American Journal of Clinical Hypnosis
48:2-3, October 2005/January 2006

Commentary: Defining Hypnosis

Herbert Spiegel
Columbia University

Marcia Greenleaf
Albert Einstein College of Medicine

Introduction

The invitation to comment on the new definition of hypnosis published by Division 30 of APA gives me (H.S.) an occasion to express some thoughts that I have had for quite some time.

The article, "Forging Ahead: The 2003 APA Division 30 Definition of Hypnosis" (Green, Barabasz, Barrett & Montgomery, 2005), represents a major effort to consolidate various points of view in the field of hypnosis. After reading it, I became concerned that the resulting definition of hypnosis is more confusing than clarifying with its emphasis on various procedures and ceremonies including disagreements about mentioning the word "hypnosis." Just as some regard a camel as a horse designed by a committee, I got the impression that the definition seems like a "camelized" version of a hypnotized horse. This led me to crystallize my thinking about our field after more than 50 years of working with trance phenomena during war and peace (Kardiner & H. Spiegel, 1947; H. Spiegel, 2000). During this period, I have engaged in an estimated 50,000 trance inductions. Inevitably, I made some observations and developed some convictions that I would like to share with a special concern for that large population of therapists who are chronically cynical about hypnosis. Then, I asked my wife, Marcia Greenleaf, PhD, to join me in adding her thoughts based on her experience in the field during the last 30 years.

Address correspondences and reprint requests to:
Marcia D. Greenleaf, Ph.D.
19 E. 88th St., #1D
New York, NY 10128-0558
Email: mgreenleafphd@aol.com

Critique

1) It is confusing to describe a procedure for how hypnosis is introduced to a patient as part of a definition. Then, telling a patient he or she will be given "suggestions for imaginative experience" may, in itself, be unnecessary. Let the patient find out by having an experience of his own imaginative processes. This is do-able in the five minutes it takes to administer the Hypnotic Induction Profile (HIP), and at the same time, measure trance capacity (H. Spiegel & Bridger, 1970; H. Spiegel & D. Spiegel 2004). The patient has an actual experience of entering, using his or her imagination and exiting from the trance. This is faster and more effective than *talking about it* to the patient.

The ability to experience trance has been observed by many clinicians and revealed in the laboratory as a capacity or ability (Hilgard, 1965, 1975). Recent findings suggest a genotype which serves "to complement an attentional phenotype such as hypnotizability" (Raz, 2005). In another study, highly hypnotizable subjects were clearly more successful controlling experimentally induced pain than lows and were found to have more rostrum volume (by 31.8%) in the anterior corpus callosum than lows. This is an area of the brain which is known to play a part in attentional systems (Horton, Crawford, Harrington & Downs, 2004). Clinically, this finding underscores our need to be more respectful of our patients and more modest in remembering it is *not* something which we have the power to project onto someone (H. Spiegel, 1981; H. Spiegel & Greenleaf, 1992; H. Spiegel & D. Spiegel, 2004). Rather, trance is an innate *bio*-psycho-social capacity that can be tapped and measured (H. Spiegel & D. Spiegel, 2004). Measurement reveals a range of trance capacity with different subjects from zero to low, to mid-range to high. Generally, it remains a stable capacity over time with each individual (Piccione, Hilgard & Zimbardo, 1989).

The apparent reluctance of so many in the profession to use *measurement* as a necessary routine part of the initial clinical appraisal contributes to some of the confusion in the recent Division 30 definition. Some of this reluctance may be due to those in the field who misconstrue measurement as a challenge to the patient or are fearful it will limit expectations for therapeutic outcome. Such misunderstandings may come from assessments of hypnotizability which were originally designed for research rather than a clinical measurement such as the HIP. Yet, the process of measurement can be a powerful means to establish a respectful relationship. It actually reduces performance pressure on the therapist to 'produce' a trance in the patient, and it avoids the patient feeling like a failure if a hypnotic state is not achieved. It is also a way to acknowledge the reality that not everyone is equally hypnotizable, and some are not at all capable of hypnotic experience. Furthermore, the goal of measuring is to have a *disciplined* way to assess hypnotizability, which can facilitate more accurate diagnoses of normal personality styles and mental illness (Frischholz, Lipman, Braun & Sachs, 1992a; Frischholz, Lipman, Braun & Sachs, 1992b; Frischholz, D. Spiegel, Trentalange & H. Spiegel, 1987; D. Spiegel, Detrick & Frischholz, 1982; H. Spiegel, Fleiss, Bridger, & Aronson, 1975; H. Spiegel & Greenleaf, 1992; H. Spiegel & D. Spiegel, 1978; 2004) and help clinicians make more rational choices for effective treatment strategies. This maximizes the potential for successful therapeutic outcome (DuHamel, Difede, Foley & Greenleaf, 2002; Greenleaf, 1992; Greenleaf, Fisher, Miaskowski & DuHamel, 1992; Katz, Kao, H. Spiegel & Katz, 1974; H. Spiegel, 2000; D. Spiegel, Frischholz, Fleiss & H. Spiegel, 1992; D. Spiegel, Frischholz, Maruffi & H. Spiegel, 1981; H. Spiegel & D. Spiegel, 2004).

When measurement with the HIP is used, studies have shown that approximately 75% of the population have trance capacity with a distribution of approximately 20% low,

48% mid-range and 7% high; with about 25% of the population who have no trance capacity (DeBetz & Stern, 1979; H. Spiegel, Fleiss, Bridger & Aronson, 1975; H. Spiegel, Aronson, Fleiss & Haber, 1976). Hilgard came up with a similar distribution with the Stanford scales (1965; 1975). Most subjects who showed a break in their *flow* of concentration revealed by the HIP, thus not able to experience trance, showed evidence of cognitive impairment because of a variety of psychiatric disorders, toxic conditions or physical trauma (H. Spiegel & D. Spiegel, 1978; 2004). These findings are in keeping with the Manhattan project which found 23.5% of the city population had moderate to severe psychiatric disorders (Strole, Langer, Michael, Opler & Rennie, 1962). There is a small percentage of individuals who are mentally healthy but do not have the innate biological endowment for hypnotic concentration. They reveal a zero Eye Roll Sign (H. Spiegel & D. Spiegel, 1978; 2004). These are critical differentials to be made by any clinician or researcher who works with trance modality.

2) Spontaneous trance was not acknowledged in the definition. Quite often, a psychologically healthy trance experience occurs spontaneously when the person engages in a highly motivated task that requires intense concentration. The trance state has much in common with the ability to have an intact "flow experience" (Csikszentmihalyi, 1996). There is also ample literature documenting pathological spontaneous trance states, i.e., fugues, conversion disorders, dissociative disorders, and medical patients in crisis. It is critical for professional health care providers to identify and know how these states will influence treatment interventions and treatment outcome (H. Spiegel, 2000; H. Spiegel & D. Spiegel, 2004).

3) The very name "hypnosis" is unfortunate. It comes from the Greek word meaning "sleep," and in no way is the hypnotic state related to sleep, but the very name itself perpetuates a confusing misunderstanding of the trance experience.

4) Even though "susceptibility" is a term historically used in the field, it is a major contribution from Division 30 to avoid this term. Considering the ability to experience trance as "susceptibility" created confusion for both the patient and the therapist. The label "susceptibility" implied there are certain weaknesses inherent in the subject and certain manipulations that must be calculated by the operator. This is quite unnerving to many professionals and the general public.

Proposals for a Definition

We offer a definition of hypnosis (or trance) as an animated, altered, integrated state of focused consciousness, that is, controlled imagination. It is an attentive, receptive state of concentration that can be activated readily and measured. It requires some degree of dissociation to enter and become involved in imagined activity, enough concentration for an individual to maintain a certain level of absorption, and some degree of suggestibility to take in new premises (H. Spiegel & Greenleaf, 1992). Long induction ceremonies are not necessary to induce trance. In fact, some rapid inductions can be achieved in 30 seconds (Finkelstein, 2003). We are not putting the patient to sleep, nor are we trying to eliminate the patient's participation in the therapeutic process. Even in regressions, the patient is sufficiently alert to interact with the therapist; and, in the laboratory, brain waves indicate an active, alert physiological state (H. Spiegel & D. Spiegel, 2004; H. Spiegel, Greenleaf & D. Spiegel, 2005).

A useful definition of hypnosis will make the distinction between the state itself and the procedures used to induce it; it will also make a distinction between inducing the

altered state and treatment strategies (Anderson, Frischholz & Trentalange, 1988; Frischholz, 2000; Frischholz & D. Spiegel, 1983; Frischholz, D. Spiegel & H. Spiegel, 1981; H. Spiegel & Greenleaf, 1992; H. Spiegel & D. Spiegel, 2004).

In defining the state, the three ways it can be achieved*must* be included: spontaneous (the most common), hetero-hypnosis (when induced by another) and self-hypnosis (self-induced to maintain therapeutic gains.) Once instructed in self-hypnosis, a motivated patient who actively seeks to develop mastery and control can induce and enter his or her own trance state in about 5 to 10 seconds to be followed by a treatment strategy.

The definition should also include the criteria necessary to experience the trance state such as the three components previously mentioned: dissociation (which unlike the dissociated states of the schizophrenic is reversible at will) for imaginative involvement, absorption for concentration and enough suggestibility to incorporate new perspectives.

When we work with trance capacity, either for therapy or research, it is relevant to clarify diagnosis and identify the individual's resources. Mental disturbance, whether caused by biological, psychological or social factors, impairs an individual's ability to go into a trance state (Frischholz, Lipman, Braun & Sachs, 1992; Spiegel, Detrick & Frischholz, 1982; H. Spiegel & D. Spiegel, 1978; 2004). In fact, most psychotics and many with mood and anxiety disorders are unable to maintain the necessary flow of concentration for specific therapeutic interactions in a trance state. (This is immediately detected with the HIP.) However, if recovery occurs, that person may be able to experience trance again.

The definition should specify that trance alone is not therapy, but when entered into, it can augment psychotherapeutic strategies. Since it is a state which reflects capacity and ability, and not a therapy, it has become a fertile ground for research.

We appeal to our colleagues to clarify our knowledge of trance phenomena in order to better appreciate its rich clinical and research usefulness.

References

Anderson, E.L., Frischholz, E.J. & Trentalange, M.J. (1988) Hypnotic and nonhypnotic control of ventilation. *American Journal of Clinical Hypnosis, 31*, 118-128.

Csikszentmihalyi, M. (1996) *Creativity*. New York: Harper Collins, p. 110.

DeBetz, B., & Stern, D.B. (1979). Factor analysis and score distributions of the HIP-replication by a second examiner. *American Journal of Clinical Hypnosis*, *22*(2), 95-102.

DuHamel, K.N., Difede, J., Foley, F., & Greenleaf, M. (2002): Hypnotizability and trauma symptoms after burn surgery. *Journal of Clinical and Experimental Hypnosis, 50*(1), 33-50.

Finkelstein, S. (2003). Rapid hypnotic inductions and therapeutic suggestions in the dental setting, *Journal of Clinical and Experimental Hypnosis 51*(1), 77-85.

Frischholz, E.J. (2000). Hypnosis is not therapy-revisited. *The International Society of Hypnosis Newsletter*, *2*(24), 33-34.

Frischholz, E.J., Lipman, L.S., Braun, B.G., & Sachs, R.G. (1992a). Psychopathology, Hypnotizability and dissociation. *American Journal of Psychiatry, 149*: 1521-1525.

Frischholz, E.J., Lipman, L.S., Braun, B.G., & Sachs, R.G. (1992b). Suggested post-hypnotic amnesia in psychiatric patients and normals. *American Journal of Clinical Hypnosis*, *35*: 29-39.

Frischholz, E.J. & Spiegel, D. (1983). Hypnosis is not therapy. *Bulletin of the British Society of Clinical and Experimental Hypnosis, 6:* 3-8.

Frischholz, E.J., Spiegel, D., & Spiegel, H. (1981). Hypnosis and the unhypnotizable: A reply to Barber. *American Journal of Clinical Hypnosis, 24*: 55-58.

Frischholz, E.J., Spiegel, D., Trentalange, M.J., & Spiegel, H. (1987) The Hypnotic Induction Profile and absorption. *American Journal of Clinical Hypnosis, 30*: 87-93.

Green, J.P., Barabasz, A.F., Barrett, D., & Montgomery, G. (2005). Forging ahead: the 2003 APA Division 30 definition of hypnosis. *Journal of Clinical and Experimental Hypnosis, 53* (3): 259-264.

Greenleaf, M. (1992) Clinical implications of hypnotizability: enhancing the care of medical and surgical patients. *Psychiatric Medicine, 10*(1): 77-86.

Greenleaf, M. (1992) Clinical implications of hypnotizability: enhancing the care of medical and surgical patients. *Psychiatric Medicine, 10*(1): 77-86.

Greenleaf, M., Fisher, S., Miaskowski, C., & DuHamel, K. (1992): Hypnotizability and recovery from cardiac surgery. *American Journal of Clinical Hypnosis, 35* (2): 119-128.

Hilgard, E.R. (1965). *Hypnotic susceptibility*. New York: Harcourt, Brace & World.

Hilgard, E.R. (1975). Hypnosis. *Annual Review of Psychology, 26*: 19-44.

Horton, J.E., Crawford, H.J., Harrington, G., & Downs, J.H. (2004) Increased anterior corpus callosum associated positively with hypnotizability and the ability to control pain. *Brain, 127*: 1741-1747.

Kardiner, A., Spiegel, H. (1947). *War stress and neurotic illness*, New York: Paul Hoeber & Co.

Katz, R.L., Kao, C.Y., Spiegel, H. & Katz, G.J. (1974). Acupuncture and hypnosis, *Advances in Neurology, 4*: 819-825.

Piccione, C.E. , Hilgard, E.R. & Zimbardo, P.G., (1989). On the degree of measured hypnotizability over a 25 year period. *Journal of Personality & Social Psychology,* 56(2): 289-95.

Raz, A. (2005). Attention and hypnosis: neural substrates and genetic associations of two converging processes. *Journal of Clinical and Experimental Hypnosis,* 53(3): 237-258: 237-258.

Spiegel, D., Detrick, E., & Frischholz, E.J. (1982). Hypnotizability and Psychopathology. *American Journal of Psychiatry*, 139: 431-439.

Spiegel, D., Frischholz, E.J., Maruffi, B.L., & Spiegel, H. (1981). Hypnotic responsivity in the treatment of flying phobia. *American Journal of Clinical Hypnosis*, 23: 239-247.

Spiegel, D., Frischholz, E.J., Fleiss, J.L., & Spiegel, H. (1992). Predictors of smoking abstinence following a single session restructuring intervention with self-hypnosis. *American Journal of Psychiatry*, 150(7): 1090-1097.

Spiegel, H. (1981). Hypnosis: Myth and reality. *Psychiatric Annals* 11(305): 711-716.

Spiegel, H. (2000). Silver linings in the clouds of war: A five-decade retrospective. In R. Menninger, & J. Nemiah: *Post World War II history of american psychiatry*. Washington, DC: American Psychiatric Press.

Spiegel, H., & Bridger, A.A. (1970). *Manual for the Hypnotic Induction Profile.* New York: Soni Medica, Inc.

Spiegel, H., Fleiss, J.L, Bridger, A.A. & Aronson, M. (1975). Hypnotizability and Mental Health. In *New dimensions in psychiatry: A world view*. Arieti, S. (Ed.) New York: Wiley. p. 341-356.

Spiegel, H., Aronson, M., Fleiss, J.L., & Haber, J. (1976). Psychometric analysis of the Hypnotic Induction Profile. *Journal of Clinical and Experimental Hypnosis*. 24: 300-315.

Spiegel, H. & Greenleaf, M. (1992). Personality style and hypnotizability: The fix-flex continuum. *Psychiatric Medicine,* 10 (1): 13-24.

Spiegel H., Greenleaf M., & Spiegel D. (2005) Hypnosis: an adjunct for psychotherapy. In Kaplan & Sadock's *Comprehensive Textbook of Psychiatry*, 8th ed. p. 2548-2568. Philadephia: Lippincott, Williams & Wilkins.

Spiegel, H. & Spiegel, D. (1978) *Trance and treatment: clinical uses of hypnosis*. New York: Basic Books, Inc.

Spiegel H. & Spiegel D. (2004) *Trance and treatment: clinical uses of hypnosis*. 2nd ed., Washington, DC: American Psychiatric Press.

Srole, L., Langer, T.S., Michael, S.T., Opler, M.L., & Rennie, T.A.C. (1962). *Mental health in the metropolis.* New York: McGraw-Hill.