Systemic-hypnotherapeutic concepts for the cooperation with clients, defined as depressed, and with their relationship-systems: from depressing to unfolding worlds

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Abstract

This article aims in showing how an integrated systemic- hypnotherapeutic model which the author have developed, can be used effectively with clients who have been diagnosed as depressed. Solution- and competence- oriented models have become more and more influential in the last years. The author together with his collagues have been using these concepts for various years in outpatient settings and since 1995 they have applied them in in-patient-settings at the Fachklinik am Hardberg in Siedelsbrunn.

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There is a broad consensus that the development of depressive syndromes is influenced by a combination of biological, psychological and social factors. This article deals only with the aspects of the psychological and interrelation dimensions, the realm of psychotherapeutic interventions. This doesn't imply the assumption that biological factors would be of no relevance. But they are restrictions which cannot be influenced directly by psychotherapeutic approaches. Effective psychotherapy has to concentrate on all the possibilities which can be created by the autonomous potential of the partners in a psychotherapeutic cooperation. The only relevant forces for successful interventions in psychotherapy are not fundamentalistic theoretical positions but what clients make out of the interventions in their self-created ways.

Systemic therapy has its roots also in various concepts of family therapy. In the German language regions, to which also this work belongs, it was especially elaborated initially in the

„Heidelberg Group (director: H. Stierlin). In its modern form it is used not only with families but also with individuals, couples and groups.

The influence grew and it transformed into the direction of a consistently competence and solution oriented therapy. This development has it's roots in the Ericksonian Hypnotherapy who´s pioneer prepared the way for all standard concepts in short-time psychotherapy. Also other methods e.g. of the Milwaukee BFTC (de Shazer et.al.), NLP or the hypnosystemic models of competence which I propose (Schmidt 1985, 199, 1998) base on the transposition of Ericksonian methods.

Due to the limited space, important premises of this complex conceptions, which are necessary for understanding the mentioned interventions, can only be mentioned very briefly. Detailed presentations can be found in other texts (e.g. Mücke 2000, Schweitzer/v. Schlippe 1996, Schmidt 1992, 1994, 1996, 1998, Sparrer 2001). The presentation of systemic concepts will be presented very briefly.

Premises

Systemic basic assumptions

The basic interest of both systemic and Ericksonian psychotherapy lies in the so-called patterns. „Patterns" are generally described by use of associative junctures of elements concerning visual, audio, kinesthetic, olfactory and gustatory sense channels (considered as parts of thinking, feeling and acting), connected contributions and context factors, which are influenced by them. These juncture processes focus the attention onto conscious and unconscious levels and are produced by this perception and experience.

The most relevant levels of pattern-forming, on which individual subjects relate to and influence each other, and create their experiences in inter-relational contexts, can be distinguished in (see e.g. Kriz, 1992):

1) level of inner self-reflexive communication/relationship to oneself

2) level of outer-perception of subjects: how are others and context factors interpreted, valued, how is the relation to oneself etc.

3) level of relational interchange (e.g. with rules as mentioned above)

The systemic family therapy approach deals mostly with the way relational patterns are built in systems of relationships (e.g. families) and the kind of effects associated with them. A system originates from single elements (e.g. persons) which are connected in exchange processes in order to mark off their environment to reach special aims and to gain a differentiating identity. Each system is organized by rules that guarantee it's survival and function. An individual is conceptualized as embedded in such patterns of interaction. The meaning of his behavior and experience can only be seen in this context. This is also of value for symptoms; they must be seen in their context of relations, too. If one wants to belong to a relation system, he has to orientate to these rules/context which is shared by its members. The actions of the system members function as feedback-loops (relational patterns).

Basic elements in Ericksonian Hypnotherapy

Constructed perception, hypnotic processes

The Ericksonian Hypnotherapy (EH) is a very differentiated model of psychotherapy. Basic premises: - Perception/experience is self-made by focusing attention in an autonomous and self-organized way (Maturana 1982, Maturana/Varela 1987, Roth 1994, Spitzer 2000, v. Foerster, Watzlawick). Each „foreign-suggestion" is only effective if it becomes an autonomous self-suggestion. – Experience is formed on a voluntary (ego-associated) and involuntary (It-level) level. – In a relational change, communications functions as captivating suggestion. – Interventions (various direct and indirect techniques of communication and imagination on all sense-channels) can activate helpful experience processes (Erickson/Rossi 1979, Kossak 1989, Yapko 1990, Schmidt 2000). – Involuntary experience is faster and more efficient than voluntary, and thus the aim is to activate wanted involuntary processes.

The context of direct hypnosis is only one of the various means of possible interventions. In EH the classical directive hypnosis is used rather seldom. The so-called trance-inductions which are mostly associated with the term „hypnosis" are only rituals of systematic attention focusing – a means to an end, to activate a wanted experience especially on the involuntary level. „Trance" mostly goes along with an increase of concentration on the focused contents (often with an inward-directed attention). These experienced contents are associated more intensively and made more alive (reactivated), while other contents of experience are dissociated (faded out). Basically in trance nothing new takes place. All experiences which are every-day-phenomena, but which are given a further multi-sensorial focus.

To reach the mentioned aims EH uses specially developed systematic, detailed descriptions for the ways, how patterns of perception and experience are created by individuals in a system. Typical pattern-elements of experience in the interne, self-reflexive communication and relationship to oneself (especially relevant for therapeutic interventions) are e.g.: thought-associations, inner dialogues (auditory channel), inner plastic processes which can occur as reminding images, images of the present or future fantasies (visual channel), emotional processes (anger, rage, joy, grief etc.) and senses (kinesthetic channel), experiences of age (experiencing oneself younger, older or as old as one really is), experience of smell (olfactory and gustatory channel), attendant

physiological reactions like patterns of breathing, experience of power or weakness, „feeling small“ or „tall“, specific body-coordination (bearing, pattern of movement), experience of tightness or wideness in the subjectively experienced space. Connected with this are contributions of behavior and specific ways of communication. As in every dream, there is always that reigning real experience, which is (voluntary and involuntary) shifting into the middle of the imaginative attention of men. The contents of imagination become a psycho-physiological reality. Modern psycho-neuro-immunology research, for example, shows that the way our perception and imagination function (especially those on unconscious and involuntary levels) can have intensive effects on physiological processes and the functioning of the immune system (Kropiunigg 1990, Hennig 1998, Bongartz 2000). Specific imaginations can improve the immune system.

As one's own experience is created in this way, one „is“ not this or that in a fixed way, one is leading himself, depending on the direction of the focus, towards an experience and sculptures himself (in a positive sense) as a multiple personality (Ornstein 1992, Gergen 1996). The choice of focusing, largely happens unconsciously. Even family-systems are not exclusively in „this“ or in „that“ way (e.g. „addiction-families“ or families with „depression-patterns“). They show a number of organization- and interaction-patterns and so they can be described as „multiple families“, with a remaining family history and genealogy. Therefore here I are not speaking of „depressive“ clients or saying that someone „is“ depressed, what I mean is that there is always someone who plans for himself an experience which is defined as „depressive“ (by himself and/or others), even though to simplify the text, I use the common diagnostic term and speech about „depressive clients“ in this work.

Once an experiences is made, it is stored unconsciously (if the brain is not destroyed). This is valid for very burdening experiences but also for beautiful, constructive experiences that build competence.

„Everyday trance“

What is experienced as reality, is the expression of the pattern by which someone is absorbed at the moment. In modern EH trance is not only seen as e.g. cataleptic relaxation and inward-directed attention. All experience-processes are seen as „trance-like“ in which involuntary experience is dominating (Beahrs, 1982), therefore those in consciousness, too. This view which is represented here, is corresponding to the findings in ethnological and anthropological research about trance and healing rituals worldwide (Bongartz 2000, Goodman 1994).

Communicative contributions by others in a relationship-system have suggestive effects on individuals, which guarantee to help maintain the system's the identity of the system. In doing so the participants direct their perception mostly onto the valid beliefs in the system. I call this „systemic rule trance“ (systemische Regeltrance, Schmidt 1985). We permanently „hypnotize“ one another (often involuntarily) when we meet, but often fall to consciously recognizing it. (For dynamics in relational trance processes see e.g. Rittermann 1983, Schmidt 1985, Schmidt/Trenkle 1986, Kershaw 1990). This perspection can be proved by numberless examples. For example, the number of suicides or attempts of suicides in certain places had increased (bridges, U-railways etc.) when there was a report about that in the media. Vice versa the number of suicides at the U-railway system of

Vienna decreased about 50% since there was a contract with the media not to report no more these events (Magazin Fakt, ARD 10.09 01).

Put focus on something is the classical way of inducing hypnosis. All means of communicating can serve to induce it, eve everyday talk. The structuring of our language patterns, associated values, conclusions and metaphors, but also our speech-rhythm, body-coordination etc. function to induce indirect-hypnosis. Erickson himself, for example, during his 50 years of clinical work, only approximately 25% of his therapies were official trance-inductive, but in general he worked consistently 'hypno-therapeutically' (personal notice).

Symptom - „trance", depression - „trance"

In depressive symptomatic (as in all psychic and psychosomatic symptoms), involuntary experience is dominates, but it is unwanted, painful, and it is directed against the aim of the conscious „I-experience". The „I" experiences itself as an impotent surrendered victim of the terrorizing, more powerful unconscious „It". With this understanding, symptoms can be seen as signs for a „symptom-trance" or „problem-trance" (Schmidt 1992, Gilligan 1991, Wolinsky 1993). We hypnotize ourselves by involuntarily focusing on special beliefs, fantasies and other pattern-elements which are dissociated from our conscious possibilities of control and therefore seem as if they cannot be influenced.

Symptoms that lead to the diagnosis of an established depression can be categorized as emotional, cognitive or physiological. Emotional symptoms are e.g.: loss of interest, swing moods, lack of motivation, guilt feelings, fear/irritability, daily fluctuation with morning depression, numbness and exhaustion. Cognitive symptoms are: thought-restraint, continuous pondering, self-devaluation/self-criticism, negative attitude towards oneself, helplessness/impotence, experience of insufficiency, gloomy expectations concerning future and catastrophic, death and suicidal thoughts etc.. Physiological: e.g. insomnia, increased fatigue, vegetative complaints, loss of appetite (ICD-10).

These symptoms are expressions of the dissociated client-activity, their involuntary, self-hypnotic imaginations and self-suggestions. One „is" not depressive but makes himself, self-hypnotically focusing , depressive on an unconscious level.

Some aspects of this self-hypnotic activity are:

- The focus of perception is narrowed to negative, painful, disappointing experiences. Therefore almost all of the other experiences are gradually valued as negative so that discouraging, depressing material of experience becomes more and more dominating. From these generalized negative evaluations about the present time and „worst-case" conclusions are contemplation about the future (negative trade, Beck 1967).
- Positive experiences, events which were eventually beautiful and joyful for a person, are in many cases used to intensify negative estimations by the fact that these experiences are now gone and thus rendering the negative experiences even more painful.
- Interaction with other persons is reduced, they are often valued and drawn in a manner of black and white (idealized or totally devaluated). In connection with this always the same patterns of behavior and relationships are repeated,

independent from the context (e.g. although there are massive devaluations, while hope that someday the relationship will become better remains. Or on the contrary, determined disappointments do prove that there will not be any hope for the future.)

- Involuntary dissociation of choice and creation possibilities, which is not perceivable.
- Massive inward focusing, even in contexts where outward focusing would of more help.
- Self-devaluation and –rejection. This is in most cases is the result of the perfectionist's demands to oneself which can not be fulfilled. Nevertheless they are kept because they are combined with hope, maybe there will be the desired appreciation from important relative persons, if they only can be fulfilled. Own requirements for demarcation, for „it is enough" or e.g. anger about experienced rejections are dissociated. Particular aspects which from the „official I´s" point of view seem unacceptable or are devaluated and fought by the rules of the relation system.
- More and more increasing focus on negative expectations, gloomy future-fantasies. Stable style of attribution e.g. belief, that no afford will make a difference.

So a kind of „tunnel-view" is developed (trance-phenomenon of tunnel vision). This contributes to an even stronger absorption in these processes (self-reflexive strengthening feedback). Thus depressive self-hypnosis becomes stronger and stronger, until an experience of almost complete loss of time or phase of standstill has been developed (trance-phenomenon of time distortion). Often there are no helpful experiences in the recollection of the past. But this is only a sign for amnesia that comes along with a depressive trance. During the last 20 years, in more than thousand sessions, I never came acroos a case where more than two sessions were required to discover and reactivate helpful episodes and combined competences, even in the cases of clients that had a painful history of psychiatric episodes. Most of the individuals which hold a reactive-depressive diagnosis, recall life events which were experienced as very frustrating and traumatizing. Recent research disproves that these are the „cause" of depression.

Various research show that traumatizing experiences are not the cause of diseases and misfortunate symptom, for example the salutogenesis (Antonovsky 1993), the life event research (e.g. Brown, G.W. Harris, T. (1978)), research about resilience, cognitive psychology (concept of learned helplessness/hopelessness, Seligman 1986) and the contributions by Beck (1986). Decisive factors for the development of depression or to help work out traumatic life events in a health-maintaining way are a) the way life events are valued, b) which conclusions are drawn from them (e.g. about the own value, own possibilities also in future, and about the sense of experience), c) how much support you can rely on.

These perspectives are not consistent, they vary depending on the context and state of mind. The processes of perception always run in the presence. By this, experiences of the past are used as material for explanations and given meanings but they do not „determine" the process, they are not the cause. This kind of pattern in the present determines how much influence is given to aspects of the past (which contains various episodes, e.g. traumatic but also strengthening). Even psychological or psychosomatic sufferings that lasted for years, do not show a lack of capabilities. The necessary abilities are only dissociated. By methods of EH we often can reactivate helpful abilities and patterns of experience even in one session.

Experienced suffering only arises when another „side" of the person fights against it, longing for more optimistic, more beautiful possibilities in life, but is defeated, again and again, by the superiority of the „gloomy side". Only this field of tension that is generated this way, leads to exhaustion and the various other symptoms.

From a resource-oriented point of view, it seems very important to have an eye permanently on this polarity: the suffering connected with the depression also shows a life oriented side (even if it seems weakly marked), which is tortured by the pessimistic one. In therapy a strengthening contact with this side can be generated again.

During the depressive phase, a person experiences mostly emotions of deep worthlessness, senselessness and impotence. Facing the depressing process the Ego experiences itself as a victim without possibilities of shaping and mostly without possibilities of insight,; this is what makes this experience so strong awesome (typical descriptions are „ the total superiority of depression" – which is made real as a dictatorial being. Someone who is suffers of depression, tries to actively fight against it, first. The kind of „fight against..."-solution-trials seldom lead to success, and thus cause a sense of hopelessness, which has a reinforces the depressive experience. Further processes of devaluation and exhaustion follows which maintain and worsen the problem.

Therapeutic interventions

Intervention as creation of differences

Experience can be transformed by trans-focusing. This can be done by forming differences in patterns, which have dominated until now. Information results from generating differences. Interventions should be search-and find-actions for experiences and visions, that offer convincing differences to those experiences which had reinforced the depressive beliefs until now. The circular questions are suitable, embedding the experience always in it´s varying situation context and so working out context relating changes.

Even small changes can be very effective. Simply changing the pattern of breathing or the coordination of the body (or both), transforms at once the depressive way of experiencing the identical same situation. In all interventions the client´s autonomy has to be respected.

The patterns leading to depressing trance also show what should be focused during therapy so as to build up helpful difference e.g.:

- Re-experience of one's own creative abilities
- Building up perspectives of hope
- Changing the evaluation of life-events
- Developing perspectives that improve self acknowledgement
- Appreciation of loyalty-efforts
- Learning to understand depression as a valuable source of information about important needs that need to be respected
- Appreciating the body's given feedbacks- the organism as a contract-partner and supervisor via impulse feedback
- Support of constructive communication processes in the social area

- Support of helpful interactions in the relationship-system + also noticing others´ needs (referred individuation for all)
- Support of optimal balance between own needs and loyalty duties (from „either-or“ to „both and“ : referred individuation). In addition one should hold realistic expectations without striving for total perfection.

The intervention used are: questions which reactivate resources (resource-activating questions), scaling, re-interpreting, changing patterns of all senses and in interactional contribution. In additional, at the end of the session, the so-called final interventions are used. They serve for a) „charging the different interventions with meaning again, b) directing attention towards relevant themes and possibilities of pattern-changes in every day life.

Time-orientation by questions in therapy

In depressing patterns the focus lies mostly on disappointing, painful, traumatizing experiences of the past. Because of this, there is a generalizing conclusion concerning outlooks in the present, but most of all in the future (Beck´s „negative triade“). The negative valuation of the past becomes an evidential „truth“ of failure, gloomy views, hopeless- and senselessness. This forms one of the strongest stabilizing factors for depressing experience. If in therapy these aspects of the past are focused with great emphasis, the problem-pattern will only be strengthened again (solution-trial of the kind „more of the same“, Watzlawick et.al. 1974).

To change these patterns, one should recognise the needed time to come to a solution. If you recognise this, then the wanted experience will be activated. Therapy-conversations should be a concentrated ritual of focusing the times of wanted experience. This is encourages the use of one’s abilities, a „self- learning“ grows. Questions, as intensive means of focusing attention, are very effective which aim to create possibile alternative experiences. They cause an imagination of the inquired contents. Thus in the Ericksonian approach questions are not only means to „meet“ informations but most of all effective instruments in creating informations (Schmidt 1985, Tomm 1994). Their advantage is that is possible to remain without obligation, which is a great help in itsef for depressive clients with their demands of perfection. Questioning for so-called scaling, which shows differences in experiences, is quickly functioning in that way that generalizings, that strengthen the depression, are “liquified” („it is never that way I need it,...„I always feel so mean,...„) I called this proceeding „imaginative journey into the wanted solution-times“. Therefore not only questions about the wanted future do serve, (time progression/pseudo orientation in time, Rossi 1995) as e.g. the so called „miracle questions“ (de Shazer 1989, 1990). Questions about helpful episodes of the past are helpful, too. Remembered success-experiences represent already lived competences that are also stored by them. For clients they are more convincing than a hypothetically drawn wanted future. The client´s attitude of expectation, to have to talk about the past, which is often to be found, can be used respectfully, too. This direction of questioning was derivated from Erickson´s competence-oriented strategy of age-regression. This should constitute about wide ranges the centre of talking. However, if clients do want talking about a painful past, this should not be blocked,

since this could be experienced as a disregard and endanger the cooperative relationship (see 4.6.). The stucturing of the intervals between sessions is essential, too. The distances between the sessions should be 14 days at least, combined with aim-directed final interventions (see 4.2.).So clients can test their own possibilities, dependant patterns are avoided, and experiences that can be collected this way, can be used as a feedback for following steps. With this way of time-shaping we seldom need more than 10 – 12 sessions (in single-therapy, too) until essential helpful processes are effectively initiated.

Individual-centered or system-centered work?

Depressions always manifest in individuals. If thus a therapy is begun, the participants mostly expect that therapy deals in first case with the processes of the individual who shows the symptomatics, called index-patient (IP).

However, familiy-therapeutic and -systemic concepts see symptoms in the context of their relationship-patterns. Symptoms are seen as expression of interactional, often dysfunctional patterns in the IP´s relationship-system (origin family, but also actual system). Questions aiming to which effects using helpful ressources it would have for themselves or for important relation persons mostly prove the IPs` fear of a dangerous development in their relationship-system (e.g. destructive conflicts). These estimations, in most cases dissociated into the unconscious, cause the IPs to refuse their ressources on an unconscious level, although they suffer from not using them.

In the actual IP´s present system we often find the dominating „ideology" that there are no family conflicts, everything is „normal" and the only problem is the depression of the IP. What implicit counts, is that own needs are not allowed to be asserted against others´needs, others´needs always have priority over the own ones. As long as oneself still has power, one is not even then allowed to mark off against others´needs, even if one wishes to do, because this would be seen as egocentric, cold-hearted and guilty. Showing results and fulfilling demanded norms and ideas of rules counts more than taking care of one´s own well-being or spontaneus individual needs, even more than noticing physiological signs as exhaustion, being unlikely etc.

Many clients report experiences in their origin family system since their childhood which can be understood as a massive counter-regulation against deviation from these dominating rules. Typical kinds of counter-regulation are experienced as e.g. *massive suppression* with basic messages like :"If you do this again, I will leave and never come back to you." or as *passing over, ignoring and excluding* with messages like: „You are locked out now (go into your room etc.). You are only allowed to be with us again, if you apologize and admit that it was just your fault(which mostly is experienced as a demand for total submission), or as a *savior-delegation* in the sense of „My well-being, maybe at last my health is depending on you, behaving that way it does not burden me, and if you do not, it will depress me very much (and i´s your fault)." (e.g. Lake, T., 1990). Many IPs report the experience of messages like:" Strictly speaking, you are nothing worth as a person, actually you do not fit with us, you are different and bad, not only your behavior but you as a person, but we are bearing you, fair as we are, even if we have to be ashamed for you..."

It is likely that a socialisation under those conditions of dependance and loyalty at the same time causes a person to dissociate his impulses, wishes and emotions, which are experienced as deviant from dominating system rules, from conscious perception. Because

if they would not be dissociated, being excluded and making oneself guilty would be more likely.

Those desires, e.g. simply being accepted and loved, being acknowledged for the own way of being without having to show a lot of effort etc.; it is true, that if these emotions are not in reach, they are suppressed („depressed") but not gone. They are quasi rumbling in the underground of the unconscious and pre-conscious perception and calling with unvoluntary signs which can be then described as symptoms of the depression. So the symptoms can be understood and used as valuable messengers of legal, suppressed needs.

In traditional systemic therapy these dynamics lead to the conclusion, that conversations must include the relevant relationship-system and the focus must be directed away from the IP to the family pattern as quick as possible. *Especially in therapy of depression this procedure has been proved as not well.* Relatives and IP himself mostly hold an individual-centered sight. Very often they do not relate the problems to interactions in the system. But they often experience this proceeding as if the therapist would draw a deficiency-picture of the family which is devaluated as the „cause" for symptoms. Family-conversations are then often experienced as a blaming tribunal. This often causes massive resistance in the family, and the IP is brought in strong loyalty-conflicts, on which they react in many cases with increased feelings of guilt, that strengthen the depression. But also if relatives cooperate they can be brought into a dilemma: Just when changes have helpful effects, this is in a review to the past interpreted as a proof for former failure with the assumption: If one had acted that way earlier, a lot of suffering could have been avoided. In that case even succes causes depression, the solution creates again problem-tendencies. And: Focusing dysfunctional family-patterns often leads to the impression, improvement requires change. By this, focus is taken away from the IP´s ability of self-structuring and so hinders reactivation.

We find the cooperation with the relationship-systems very helpful, but with other premises. Like individuals theses systems own various patterns, also very functional and helpful ones. Family-conversations are means to help the depressive IP to health. Thus conversations should concentrate onto interactional patterns in the family that are helpful for this aim. These patterns can be found almost every time. When we ask relatives to concentrate on these patterns as a help for the IP, we nearly always find high agreement for cooperation. This way relatives can as a cooperative support system bring in valuable support for the IP. Loyalty conflicts for the IP are resolved. To avoid disadvantages or overburdening for relatives by this proceeding, we also work out together with them what is helpful for them to be able to help. This way, their needs is paid attention to, indirectly the therapy is useful to their health , it becomes a success-situation for all participants.

The principle of utilisation

If therapy should become a ritual of competence-experience, it must be useful for constructing a reality that makes the client´s contributions understandable and useful as competences. This requires an appreciating way of dealing with them. The Ericksonian principle of utilisation serves to these aims. „Utilisation" is understood as an interpretation of different contributions (valuations, emotions, acts etc.) by participants (either clients or therapists) in a way that they can be used as valuable informations, which show what concerned persons find necessary to go on with a suitable cooperation. If something can be

described as competence, as appreciating solution-trial or even as adequate solution for special aims under special situation-contexts, or if exactly the same phenomenon is rather seen as incompetence, depends exclusively on the context that it is put in. Thus in therapy one should always start from the assumption that the client´s contributions are always competent, commendable measures in the context of their momentarily experience of the situation.

Contributions can be then systematically used when each impulse 1) is first utilized as a valuable information about legal needs that are joined with it („pacing", i.e. an accepting, quasi welcoming attitude), 2) and then it is worked out in which way to cope with it (what kind of attempted solution in dealing with it) would be more useful and conductive, and which way would be more destructive and stabilizing or strengthening the problem. So all contributions can be appreciated and simultaneously can be proved what effects they bring. With this a helpful meta- position is built up, perception is associated with the aim area, and attention is focused there. Helpful would be questions like:"in which context would the client´s reaction be more making sense and competent, which of his legal needs do they point to, and how can we together use exactly that power and competence, that he shows in his contributions, for a successful therapy-coordination?" So can e.g. pessimistic future-estimations be understood as a commendable strategy to guarantee security, clearness and protection against further disappointments, quasi as „bodyguard-competence". The „tunnel-view" towards the always same negativistic perspectives can be seen as ability for a deep absorption and concentration. In therapy this can be used for focusing intensively helpful patterns. Negativistic fixation towards evil events in the past can be appreciated as a loyalty effort to the child that was hurt at that time, and that at last gets appreciation and sympathy, and whose disappointed but legal needs today and in future times will not be forgotten. In therapy such client´s reactions can be used as an important request to look together for optimal possibilities yet to fulfil frustrated needs, or to develop the best strategies to deal with in a healthy way in case they cannot be fulfilled in the desired way any longer. Perfectionistic „pushers" towards themselves can be appreciated in their endeavour to activate their best, and not to be content with „half things". So, previous solution trials that were problem stabilizing (mostly a struggle with one or more sides of oneself) are step by step substituted by integrating measures (see 4.8.).

This attitude of utilisation nearly always leads to differentiating and health providing goal–design, expectations and thinking processes of the clients in the sense of „either – or" can be transformed into pattern changing „both – and"- patterns(see Simon 2001) (see 4.8.).

Further examples: the IP´s hopelessness and scepticism can be used by means of invitation to prove each of the therapist´s intervention critically and give feedbacks quasi as a supervisor. This supports the IP´s autonomy and meta-position, the focusing on differences in the here-and-now, and thus on the possibilty of change. Often IPs feel very relieved when I tell them that their eventual critics, which they are asked for, and also every „yes, but.." can be a great help for cooperation, since as a sender of messages one can never know how own contributions are received. This way clients are appreciated as authorities. Fears, scepticisms, hesitating are valued as ressources, clients are respected as steering and are allowed to keep the distance. So the helpful is lived as a model in contact with the therapist. So traditional concepts of interpreting and treating clients´contributions as problematic resistance, which has to be "worked through", can be put into "the museum of therapy history".

Psychotherapy can be experienced as threatening. Because it promises hope again. Many IPs then project expectations in it which mostly can not be fullfilled that way. This again leads to disappointment that can strengthen the depressive process. Seen in that way, the IP´s ambivalences and fear of therapy can be used as valuable information about legal needs for security.

Utilization of attributional style

As shown, we often find as a part of the depressive pattern a very strong attribution that no (even so great) effort would lead to a difference. At least, implicitely therapy is thus defined as an event which makes actually no sense. Nevertheless, if we want to cooperate with clients with this orientation effectively, this sight has to be adapted or resolved. But if we question it directly we will meet adequate resistance. Also this very frequent and central dilemma can be utilized again in the shown way. First we describe the dilemma by meta-communicating directly and transparently to the client; then again we outline in a transparent way the experiential knowledge about the fact, that helpful experiences which are once made are scored as ressources, but that it is often not clear to the concerning person which experience makes a helpful difference to the suffering, and even more, what was helpful for that. Then we invite to search for these differences. Almost everyone reports day-fluctuations with a harmful morning-depression and high mood in the evening. Clients experience these fluctuations as totally beyond control. But from psychotherapeutic sight these fluctuations are very valuable informations. The high mood in the evening represents an unvoluntarily occuring episode of ressources, but the contributing processes are completely dissociated from conscious perception, only the result is noticed. We offer this view to the clients, with empathy that they could not deal with it in a constructive way yet because the containing ressources have been dissociated. Then they are invited to reconstruct with our search-methods what could be helpful pattern-elements (exploring phase). By systematically comparing morning-depression and high mood in the evening on all senses we can always work out what other thoughts, valuations, future phantasies, inner dialogues, expecting attitudes towards oneself or others are produced on unconscious levels, on one hand with depressing, on the other hand with lightening and easing result. By this, yet dissociated kowledge becomes more conscious and voluntary approachable. So even just day-fluctuations can be used very well focusing-competences.

Typical proceeding steps

Phasic steps in the process of a hypnosystemic therapy with depressive clients can idealtypical be:

1) Phase of clearing the context that led to the idea for consulting
2) Phase of from 1) derivated contract discussions/ building of a cooperation system which is useful for solutions in consultation
3) Phase of easing dissociation-invitations and other interventions that mediate creative possibilities and hope
4) Phase of translation of depression as information about legal needs

5) Phase of developping goal-visions
6) Phase of exceptions/focusing "solution experience"
7) Comparing problem-patterns and solution-patterns with many interventions that make patterns understandable and changeable
8) Comparing effects of different experience- and relation-forming, especially comparing the effects of problem-patterns and solution-patterns ((cost-profit-analyses)
9) Eventually ambivalence-coaching and new aim-development
10) Development and agreement of next steps that ca be clearly verified
11) Evaluation steps
12) Closing

Creation of relationships in therapy and construction of therapy-system as a sensefully experienced, systematical, competence strengthening cooperation system

In depressive-reacting persons we mostly find a particular strong lack of a so-called „feeling for coherence" (salutogenesis, see 2.2.1.). This means someone has a feeling of trust that"first the demands from the inner and outer world of experience...can be foreseen and explained, and second, ressources are available which are necessary to meet those demands. And third, these demands are challenges which need investments and engagement."(Antonovsky, 1993). In the sense of ressource-orientation this means, each step in the contact with depressive patients should be created that way, that it could become a contribution to experience these ressources again in interaction.

All therapeutic interventions serve as a ritual for developping a feeling of coherence. They should be able to be experienced as expression for the cooperation of equal cooperation partners. Thus they must be made clear and understandable, that means concretely. The aims of therapy and each single step must be discussed in a transparent way and orientate at the client´s autonomous ideas. Therapists can give hints to this, but should take the client´s autonomous decision for serious.and appreciate it (instead of e.g. pathologizing it.) I see transparence by meta-communication which explains all these points of views ("product information by the therapist") as central. However, De Shazer´s solution-focused approach e.g. avoids this explicitely. In each case the interventions are offered without explanation because of fearing that transparent explanations would be answered by clients with struggle for previous beliefs (de Shazer, personal notice, 2000). From my point of you then there is a great danger that depressive clients again experience themselves as managed and controlled by others and in a passive-helpless position, in case therapists just offer interventions without explaining them. IPs strive for experiencing self-competence, self-contempt, ability for self-determination. For this the agreed aims must be proved whether they seem to be realized by clients (basing on the abilities which clients experience at that time.) Therefore one should recommend small steps and minor aims, since these are more likely to be carried out. Constructive power emerges from the the aim-based relationship buildt between therapist and patient and fulfilling of these aims.

When working with patients with strong suicidal tendencies, the usual therapeutic context becomes redundant, and is eventually replaced by another law abiding context that safe-guards citizens from self- harm. This must also been explained very clearly when this in the therapist´s view becomes actual. If an IP cannot guarantee his self protection any

longer. this competence must be taken over by institutional rules (e.g. assignment), until a life-oriented side gains enough influence in the IP again(see 4.8.) Assignment does not happen, because the therapist requires to know better than the IP what is good for him, but as noticing the therapist´s mayor duty, and thus as a solution for the problem. This is very important to be made clear as an ego-message of the therapist, which includes messages about the therapist and his context, not as a description of the client, so that the IP does not feel defined or suppressed again, which could strengthen suicidal dynamics.

Typical patterns of expectations, their utilization, clearing the context, and solving of dilemmata in cooperation

Therapy can only been built up as a useful cooperation-system, if clients are accepted in their own points of view. These are their „contract-conditions" for an eventual cooperation. If these are valued as an expression for pathology, rejection, obstinacy etc. and doubted this way, it does not make any constructive sense to cooperate in such a context. In Ericksonian concepts, a number of helpful strategies are to be found for an optimal „pacing" (appreciating „meeting" and escorting clients in their actual world-outlook).(Zeig 1995). A very useful version is proposed by de Shazer (1992). Expecting attitudes of clients are differentiated in the that they can be described as „customer-" „complainer-" or „visitor-" pattern. As a 4. category I proposed „co-therapist-" or „supervisor-" pattern (Schmidt 2000).

„Customer"-patterns express clients´attitudes by which they experience a problem, and assume that they semselves create the solution. „Complainers" experience the problem. but see themselves as a victim which can not directly do anything for the problem. Others have to do this by changing. In therapy this leads immediately to dilemmata especially when others are absent or do not give permission. As „visitor"those clients are defined, who do not bring own requests into therapy. For those clients it does not make sense to show engagement for cooperation, even if they can see solution-competences by themselves. „Co-therapists/supervisors" means attitudes (often by relatives), who see others as the problem and who come with preconceived minds about how therapists should deal with those others. Each of these patterns can be very constructively worked with, but only then if contracts are explicitely and congruently treated.

In systemic view client´s behaviour in therapy expresses how they interpret the context of the therapy. Depressive clients often do not take initiative for therapy, but were sent. Then they rather come as „visitors". This can cause them to the view, that also therapy is seen as a context for outer control and submission, which problem patterns can be strengthened with. Therapists then should not take party be to partial for therapy, but appreciate eventual ambivalences of the IP and work out with them, under which conditions they could agree autonomously to a cooperation at all.

But also if they come by own initiative they are mostly absorbed in attitudes of hopelessness. In their conscious perception they experience problems as made externally. Often others are seen as causes. This mostly comes with the idea that therapy can only make sense when those are changing. But this is a demand for therapy that cannot be fulfilled. The contract alsways must be changed into a cooperation with the goal to activate possibilities of self-competence of the IP. Since this is opposite to the original IP´s demands, they might quickly feel rejected. Or they experience their own unvoluntary

processes as „actor“ („it happens against my will“) and feel impotent. Then they also react hopeless or they expect the therapists to eliminate and overcome the „bad actor“, their unvoluntary experience, by clever strategies. So they try to delegate their previous strategies they have used. This would only mean problem-stabilizing attempted solutions („more of the same which brings more of the same“) . At the same time own experiences of former failure would be projected onto the therapy, this is experienced hopeless then. Those expectations have to be transformed, too, which is bearing the same dangers (disappointment of the IP). So therapists can come easily in intensive dilemmata, while working with depressive IPs (double-binds). Some others are e.g.:

- a kind of a basic rule of systemic therapy is, that therapists should take an attitude of neutrality: a) towards persons and opinions in the client-system, b) towards the tendency of change or not-change of experiences or situations (v. Schlippe/Schweitzer 1996). The notion is thta if this rule of neutrality is hurt, there are often destructive irritatons in the client-system. *But strictly being used, neutrality in the contact with depressive clients often has an unfavourable effect.* They interpret such an attitude as a proof for their hopeless perspective and assume, if there were chances, the therapists would very actively extend for them. But this is strengthening the depressive pattern. From the beginning of the therapy therapists should, by creating differences, support clients´ experiences that provide hope and show that they can develop helpful things on their own. Clients are only convinced by own experiences, that they have the competences for wanted solutions. But this needs that therapists are partial towards a life-oriented side in the clients.
- Most depressive clients come and expect to talk long and almost only about their painful experience and to look for causes in the past. To use these „journeys into solution times“ (see 4.2.) therapists have to interrupt this „problem talk“ and invite to change the direction in the conversation. This is often critisized by representatives of other concepts by the argument, this would interfere too much the client´s self-process. But one should let it unfold, in order to work with this so generated material. Here I want to warn intensively to just encourage clients to perform “problem talk”, because what clients are unfolding then is nearly always their „problem trance“, in this way the painful experience is reproduced again and again. Clients do not deserve this. As quick as possible they should be supported in coming out of the suction of the problem patterns in order to unfold more helpful patterns (Yapko 1996). But since they are still fixed in creating „problem talk“, they might experience these invitations to change the direction in conversation as a rejection and disregard. Feedbacks like „You are not really interested in me, I am actually not important“ are not so seldom. So again we have a dilemma- it is not at all helpful on the other hand to neglect the wish for “problem talk” of clients.
- When clients quickly discover their solution-ressources again (which is rather regular with our proceeding) and experience already a short improvement by this, they often begin to regard their previous way of life again very self-critical and devaluating. We not seldom hear:“ Then I have done almost everything wrong until now. What could I have saved myself. Have I suffered for years in vain?“ Such reactions can reactivate depressive patterns very quickly again. They often develop from this view additional strong efficiency pressure. Because it was so easy, they

expect from themselves a further, a very fast and much greater improvement in future times. If this does not occur it is often interpreted as own failure again.

But those dilemmata can be utilized therapeutically(Schmidt 1998). They can be resolved by making priorities (first this, then that) or by meta-communication. We then have special helpful experiences, when we join meta-communication with our clients about our proceeding with procuring information. As psychotherapy-evaluation-research has shown, an essential contribution for the success of a therapy is the mediation of helpful informations (Yalom, 1996). It has been well tried, to show clients and their relatives informations about helpful strategies to deal with depression, and to make the ways of therapist´s proceeding, their knowledge of experiences and the conceptual background of their offers transparent. In a simple, understandable form we explain exactly this to the client, what is shown in this article, too.

We begin this proceeding by sending an information letter already before the first appointment, together with the suggestion for the first interview date to the client, in which we briefly describe our method of competence-focusing. Nevertheless this proceeding is not defined as obligatory for the clients. If a client is moving again and again in descriptions of his problems and evil experiences, we do meet this with empathy and appreciation.

Here are some excerpts of a therapy to illustrate some typical steps in our proceeding: Mr M., teacher, 50 y.o., married, 2 children (20, 16) comes, urged by his wife, to the first interview. His wife cannot join him because of a sudden duty on her job. Mr M. describes himself as having no hope any longer. Since years he has become more and more depressive, sometimes he has been given a sick-certificate for months, he has been in short-time stationary psychiatric treatment two times. Actually he does not believe any longer that anything could help. He sais he has tried everything. But just this view makes him even more depressive. Sometimes he is only crying and desires the end of everything. I pick up his description and say: *„ Listening to you, I get the impression that you have made very, very lots of efforts. You have already tried so much. It must be very painful not to experience the deserved improvement. And I find that unfair, too. I can imagine that it is sometimes even harder, harder as if it can be said in words, so that you sometimes feel completely alone in your pain.* (Depressive patients mostly feel much more understood, if therapists do not claim to understand them fully. Because they often assume that nobody at all can understand the way they feel.To give signs of understanding is sometimes even experienced as a disregard.)

Mr M.: There you are right; but when I feel that bad I often think it does not make any sense to burden others with it, at least noone can understand it, and noone can help me, either.

Th.: I find it to be honored, that you want to take care of the well-being of others, even when you feel so bad, even so much, that you take yourself back.

Mr M: But that is the least I can do. I am enough a burden.

Th.: The more I think, our conversation should directed very carefully to be a helpful means for you.You have suffered disappoitments enough. When we work together this should serve to do justice to your request. For this it is important to know what should come out as a desired goals for you. What would happen if our cooperation would to some extend bring out what you would like to have? Where could you read off this?

(This direction of asking focuses the desired future experience.)

Mr M: It would be nice if it works, but honest, I can`t imagine.

Th.: If you feel this way it is only natural when you first see many things as hopeless. I could even feel with you, being at first sceptical or rejecting when someone like me tells you there are possibilities of a helpful kind, there could be something helpful done.

Mr M.: No no, you do mean it well, I see it. And my wife has also done a lot already, she also means it well. She persuaded me to come here. Something must happen, it cannot go on this way. I tell myself each day x-times. She and the children would have deserved it. With me it is beyond endurance. But as much as I tell myself, I am so without power, sometimes I feel like immured, and that makes me even more done.

Th.: This must be an evil dilemma for you. It occurs to me as if there is a soul or a side in you urging you, finally to do what you experience as desirable, but there is another side that is completely overcharged.

Mr M.: Exactly, yes, that´s it, I often feel completey torn inside.

Th.: This could be related to many aspects. I am also just asking myself, if you would be here if your wife had not taken initiative?

Mr M.: I guess not. I myself often resigned and I think it all does not make any more sense.

Th.: Then I find it to be especially commended that you are here at all. For me that is an enormous effort. It shows me, too, that you obviously take it to heart, agreeing to other´s wishes, even if you yourself would act in a different way.

Mr M.: Yes, that´s right. But that is what I must do at least. Otherwise I am almost useless.

Th.: But under these circumstances we should, from my point of view, not start from taking the conversations here with me as helpful for you so soon. I know people who then would feel controlled by others and overgone, and experience the conversations as almost forced. But then they would not be helpful. If you would cooperate, your sceptics should be appreciated as legal, and we would have to take very much care of what you need, so that our cooperation would fit.

Mr M.: But something has to happen. I told myself that I have to pull myself together and suppress this bloody scepticism.

Th.: What are your experiences in such dealing with own reactions? Does it feel good to suppress it? I could imagine that it even causes more stress. (With this question I try to focus already first hints for previous attempted solutions and their effects. If we would stay in this way of trying solutions by stress, therapy could become again a stressing ritual.)

Mr M.: Yes, that´s right. I have often so much stress. Maybe I even cause sometimes more by myself. But otherwise I got completely bogged.

Th.: Yes, you seem to be afraid of this. Would yo be interested in finding out whether there could be other ways to come into movement in an adequate way?

Mr M.: Yes, if this was possible. Do you think it will work?

Th.: In my experience, yes. By this, the deciding point is how to be able to deal with one´s own contradictionary impulses. Fighting something costs a lot of energy, that can exhaust someone, too. If you are interested I can show you which alternatives have been especially proved in our work. (I want to offer new informations, make curious, but respect possiblities of choice at the same time and avoid that Mr M´s strategies until now seem to be devaluated.)

Mr M.: This would interest me... (Nevertheless now I should not praise one-sided the positive possibilities of therapy, but offer an appreciating pacing for Mr M´s surely remaining anbivalences and utilize them at once, by making the dilemmata transparent.)

Th.: By this I myself have a dilemma. Because of course, if you do want that, I will help you to see as quick as possible what is helpful for you and how you can manage that. And my experience in the work with persons in similar situations shows me that I probably can offer you something helpful. But being in your position I would be probably very sceptical if something of that kind could exist. It is likely that I would be very mistrusting or set myself under pressure if I would hear about that. You have experienced this by yourself so often. To respect this, one could think it would be better to be more taking back myself and not offering you something that is deviating from your estimation. On the other hand I do not want to conceal which proceeding especially for persons in the same situations like yours have been proved as helpful so often, right?

Mr M.: I don´t know if I understand you. And you think there are possibilities?

Indeed it would be nice, and I do need help! But probably again it does not work. But does that mean, you do not want to help me?

Th.: Of course I want to help you. But simply starting could be understood by you, as if I would disregard your understandable scepticism and do not take you for serious. This would surely be no help, then. I want to respect you.

Mr M.: Yes, that makes sense to me. But what can I do then?

Here it is advisable to offer dissociation-techniques for coming up to the client´s ambivalence in an appreciating way and to open up new options.

Dissociation-techniques and „inner conferences“

Processes, running as a part of depressions, are most of all for that reason so harmful because IPs identify associatively with them, the greatest part of attention is absorbed, and thus they become dominating. Their dominance can be resolved by more dissociating the unwanted unvoluntary processes again and so distancing oneself mentally. Therefore methods that are else used in trance-inductions can help to reconstruct yet unconscious problem-induction in a conscious way. By this it becomes more accessible for voluntary experience and can be transformed (exduction out of problem-trance). This also supports constructive dissociation. Inner struggling which manifests e.g. by self-devaluating inner dialogues, and which we heard from Mr M. can be found in all depressive IPs. This dynamic can effectively be utilized by making them to a metaphorical material, so as if there are contradictory „sides“ or parts of a personality. Then it can be seen, that they first deal very hostile with each other, they represent opposite value beliefs. By using metaphors, chances can be created for the clients to externalize urging processes mentally. The IP´s different and contradictory tendencies are all associated with the „ego“(“I do, I experience...”) of the client. They should be dissociated from the „ego“ again to gain free space.

I developped such interventions from hypnotherapeutic dissociation-techniques These are e.g. very often used in therapies for strong pain or traumata with imaginations in which e.g. someone imagines as less being connected with the hurting part of the organism, which leads to a markable pain reduction (Barber). Since we find more and more parts by this that communicate in a similar way as in conferences, I developped 20 years ago so-called „inner

conference"- or „family-parlament"-models (Schmidt 1989, Stierlin 1995, Hesse 2000). In the last years, several similar models have been published (Schwartz 1997, Schulz v. Thun 1999). In the Fachklinik am Hardberg we use these concepts as part of a systemic group context; therefore group members can perform different „sides" and important relation-persons, which makes the reciprocal effect between the inner system-dynamic and outer-system evident, so that helpful reactions can be tested then. In the clients-therapy-group there is often a very touching, intensive sympathy and reciprocal solidarity that is experienced as especially helpful and encouraging by depressive IPs (further effective interventions in stationary range can not be entered in this place, for this see Schmidt 2000).

This proceeding offers many advantages at the same time: a) Improvement can be experienced very quickly. b) It enables to design metaphorical description of these „sides". This helps to a stronger dissociation from urging patterns and enables better possibilities of imagening helpful processes. c) It supports building up a sharing meta-position. In conversation with Mr M. it looks like this:

Th.: In our experience there can be built up something helpful very well. But for this it is important to meet all aspects in you. It seems as if there are various souls or sides in you struggling with each other. We are all like you talking about these processes, so as if we would always have a standard experience. But strictly taken, to do justice to you one must say that one side is feeling so down and another side is fighting against it. Because that side that is depressed surely is not the same as the fighting one. Today we know that the way of describing human experiencing leads to completely different effects. If you would compare which effects it would have describing the process as previously and how it would be if you would say, there is one side an there is another one, but both are not me as an integrated being, what different effects do you experience with this?

Those simple invitations to dissociation are very effective, more than 90% of our clients report immediate improvement by using these strategies. I do not know any other intervention that is such effective in a short time, immediately, completely transparent and, as a self-management, available for concerned persons.

Mr M.: When I say „I am depressive" and then „I should not be" I feel a lot of pressure. But when there is only one side depressed I feel much less pressure. And if there is one depressive side there can be others. I feel as if there is a window opening and I get more space...

TH.: Do I understand you right, your organism tells you by other feelings and physiological reactions at once that the second one does you more well? (With this question I already want to offer the idea to take feedbacks of the own organism for serious and treat them respectfully as helpful informations for needs)

Mr M.: Yes. It is more easing if I can imagine it is only one side.

Th.: I get the impression your easing hints to what you can need e.g. more space and unburdening; as if your organism shows you with his spontaneous reaction your intuitive knowledge, what is helpful for you (Invitation to ideas and experiences which can support a more positive self-image and step by step appreciating treatment with unvoluntary processes).

Mr M.: What do you mean? You mean I have intuitive knowledge? I often feel so empty and hollow.

Th.: Well, depending on the way you are talking and thinking about yourself, your organism immediately reacts differently. You do not have to do something extraordinary for this. It happens unvoluntarily. That is the way unconscious knowledge is shown by humans.

And if you are feeling bad, it happens unvoluntarily too. If you allow yourself again to percept your different sides this creates obviously space and distance to you from the depressing at once and you experience easing. From this I draw the conclusion that your organism tells you in his body language his knowledge about what you need. And when he gets it he answers with a reward at once. (Invitation to the idea to treat the organism – as a metaphor for unconscious needs – as a cooperation-partner with needs respectfully, to build up loyalty to oneself, too. And: by comparing different situations, their patterns and diverse effects, changes are possible to be experienced and a meta-position is built up).

Mr M.: I have not seen that this way, yet. Do you really mean I could have influence in the way I feel? I`d like to have that, but I often feel so bad that I can`t do anything.

*Th.: That is understandable. It would be said much too easy if someone would tell you that you can do this so easily. You experience this everyday. But when would you feel more impotent and surrendered: when you tell yourself, I am so depressive and cannot do anything, or or if you would say, one side of me experiences that? (*Competence-focusing here is never to be associated with the idea it would be easy. In this case the IP would devaluate himself very quickly if he has not succeeded yet, put himself under stress- and the depressive spiral would be even strengthened.)

Mr M.: Well, it would be worse if I´d say I am thiscompletely, as if there wouldn´t be something else in me.

Th.: Then I feel almost obliged to describe from now on your experience that way, that it is clear it is one side in you that has got a lot of harmful influence yet. It might appear unusual to you because we all do not talk this way in every day life. But I understand you that way that you often feel awful surrendered and impotent, as if you yourself can not do anything to ease your pain or stop it. Do I understand you right here? (Again and again my invitations are supplied with check-backs, so that the IP does not have to feel foreign-defined and is appreciated as authority).

Mr M.: Yes, exactly. And the same time I tell myself a thousand times there must be something to be done, but it does not work, and then I feel so depressed and resign.

Th.: But that is clear that you feel this way. Everyone else would feel the same. If you would notice that you could do something helpful, you would do it, wouldn´t you? (Invitation that his reactions are general human and nothing which is worse in him).

Mr M.: Of course.

Th.: And that is exactly why I see myself in duty to invite you to talk about one side which is feeling depressed instead about you as a whole person. Because as if you have just experienced, this awful experience being immured can by this brought into movement in first steps. You experienced yourself that it can be changed, or did I understand you wrong? (Invitation to remind helpful experiences, which are often forgotten very quickly.)

Mr M.: No, that´s right, now as you call my attention on this. I have already forgotten it.

Th.: I find this quite natural. The usual thinking and dealing with these important subjects is almost like automatized, it works faster as one is aware of. It has quasi contest advantages. To provide any chances for more helpful patterns there are means needed, which help to interrupt old habits and strengthen the more helpful ones. Would you be interested if I invite you to some strategies which in our experience can very often help a lot ? (Here I try to win him for a new more differentiating order, the IP is appreciated again as authority who permits interventions or not.).

Mr M.: Yes, I´m interested very much.

Th.: O.k. But before I start I would like to ask you for something. If that what I am offering would be plausible to you and you would find it adequate, I have the experience with persons who are very conscientious and eager to do things very well that they tend to put themselves immediately under stress and expect themselves to transform that what they heard quickly to 100%. But this would be an evil overcharge. As a rule it is only helpful to allow oneself slowly and step by step and with a lot of patience and consoling tolerance, in case things do not work so well, to test carefully one thing after the other and to deal very carefully with the reactions on it. But then it can be a great support. So I would like you to ask to treat everything that I invite you to this way, and if you notice that you set yourself under stress, what would be only natural, or if it is going on too fast, please tell me as soon as possible. Are you ready for this? (This intervention shall invite to offer the permission to relativize the perfectionistic urgers; the IP would probably not give it by himself; and it shall make curious for oneself and the feedbacks, and by this strengthen the meta position, but also to build up an appreciating attitude in a more self-responsible way).

Mr M.: Actually I thought if I finally don´t pull myself together it will come to nothing. But if it is more helpful according to your experience I will try to have an eye on it (the client cautiously accepts the permission).

Now I explain in a simple way exactly the concepts, the same way I do in this place here for the readers, step by step, session by session, according the development. This way the IP is treated as an equal cooperation-partner, quasi as co-therapist. He causes the success by transforming his competences; according to this a collegial communication, that sends my own contributions again and again into temporary retirement is just appropriate. For the aim that the client becomes independant from therapy and as soon as possible his own „coach" or therapist whenever he needs it, it is much more useful to make everything transparent to him, and to build up therapy rather as a kind of training with the character of self-experience.

By this the client can build up a meta-position very soon, that helps him learning even to control and use in a health-supporting way ever so urging experiences more constructively. This is functioning as a very effective prevention, too.

Translation of depressions into informations about valuable, justified needs

As long as someone lives in depressive trance he can see symptoms only as evil, bad, as signs for incompetence – then attempted solutions are mainly chosen as attempst to „eliminate", which nevertheless strengthen the problem. By metaphorical description of diverse „sides" and their interactions with each other positive re-interpretations and more integrative strategies can be supported, which provide more appreciation and inner peace.

Most clients report, that extreme perfectionistic sides meet the sides of a conformed, submissive child (age regression), that tries until exhaustion to fulfil the demands. At the same time there is the child´s side calling, full of longing for symbiotic nearness, safety, total harmony and for being simply accepted, as one experiences oneself spontaneously, without having to do something extraordinary for it. If such desires are always ignored, there is a side appearing full of anger. But the angry side is mostly devaluated and supressed. It is a minority against the others, but is defending with rejection and bracing. At least it turns against the person itself. The inner struggling costs a lot of energy and leads to exhaustion which finally goes along with desire for death.

When rehearsing the depressive processes with the clients in a metaphorical way, they can clearly understand quickly that depression is not an expression for a basic incapacity, but an understandable and adequate reaction to suppression and devaluation. It always occurs as an unvoluntary reaction then, when clients let the perfectionstic devaluating side become a dominating „majority". So it can be translated as a source for information about important and legal needs. When these suppressing processes in the depressive pattern are compared to those patterns, in which clients treat their needy sides more friendly and emphatic, it can be seen that depressions become less at once or are even resolved.

Nevertheless in the long run it is not shown as helpful to recommend clients to devote themselves now completely lovingly to the needy sides. Because also the perfectionistic side is part of their value systems, and expresses loyalty against important relation-persons.

Excluding them would bring inner quarreling and weakness. None of these „sides" is problematic in itself. They are all representing importing partial aspects which are necessary for an individual, that wants to come up to his relationship with other men. They are only then contributing to a depressive escalation, when they occur as implacable polarities, which are standing against each other- as „all or nothing", „either-or" patterns. The trial to eliminate definitely the ambivalences leads to depression.

Thus we invite the clients, following the long tradition of family-sculpturing, to pose the diverse sides with an adequate nearness-distance-regulation that way around themselves, that they can percept themselves as functioning, power and wellness feeling conference-members. It is then proved most effectively if they both do not identify onesided with one side and do not exclude one. It is of greatest importance to then focus to a new "entity" inside the client, e.g. the "manager" or "president of the conference" and their organismic reactions. In special constellations, clients suddenly experience strong physiological signs of harmony that express their intuitive knowledge about optimal inner organisation. Focusing that, they quickly come to an attitude from which they can percept impulses of their sides like in a hearing, and find more easily optimal treatment for it (depending on the context). This way depression can be translated as an information about desire for: -To need and to be needed, -sense, -to be respected in one´s value, -to be accepted, -safety, -to be allowed to just being, -finiteness, -to be allowed to mark off oneself and being o.k. with this, but at the same time being „melted", -to be allowed to give, but also to take, -security, - and often for a spiritual home.

Therefore quickly an empathy is generated for all relevant sides, internally the clients quasi develop a culture of multicultural tolerance and cooperation.

Mr M. e.g. showed that since his youth he always tried to gain his father´s respect. He was the only son. His father was an official in a subordinate position, but gladly would have studied and „developped something greater" – in the hope to meet more his father´s expectations by this. M . always had the impression that his father has set big hopes in him and dreamed that he could reach it- this points to a subliminal delegation contract in the sense of Stierlin- (Stierlin 1978). But whatever he has done, he always experienced it as not being enough for his father. So he exerted more and more but also loses more and more hope to be ever able to make it. When he sometimes became angry and kept distance to his father his mother suffered from this very much, and was afraid of the father becoming furious or depressed himself, and the whole family would suffer from this. As a result Mr M. devlopped feelings of guilt each time and exerted again. In his actual family he carried on these patterns by trying to do it right for his wife and children until exhaustion. These numerous inner struggles can be reproduced in therapy by the „side"-model very well, but

also acknowledged. This way, the depression became understandable as a loyalty-effort in duty of the family and as a valuable information about disregarded needs at the same time. By scaling-questions for different situations of experience, those in which Mr M. once felt better, too, it could be worked out quite fast that „better" times came along with him allowing more distance and some time treating himself more respecting. So he gradually understood that the depression was a feedback about his unconscious knowledge of what came too short and what has to be more regarded to come to an improvement. Depression could by this be redefined as a „warning lamp" or „bodyguard" that requires more healthy dealing with himself and others.

Symbolizing depression as „visitor" and other symbolic, ritual interventions to establish more helpful solution-strategies

The proceeding described before opens up a lot of chances to substitute previous problem stabilizing attempted solutions by others. The way someone tries to solve a problem is a central element of the pattern, which maintains the problem: „the solution is the problem" (Watzlawick et.al. 1974). The depressive experience is nearly almost the conclusion of many wasted solution trials, which nevertheless do not show an IP´s basic incompetence, but only, that attempted solutions at the cost of an exhausting high price have been chosen. At first clients mostly try to solve rising depression, sadness etc. by direct interventions (encouraging oneself, accusing, „pulling together" etc.). But unvoluntary processes can hardly be directly controlled. So an even stronger becoming struggle against oneself is grown, that lets escalate the depression. Then it is experienced as powerful. Resignation is following. We have very good experiences to define depression in such cases as not directly changeable. An appreciating comprehension of depression as a source of information even leads to the insight, it would not be that good to eliminate it, because an important „bodyguard" would be wiped out. Clients are eased, that it has not to go away completely, the selfmade stress of expecting is largely resolved, but they do not have to resign because a large field of creating possibilities (concerning the contact with it) is opening to them.

Then we invite the clients to look together with us for the most helpful solution strategies in dealing with restruction. Again, hypothetically asking for compares serves for this: „Suppose you would forgive yourself being again impatient, and asking too much of yourself, which effects would that have?" Clients´ feedbacks show that this would be very helpful. Depression can be utilized as a "quasi-supervisor" for following steps in therapy, and for optimal timing. Because it occurs as a „reminding visitor" only then, when needs which have to be regarded for health are disregarded. This way so called „relapses" also can be each made clearly understandable as valuable feedbacks for something going too fast, being overlooked, or one being again hypnotized by the old patterns.

From this we can immediately derivate experiments for the intervals between the sessions (as focusing help), which strengthen favorable patterns. It is often shown as very effective to invite clients to a non-commital curious obligation of their own reactions and those of others. Is e.g. the depressive side metaphorically described as an exhausted help-needing child (often a desperate child, which somehow feels stone-old at the same time- a hint for early parentifizing, etc.), from this can be concluded what (the principle of word-to-word effect like in a dream) treatment the being could need to feel better (e.g. protection, consolation). What is good for the IP as a whole person can so be described metaphorically

as an „aid-action for needy persons“ or as a contribution for „children´s weal“ etc.. This again meets the IP´s value-system who actually is willing to do more for others, also for the others in himself. When the IP e.g. keeps distance then from overburdening expectations, he can much better legalize this to himself, because he does not do this only in an egoistic manner for himself (this is often too much seen a taboo very long) but on duty of the organism and it´s needs, or on duty of the higher aim „health“, which then serves all in the system, too.

As we could show in an extensive study about the work with manic-depressive diagnosed IPs and their families, even interventions with this client group were very effective, who treated the „illness“ as a „being“, which can be learned to be handled with (in family, too)(Retzer et.al., 1989; Weber et.al. 1987).

Helpful dissociations providing relief are even more helpful, if depression itself is made metaphorically describable. Numerous are pictures like „an extreme heavy burden, a millstone that pulls me down“„a terrible swamp I sink into further and further“ or metaphors from the range of meteorology „icy cold“, „dark thunderclouds“. These pictures, even if they sometimes sound awful, help the IP to give the depression more contours, to provide more distance and by this to deal with in a better way, marking off, too. Intervention mostly have a very releasing effect, in which clients are invited to derivate very concrete symbols from these pictures, which they they can carry along in every day life or pose at a well seen place.

Mr M. e.g. describes his depression as a very heavy black burden that he always carries along. I suggested him to get himself as many briquettes as he thinks are appropriate. He decided himself for 6 briquettes, in doing so he imposed them also with demands that he requires by himself concerning his parents, his sister, his wife and both of his children. We agreed, that he would pack them in a backpack for some weeks and drag it along daily wherever he thinks it is possible without attracting attention. Then he reported that once again it was made really clear to him what he had dragged at all, but also what he has achieved by doing this. And each time he took down the rucksack again he felt better.Ritually he got metaphorical inspirations how he could provide himself relief. Cognitive ideas into the same direction are mostly following these rituals promptly and then an even be better transformed in every day life. For his perfectionistic, merciless treatment with himself, he developped the imagination of a whip with which he drives himself forward. I told him to make or provide a whip and to watch when he uses it again, and which alternatives come into his mind. He did and reported that he often catches himself whipping but was then able to interrupt this pattern and give in. In other analogies we found the picture of a never-ending marathon run that he practises. Inspired by hypothetical questions for the effects in case he would really start jogging he began regular endurance runs. This offered many chances to find out again the best way to reach the finish without slave driver yet. Finally he bought a pulse watch that always showed him when he became too fast, so that he built himself up a pattern of strong power without driver. Analogizing we only translated this into every day life and creation of relationships.

In a metaphorical way antidepressive medication can also be utilized as „quasi relation-partner“. It represents competences that the IP can use, also in an externalized form. We treat them as the IP´s cooperator, who as a „leader“ delegates tasks to the medicament. As long as he believes not to be able to guarantee them by himself, the use of medication is shown this way as a responsible act. Devaluating positions as they were not seldom in anti-psychiatric tradition (but which would bring the IP only in loyalty-conflicts) can be so

effectively avoided. But then the price, that a delegation onto the medicaments can have, that means to experience onself dependent, not to be able to experience own competences any more, can be discussed constructively. So in small steps a mostly effective motivation in the IP is developped to try little by little few or no medicaments at all and use all reactions on it in a constructive way.

Balance between solution-focusing and appreciating of the „problem“

In many cases solution-focused concepts are understood that way, that the central therapeutic task is the activation of ressources and concentrated focusing it. From a systemic side this is too rigid and too undifferentiated. Just when helpful competences of clients are discovered again, the question should be asked what could have been the reason to dissociate these competences. Because in the sense of the here represented perspective this does not show incompetence. But it can be only understood in the relation-context of clients (re-contextualising of problem- and solution-pattern). Thus it should be asked immediately when competences could be discovered and activated again, which effects would clients expect a) if they would go on using these competences in a healthy way and compare this with b) if they would go on dissociating and living the former problem patterns. These comparisons mostly generate very quickly important informations that show the clients´ fear to raise conflicts, burden others, making themselves guilty and so on, if they would do what is good for them. But then problem-behaviour and dissociation can not be defined as as a pure incompetence any longer, but also be appreciated as a respectable competence, although for different aims. These aims mostly express loyalty-obligations that clients see for themselves. Nevertheless, a onesided-competence-focusing then is not enough, it could even lead to new serious problems for clients. Because for depressive IPs their own well-being as a primary aim alone is no senseful perspective, since they are very strictly oriented in loyalty and would not be motivated enough to do something good alone for themselves. Instead of the view „ clients cannot use their ressources, they do not find the entrance“ it should be „from their view about loyalty clients do the necessary work to refuse their competences by dissociating...“. Symptoms become understandable as a result of massive dilemmata and aim-conflicts in which clients experienced themselves and still do. They are not only problems but also express the trial of solutions, nevertheless at a high, destructive price.

Even after reactivating competences a further central task in therapy is grown, that means to support clients in solving these dilemmata and aim-conflicts constructively (related individuation in the sense of Stierlin, Stierlin 1995). „Relapses“ can often be very quickly understood and used as a hint to neglecting one needy side of the system and then being counter-regulated, so that „relapses“ can be valued as an effort for the system (Schmidt, 1988).

Even for this it is very helpful to include the relevant relationship-system into the consultation. Family-conversations then focuse a) to prove if the IP´s fears are correct, b) who in the family would agree to support the IP in those patterns that would help him, c) what the others themselves do need to deal with changes in a healthy way, too. By this it is mostly shown that also the others in the family had to stand heavy burdens during a depressive phase, but did neither keep distance in a healthy way, because they were following the same value system as the IP. By comparing questions wich make clear the

effects of different family interactions, constructive variations are to be seen, and the participants notice, too, which pattern would rather be problematic, even if it is meant well. Typical family member-reports about helpful things for all participans are e.g.: to listen to the IP by being turned towards him, but let it „stay", i.e. simply accept it in the sense of „yes, that´s the way it is now for you", without at once making any suggestions or efforts to change, - to treat the IP as sick and not as „being guilty" and to look together for an optimal coping with the disease;- to mediate patience to the depressive, but to oneself,too, and own reactions and inner strife (ambivalence-coaching);- „ego-messages", i.e. to talk about the own emotions, perceptions, reactions, frustrations, fear, anger, aggressions, too, when they occur, without accusing the IP as a „cause"; -not to pretend „false" (e.g. positive) emotions, because the depressive person does notice it immediately and values it as a proof for his loneliness or being a burden; to care for the own power limit. To overcharge oneself would cause the IP a sense of guilt. Helpful is to him „love, that sometimes says no";- sometimes to ask for help for oneself and mention the own need for help; to react to each „non-depressive" reaction in a respecting way, and to mediate, one does not think that this must remain this way. (moderate attitude of expectation); - to invite the IP to common activities; quite to expect things of him (moderate), because expecting too less could make the IP ashamed.

Mr M. e.g. was afraid, as he just only mentioned after being asked for expected effects of solution-patterns that were helpful to him, that he could make a cold, hard-hearted and ungrateful impression towards his wife and children and mark off against his parents so decisively that their relationship could break. And he worried about perhaps becoming careless and arrogant. To prevent from creating with this „black and white thinking"new conflicts we offered him to look for an optimal balance between these so contradictional appearing aspects. He was very much eased by this. In family conversations his wife and children brought in more and more own wishes and slowly allowed themselves to mark off themselves sometimes, but could just this way develop more congruent empathy for him. Mr M. noticed that he was released at all, when his wife and children did not take too much responsibilty for him. One session his wife asked him to give her the briquettes for some time, which symbolized his depression, so that she could feel herself how this might be, and because she had the impression to overcharge herself, too. After that both children wanted to carry the briquettes, too, the depression was quasi made liquid in the system. Mr M. experienced himself as very touched and supported. At first I had the intention – as often practiced – to suggest a farewell ritual for the depression to the family, in which e.g. the briquettes would be burnt (see v.d.Hart, 1982). Mr M. however, supported by his wife, rejected this decisively. He wanted to keep the briquettes as a remaining memorial for his struggle lasting for years, as an acknowledgement for his suffering and especially as a rememberance help for more healthy patterns at a „place of honor on the cupboard". I accepted this, remembering many similar reactions of other „depressive" clients. After 9 sessions in a range of about 7 months we finished therapy, but like always with the arrangement, that Mr M could always claim to a session again, but not only when needed, but also then when it is wanted as a reward (this way cooperation is taken out of the deficitary spot).

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References

Antonovsky, A. (1993): *Gesundheitsforschung versus Krankheitsforschung*. In: Franke, A., Broda, M. (Hrsg.): Psychosomatische Gesundheit. Versuch einer Abkehr vom Pathogenese-Konzept (S. 3-14), Tübingen: dgvt.

Beahrs,J. (1982): *Unity and Multiplicity*. Irvington, San Francisco.

Beck, A.T. (1986): *Kognitive Therapie der Depression*, PVU, München-Weinheim

Brown, G.W. ,Harris, T. (1978): *Social origins of depression*. A Study of psychiatric disorders in women, Tavistock, London

Damasio, Antonio R. (1999). *Descarte's Irrtum- Fühlen, Denken und das menschliche Gehirn. München*, dtv.

de Shazer, S.(1989). *Wege der erfolgreichen Kurztherapie.* Stuttgart

ders. (1989). *Konferenzen mit der inneren Familie*.(Toncassetten), Müllheim, Audiot.-Verlag

ders (1992) *Sucht-"Krankheit" und/oder Such(t)-Kompetenzen; lösungsorientierte systemische Therapiekonzepte für gleichrangig-partnerschaftliche Umgestaltung von "Sucht" in Beziehungs*- u. Lebensressourcen. In: Richelshagen, K. (Hg.): Süchte und Systeme, Freiburg, (Lambertus-Verlag)

ders (1992) *Systemische und hypnotherapeutische Konzepte für die Arbeit mit psychotisch definierten Klienten*. In: Peter, B., Schmidt, G.(Hrsg.) (1992): Erickson in Europa, Carl-Auer-Systeme, Heidelberg

ders (1992): *Das Spiel mit Unterschieden*; wie therapeutische Lösungen lösen.Heidelberg, Carl-Auer-Systeme

ders 1996). *Vom sog. "Rückfall" zur Nutzung von "Ehrenrunden" als wertvoller Informationsquelle*, In: Richelshagen, K.(Hrsg.) Systemische Suchttherapie, Lambertus-Verlag

ders (1999) *Hypnosystemsiche Kompetenzentfaltung. Nutzungsmöglichkeiten der Problemkonstruktion*, in: Döring-Meijr, H.(Hg.): Ressourcenorientierung - Lösungsorientierung, Göttingen, Vandenhoeck u. Ruprecht

ders (2000) *Die Utilisation von „Wahr-Gebungs-Prozessen" aus der „inneren" und „äußeren Welt" von TherapeutInnen/ BeraterInnen für eine zieldienliche Kooperation* in der Therapie/Beratung, in: Familiendynamik 2/2000

ders (2001). *Kompetente jugendliche Kunden und Familien als ko-therapeutische Helfersysteme- das Hardberg-Modell einer stationären systemisch-hypnotherapeutischen Jugendlichen-Psychosomatik*. In: Rotthaus, W.: Systemische Therapie mit Kindern und Jugendlichen, Carl-Auer-Systeme-Verlag, Heidelberg

ders (1988). *Rückfälle von als suchtkrank diagnostizierten Patienten aus systemischer Sicht*. In:Körkel,J.(Hg.):Der Rückfall des Suchtkranken. S:173-213.

ders (1990): Der Dreh. *Überraschende Wendungen und Lösungen der Kurzzeittherapie*. Heidelberg, Carl-Auer-Systeme

Erickson, M., Rossi (1981): Hypnotherapie, Pfeiffer, München (1979, Hypnose, Pfeiffer, München)

Gergen, K.J. (1996). *Das übersättigte Selbst- Identitätsprobleme im heutigen Leben*. Heidelberg, Carl-Auer-Systeme

Gilligan, St.(1991).*Therapeutische Trance. Das Prinzip Kooperation* in der Erickson'schen Hypnotherapie. Heidelberg, Carl-Auer-Systeme

Goodman, F.D. (1996): *Trance- der uralte Weg zum religiösen* Erleben.Gütersloh.

Haley, J. (1978): *Die Psychotherapie von Milton Erickson*, Pfeiffer, München

Hesse, P.U. (2000): *Teilearbeit: Konzepte von Multiplizität in ausgew*. Bereichen moderner Psychotherapie. Heidelberg, Carl-Auer-Systeme

Hoffmann, L. (1982): *Grundlagen der Familientherapie*, Isko-Press, Hamburg

Kossak, H.Ch. (1989): *Hypnose- ein Lehrbuch*, Weinheim- Psychologie Verlags-Union

Kriz, J. (1992): *Chaos und Struktur. Systemtheorie*, Bd.1. München (Quintessenz).

Lake, T.(1990): *Depressionen bewältigen*, A.Müller-Verlag, Zürich-Stuttgart-Wien

Maturana, H. (1982). *Erkennen. Die Organisation und Verkörperung der Wirklichkeit*. Braunschweig, Vieweg

Maturana, H., Varela, F.(1987): *Der Baum der Erkenntnis*, Scherz, Bern/München/Wien

Nuber, U. (1996): *Der Mythos vom frühen Trauma.*

Ornstein, R. (1992). *Multimind - ein neues Modell des menschlichen Geistes*. Paderborn, Junfermann.

Penfield, W. (1975). *The Mistery of Mind*. New York

Reddemann, L. (2001): *Imagination als heilsame Kraft- zur Behandlung von Traumafolgen mit ressourcenorientierten Verfahren*, Stuttgart: Pfeiffer bei Klett-Cotta

Retzer,A.,Schmidt,G.,Simon,F.B.,Weber,G.,Stierlin,H., (1989).*Eine Katamnese manisch-depressiver und schizo-affektiver Psychosen nach systemischer Familientherapie*. Familiendynamik 14:214-235.

Rossi,E.(Hrsg.)(1995). *Gesammelte Schriften von M.H. Erickson*. Heidelberg, Carl-Auer-Systeme.

Roth, G. (1994). *Das Gehirn und seine Wirklichkeit*. Frankfurt, Suhrkamp

Schmidt, G. (1985). *Systemische Familientherapie als zirkuläre Hypnotherapie*. In: Familiendynamik 10: S.242-264
Schulz v.Thun, F. (1999). *Miteinander Reden 3. Das „innere Team" und situationsgerechte Kommunikation. Rowohlt*, Reinbek b. Hamburg.
Schwartz, R.C. (1997). *Systemische Therapie mit der inneren Familie*. Pfeiffer-Verlag,München.
Seligman, M.E.P. (1986): *Erlernte Hilflosigkeit*, PVU, München-Weinheim
Selvini-Palazzoli,M.,Cecchin,G.,Boscolo,L.,Prata,G.(1978): *Paradoxon und Gegenparadoxon*. Stuttgart, Stuttgart, Klett-Cotta
Simon, F.B. (2001). *Die andere Seite der Gesundheit*. Carl-Auer-Systeme-Verlag, Heidelberg
Spitzer, M. (2000). *Geist im Netz- Modelle für Lernen*, Denken und Handeln. Heidelberg/ Berlin, Spektrum Akadem. Verlag
Stierlin H. (1978). *Delegation und Familie*. Frankfurt, Suhrkamp
Stierlin, H.,(1995): *Das Ich und die Anderen*. Stuttgart, Klett-Cotta
Tomm, K. (1994). *Die Fragen des Beobachters. Schritte zu einer Kybernetik 2*. Ordnung in der systemischen Therapie. Heidelberg, Carl-Auer-Systeme.
v. Schlippe, A., Schweitzer, J. (1996): *Lehrbuch der systemischen Therapie*. Göttingen, Vandenhoek u. Rupprecht
Watzlawick, P., Weakland, J., Fish, R. (1974). *Lösungen- Zur Theorie und Praxis menschlichen Wandels*. Huber, Bern
Weber, G., Retzer, A., Schmidt, G., Simon, F.B., Stierlin, H.,(1987).*Die Therapie der Familien mit manisch-depressivem Verhalten*. Familiendynamik 12:139-161.
Wolinsky, S. (1993). *Die alltägliche Trance*. Freiburg, Lüchow.
Yalom, Irvin D. (1996). *Theorie und Praxis der Gruppenpsychotherapie*. Pfeiffer, München
Yapko, M. (1995): *Depression und Hypnose*, München, Pfeiffer-Verlag
Yapko, M.(1990). *Trancework: An introduction to the practise of clinical hypnosis*. New York, Brunner/ Mazel.
Zeig, J. (1995). *Meine Stimme begleitet Sie überall hin- ein Lehrseminar mit Milton H. Erickson*. Stuttgart, Klett-Cotta

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