show, I would say 32.

CM: Do you think the truth is out there?

MY: I don't think that Fox Mulder's ever going to find it out there, if that's what you want to know. I think that there is no absolute truth or universal truth. I think that truth is in the eye of the beholder.