Positive Mental Training

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We all accept today that education is a lifelong experience. We do not expect to leave school with all the skills we need for all our jobs for the rest of our life. And yet, when it comes to mental skills we are expected to just pick these up as we go along. We are not equipped for any of the stresses and strains we will encounter after we leave school, indeed most schools do nothing to even make us aware of how to deal with stress. The most we are likely to encounter are 'leadership skills' (if we are lucky). These mental training CD's allow us to resist the negative thoughts of depression and anxiety, and use a number of accepted psychotherapeutic tools to encourage and foster coping skills.

Positive Mental Training is a system of personal development through the acquisition of mental skills, using relaxation, visualisation and hypnosis techniques. This system was developed in Sweden by Professor Lars-Eric Unestahl of Uppsala University, based on his research done in the 1960's (Unestahl 1973). This demonstrated two fundamental points, that self-hypnosis using pre-recorded material was as effective as having a hypnotist present (hetero-hypnosis), and that regular practice increased hypnotic effectiveness. In 1970 the first mental training programmes were licensed for prescription by doctors in Sweden for stress. In the first year 27,000 prescriptions were issued. There were **no reported side effects**, hence it was removed from prescription, and has been freely available in all pharmacies in Sweden since then.

Recently Dr Alastair Dobbin a GP in Edinburgh in collaboration with the University of Edinburgh has been running a trial looking at the feasibility of using Mental Training in the treatment of clinical depression. This was a patient preference trial with patients allocated to receive mental training via self-hypnosis CD's or anti-depressants. The use of mental training for those who chose it was significantly more effective than the use of anti-depressants, and the treatment was very acceptable to the patients using it, indeed far more people opted to use self-hypnosis than to use anti-depressants, and in every case there was an improvement. This involved the use of 12 CD tracks used in sequence (Dobbin A, Maxwell M 2005).

This fits well with the recent NICE (National Institute for Clinical Excellence) guidelines, which suggest that anti-depressants should not be prescribed on their own without some sort of psychological therapy. Traditional psychological methods of treating depression (almost universally approved in the west), based on the ideas of Aaron Beck in the 1960's, focus on the negative patterns of thinking that depressed people experience, and examines the way this affects behaviour (Cognitive Behavioural Therapy (**CBT**)) (Beck *et al* 1961: Beck A 1967). The theory was simple, depressed people had a negative schema or world view which coloured their whole belief system. Thus by getting people to consciously acknowledge their negative view (encouraging **metacognitive knowledge)** they are able to resist their negative thoughts. Since Dr Beck proposed his original idea 44 years ago there has been a huge amount of research into the functioning of the depressed mind. Whenever researchers have looked for a measure of thinking style that predicts relapse effectively, they have failed when using the Dysfunctional attitudes scale (DAS) or the BDI, which are the measurement based on Dr Becks theory. The most effective predictor of relapse is overgeneralisation, so any test for a thinking style problem should be based around the tendency to over generalisation. We now know depression is not the simple expression of a fundamentally pessimistic mind, it is a complex response to stress with widespread effects on memory and mood (Brewin et al 1998: Brittlebank et al 1993). It is probably the effects on memory rather than pessimism that reflect more accurately the true causes of depression.

Positive Mental Training uses self hypnosis to focus on the positive. Research done in Cambridge and Canada has shown that it is not the *action* of focusing on the negative thinking but the ability to *experience* thoughts as separate from the self that is effective in CBT (Teasdale et al 2002). This is called **metacognitive awareness**. Metacognitive knowledge is only effective in that it increases metacognitive awareness. So it is not necessary to focus on the negative thoughts; research shows that encouraging this kind of **self critical** analytical style is **not** a good idea for empowering people and giving them self esteem, indeed that it is best to foster quite the opposite (experiential focus = low self analysis: analytical rumination = high self focus) (Watkins E, Teasdale J 2001 & 2004). If this is the case it is quite counterintuitive to encourage self-analysis. The researchers also found that by encouraging people to focus on external images they reduced low mood and despondency (Watkins E, Teasdale J, 2001). Our self-hypnosis has powerful modules of experiencing visualisation (building a positive visualisation), which simultaneously encourages metacognitive awareness without the self-analytical thinking that traditional CBT encourages, and is good for low mood at the same time. But there are many other reasons why our self-hypnosis is effective.

Many researchers since Aaron Beck have recognised that the problem with depression comes when people are *under stress*. Under stress depressed people do not have the processing power to exercise metacognitive

awareness (Teasdale J, Cox S (2001)). They accept their negative thoughts as true. The concept of the negative schema has also been disproved; depressed people have no problem agreeing with functional positive statements, and are no different to controls in this. So we believe that the reason why Positive Mental Training an even more effective way of helping depression is not only to develop their metacognitive skills but also to *give them the resources to deal with stress.* Hypnosis has been shown to be a powerful method of delivering psychotherapeutic tools (Kirsch et al 1995). These CD's deliver a number of accepted psychotherapeutic tools to encourage and foster coping skills, and the client will use those tools that fit their needs best, ***and in a way that suits them best*** (author: personal observation).

Overgeneralisation is the tendency of individuals to recall categories (– I'm no good at ball sports, rather than specific events – I had a good game of tennis with Mike last month), and is the most effective predictor of relapse. The experience of low mood (dysphoria) increases overgeneralisation (Teasdale J Cox S 2001). We have picked the most effective method of relaxation in depressed individuals, Jacobson relaxation, which by exercising the body sequentially means relaxation is experienced rather than sought for, which directly reduces low mood (Laverture N et al 2001). We make this a positive experience and then give the individual a trigger to be able to instantly rediscover it by a Pavlovian reflex. Fundamentally relaxation allows us access to a better set of memories, which allows us to problem solve by boosting our self confidence. *Because the relaxation is not dependent on hypnotic susceptibility this is a positive experience even for the 10% of people who cannot be hypnotised.*

Reporting on the full data sets released in the USA in September 2002 under freedom of information legislation on fluoxetine, paroxetine, sertraline, venlafaxine, nefazodone and citalopram, the manufacturers report showed that although the response to antidepressants was substantial, the response to inert placebo was almost as great. The mean difference was 2 points on the Hamilton Rating Scale for depression. Although statistically significant, the result was not clinically significant. More than half the trials sponsored by pharmaceutical companies failed to find significant drug/placebo differences. Respected analysts concluded that there is basically no difference between antidepressants and placebo (Kirsch et al 2002) all the studies done with 'activated placebo' (placebo with side effects) completely abolished the benefit of antidepressants over placebo.

CBT is 'as effective as antidepressants' in most studies (Antonuccio D, Danton W 1995), although better at preventing relapse, but if anti-depressants are no better than placebo this is scarcely a ringing endorsement of CBT. We think that although CBT may increase metacognitive awareness its inherently self critical bias may cancel out its benefits, at least to some extent. So it is time for a new and positive approach, the approach of Positive Mental Training, where we believe we have addressed all the new research in depression and have a truly holistic and effective method of treatment, which has had a very positive outcome so far. We are able to offer simple training to any group of health professionals to allow them to supervise the use of the CD's by depressed patients. As this is a self-help program minimal supervision is usually required, availability is the key, in office hours, after the first assessment our patients only required occasional phone calls.

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