Rapid Self-Hypnosis: A New Self-Hypnosis Method and Its Comparison with the Hypnotic Induction Profile (HIP)

Juan Martínez-Tendero
Centro Psicológico para la Salud
Antonio Capafons
Universitat de València
Viola Weber
Universität Mannheim
Etzel Cardeña
University of Texas, Pan Am

Despite its clinical importance, there are few systematic studies on the application of self-hypnosis. Rapid Self-Hypnosis (RSH) was created to provide a new procedure that is easy, comfortable, fosters alertness, and can be done covertly in everyday life. We present it as an alternative to the self-hypnosis version of the Hypnosis Induction Profile (HIP). Using a crossover design, we found in an experimental session that the RSH and the HIP produced comparable objective and subjective scores in the Barber Suggestibility Scale (BSS). However, as compared with the HIP, participants rated RSH as significantly more coherent, pleasant, faster and easier to learn, more likely to be used in everyday life and go unnoticed by others, less bothersome to use, and more likely to be used in private. Additional research should clarify whether these differences are reliable and have clinical significance. Our results suggest that RSH will be a valuable addition to the clinician’s arsenal.

Introduction

The history of self-hypnosis, defined as the self-administration of hypnotic induction and suggestions, is as old as that of hetero-hypnosis, the administration of induction and suggestions to a hypnotic subject by somebody else (Ruch, 1975). The behavioral effectiveness of self- and hetero-hypnosis are comparable (Johnson & Weight, 1976; Johnson, 1979; Ruch, 1975), but there is evidence that hetero-hypnosis and tape-
assisted hypnosis are experienced more positively than self-hypnosis, although that advantage may fade with practice (Hammond, Haskins-Bartsch, Grant, & McGhee, 1988; Johnson, Dawson, Clark, & Sikorsky, 1983). It may be that self-hypnosis requires, at least in the beginning, greater effort than hetero-hypnosis because the participant must be simultaneously the agent and recipient of the suggestions.

Self-hypnosis has often received a secondary role in the specialized literature, partly because many authors have discussed it only in the context of post-hypnotic suggestions given by the hypnotist to the client (Weitzenhoffer, 1957). This is paradoxical because some form of self-hypnosis is included in many, if not most, therapeutic approaches to hypnosis. An important exception to this trend is the programmatic work on the theory, phenomenology, and clinical application of self-hypnosis carried out by Fromm and collaborators (for a review, see Fromm & Kahn, 1990). However, specific research on applied aspects of self-hypnosis has generally been scant. Although Barabasz and Barabasz have described the successful use of their INAP procedure to treat ADHD, their reports have referred to a combination of hetero- and self-hypnosis, without specific data presentation or analysis about self-hypnosis alone (e.g., 1999).

One of the advantages of self-hypnosis is that it can be easily incorporated into therapies that emphasize the use of relaxation in everyday life, such as active management of stress (Denney, 1983), and training on applied relaxation (Hutching, Denney, Basgall, & Houston, 1980). A second advantage is that it can reduce the clients’ dependence on the therapist, thus enhancing their self-control and perception of self-efficacy. In addition, self-hypnosis can be used with individuals who are afraid of losing control or volition if they are hypnotized by someone else. In our observation, a number of people refuse to be hypnotized because of this fear, thereby hampering the application of hypnosis in clinical and research settings. Finally, there is evidence indicating that hypnosis in general can have a synergistic effect on general therapeutic strategies, whether psychodynamic or cognitive-behavioral (Kirsch, Capafons, Cardeña, & Amigó, 1999; Kirsch, Montgomery, & Sapirstein, 1995).

Despite these advantages, few clearly defined methods of self-hypnosis have been tested empirically or are easy to adapt to the clients’ everyday lives. We think that, in general, these procedures should be enjoyable, not require unusual abilities, and be easy to understand. They should also lead the individuals to exhibit and experience apparently unusual and automatic behaviors, which will enhance their response expectancy of being hypnotized (Kirsch, 1990).

In this study, we compared two self-hypnosis procedures that provide certain experiences that can be thought of as hypnotic, while interfering minimally with everyday tasks. These techniques are also rapid, easy to learn, and use in everyday life, convenient, and may be done in a concealed or “camouflaged” way.

The self-hypnosis version of the Hypnotic Induction Profile (HIP; H. Spiegel & D. Spiegel, 1978) fulfills these criteria and is perhaps the best known and most widely used self-hypnotic procedure. It can be used in the midst of many common activities and has empirical backing. Its instructions, after a previous induction through hetero-hypnosis, are as follows:
You sit or lie down and, to yourself, you count to three. At one you do one thing; at two, you do two things; at three you do three things. At one, look up toward your eyebrows; at two, close your eyelids and take a deep breath; and at three, exhale, let your eyes relax, and let your body float. As you feel yourself floating, you permit one hand or the other to feel like a buoyant balloon and let it float upward as your hand is now. When it reaches this upright position, it becomes your signal to enter a state of meditation in which you concentrate on these critical points. (p. 76)

Instructions are given about how to come out of hypnosis by counting backwards, and a camouflaged version to be done in public is explained. The latter consists of doing the eye-roll surreptitiously and levitating the arm to casually touch the forehead (see Spiegel & Spiegel, 1978, p. 77).

There is evidence for the efficacy of the HIP self-hypnosis procedure in the control of pain (D. Spiegel & Bloom, 1983) and smoking (D. Spiegel, Frischholz, Fleiss, & H. Spiegel, 1983), but we have observed that some people have problems with the method. They include mild ocular pain, inability to roll up the eyes, feeling the arm heavy instead of light, and difficulty in covertly keeping the eyes closed and the arm raised in some public situations (Capafons, 1998b; Capafons & Amigó, 1993).

The second author developed the Rapid Self-Hypnosis (RSH) method to address these problems (Capafons, 1998a, 1998b). RSH is based on a rapid hetero-hypnosis induction that uses slow and relaxed breathing, an abrupt fall back into a chair and hand clasps. It can be done with eyes open or closed. RSH has three steps: In the first, the participant must sit in a comfortable chair, clasping the hands lightly, with his or her back separated from the back of the chair about 3 inches. He or she should then make three exhalations after three deep inhalations, accompanied by a light but increasingly stronger hand press, with suggestions that the arms are feeling heavy. If the exhalations are too abrupt, the client can be told to imagine a lit candle about 10 inches from the nose, and that the exhalation should make the flame waver lightly, without going out.

The second step in RSH involves having the client separate the body from the back of the chair and letting the body fall back suddenly, while self-administering a suggestion of momentary immobility. Steps 1 and 2 are then chained by repeating the hand clasping and, at the third exhalation, letting the body fall back and the hands fall down, while self-administering suggestions of relaxation and immobility. The final step is to repeat the exercise with the suggestion that one of the arms will feel so heavy that it will feel glued to the legs. Although this heaviness sensation can be experienced without the assistance of images, participants can enhance the sensation by imagining that they are made of lead or that there is a very heavy object on their legs.

Participants are told that the sensation of heaviness signals that they are hypnotized and ready to give themselves suggestions. This method must be practiced until all the steps can be done with the eyes open. Participants also learn to “cover” the procedure by making it seem as if they have just been clasping their hands before changing posture. To end the procedure, the client must count to three, open the eyes if they were closed,
and lightly move the arm until it feels normal (Capafons, 1998a, 1998b; Capafons & Amigó, 1993). Although the initial training procedure is somewhat elaborate to instigate hypnotic experiences, in clinical practice clients have been taught to “fade out” these initial steps so that the sensation of a heavy or dissociated arm alone will produce similar effects as the whole procedure (see Capafons, 1998a).

In this study, we investigated the effectiveness of RSH on suggestibility by comparing its scores on a suggestibility test with those of the HIP. We also measured the preference for each procedure.

**Method**

**Participants**

The sample consisted of 30 participants (19 women and 11 men; mean age = 23.4, SD= 3.13). They were recruited through acquaintances of the researchers and word-of-mouth, and did not receive payment or academic credit; they were not provided any additional information than that required for informed consent. Three participants had previous experience with hetero-hypnosis, but none with self-hypnosis.

**Instruments**

To evaluate suggestibility, we used Barber’s Suggestibility Scale (BSS; Barber, 1969/1995; Barber & Wilson, 1979), which contains an objective scale with 8 items, scored as 1, “pass,” or 0, “fail.” The BSS also has a subjective scale, which evaluates the experience on those same items according to a score from 0-3. The 8 items are: arm lowering, arm levitation, hand lock, thirst hallucination, verbal inhibition, body immobility, “posthypnotic-like” response, and selective amnesia. The BSS has good reliability and validity, and a strong correlation with the Stanford Hypnotic Susceptibility Scale, Form A (Barber, 1969/1995; Council, 1999). Although not widely employed nowadays, we used the BSS because it includes objective and subjective scales for various items, and requires less administration time than most hypnosis scales.

To determine if there was any preference for either the HIP or the RSH, we developed the Preferences Questionnaire for Self-Hypnosis Methods (Martínez-Tendero, 1995). This instrument consists of eighteen questions that evaluate which method is more pleasant, easier to use and learn, and so on (see Table 1). Participants can state a preference for either technique or for none.

**Design and Procedure**

We used a cross-over design, with random assignment to presentation order. The experiment was conducted by two experimenters, a man and a woman, both previously trained in teaching both techniques. The procedure consisted of individual sessions, lasting between 1-2 hours, which adhered to these steps:

1) Rapport was established, a demographic form was filled out, and information was given to the participant on hypnosis and the experiment.
2) The first self-hypnosis technique (either HIP or RSH) was taught by having the experimenter verbalize the procedure and model it until the participant understood it. Afterwards, he or she practiced the method with the help of the experimenter until it had been learned. Finally, the camouflaged version of the technique was taught and modeled. Afterwards, the participant did the non-camouflaged version and the BSS was administered.

3) After a small rest, step #2 was repeated for the second technique.

4) At the end of the session, the Preferences Questionnaire for Self-Hypnosis was administered.

Results

A repeated-measures ANOVA was conducted to evaluate the effect on suggestibility of technique (RSH vs. HIP), order of presentation, and their interaction. The techniques did not differ in objective (F = 1.27, p>.05) or subjective (F = 0.88, p>.05) BSS scores, nor were there significant order or interaction effects. There were no significant gender differences in either of the BSS subscales. As expected, the scores on the objective and subjective subscales were highly correlated (r =.86, p<.01 for the HIP; r =.8, p<.01 for the RSH).

The means and standard deviations for the objective scores on the BSS obtained after using the HIP (M= 4.72, SD = 1.91) and the RSH (M = 5.36, SD = 2.06), were comparable to those obtained by the second author (Capafons, 1993) using the heterohypnosis relaxation procedure of Friedlander and Sarbin (1938) (M = 4.8, SD= 2.13) with a sample of 20 undergraduate students (14 women; mean age = 23.8, SD = 4.4). The means and standard deviations of the BSS subjective scales for the HIP (M=14.4, SD=10) and the RSH (M=12, SD=4.67) were also comparable to those obtained by the second author (Capafons, 1993) with the sample described above (M=11.10, SD=5.14). However, scores on the objective scale were somewhat lower than those reported by Barber and Wilson (1979) for a North American sample, (M=5.8, SD=2.1).

We also analyzed the results on the BSS by experimenter, because the main experimenter was not blind as to authorship of the RSH (a professor of both experimenters), but the second experimenter was. There were no significant differences between experimenters either for the HIP (for the objective and subjective subscales, F =.05, p >.1, and F =.02, p>.1, respectively) or the RSH (for the objective and subjective subscales, F = 1.32, p >.1, and F = .46, p >.1 respectively).

Finally, we evaluated whether participants showed any preference for either the HIP or the RSH. Table 1 shows that, as compared with the HIP, the RSH was rated as significantly more coherent, pleasant, faster and easier to learn, more likely to be used in everyday life and go unnoticed, less bothersome to use, and more likely to be used in private.
The high correlation between the BSS objective and subjective scales supports a close correspondence between the behavioral response to suggestions and the accompanying subjective experience (Tart, 1970). This correspondence has clinical implications because an unusual subjective experience, partial involuntariness for instance, may enhance a therapeutic response expectancy in the majority of individuals who can follow at least a few self-hypnotic suggestions (Kirsch, 1990).

The RSH and the HIP produced similar objective and subjective scores on the BSS, which were also similar to those obtained by hetero-hypnosis in other studies. Thus, we predict that the RSH will have similar clinical efficacy as that already reported for the HIP and for hetero-hypnosis procedures. In our study, both self-hypnosis techniques were explained and modeled thoroughly before the participants attempted them. This is, of course, different than just buying tapes or reading about self-hypnosis.

### Table 1: Preference between self-hypnosis methods (N=30)

<table>
<thead>
<tr>
<th>Category</th>
<th>HIP</th>
<th>AHR</th>
<th>$X^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>13.3</td>
<td>30</td>
<td>1.92</td>
</tr>
<tr>
<td>Coherent</td>
<td>16.7</td>
<td>60</td>
<td>7.34**</td>
</tr>
<tr>
<td>Easy to learn</td>
<td>16.7</td>
<td>23.3</td>
<td>0.33</td>
</tr>
<tr>
<td>Easy to understand</td>
<td>20.0</td>
<td>33.3</td>
<td>1.00</td>
</tr>
<tr>
<td>Pleasant</td>
<td>10.0</td>
<td>63.3</td>
<td>11.63***</td>
</tr>
<tr>
<td>Fast to learn</td>
<td>16.7</td>
<td>70.0</td>
<td>9.84**</td>
</tr>
<tr>
<td>Easy in everyday life</td>
<td>23.3</td>
<td>40.0</td>
<td>1.31</td>
</tr>
<tr>
<td>Will use in everyday life</td>
<td>23.3</td>
<td>53.3</td>
<td>3.52*</td>
</tr>
<tr>
<td>Easy to do</td>
<td>13.3</td>
<td>30.0</td>
<td>1.92</td>
</tr>
<tr>
<td>Helpful for my problems</td>
<td>10.0</td>
<td>16.7</td>
<td>0.50</td>
</tr>
<tr>
<td>Helpful for psychological problems</td>
<td>6.7</td>
<td>16.7</td>
<td>1.28</td>
</tr>
<tr>
<td>Bothersome to use</td>
<td>43.3</td>
<td>10.0</td>
<td>6.25**</td>
</tr>
<tr>
<td>Unnoticed in public</td>
<td>13.3</td>
<td>46.7</td>
<td>5.55**</td>
</tr>
<tr>
<td>Easy to remember</td>
<td>50.0</td>
<td>36.0</td>
<td>0.61</td>
</tr>
<tr>
<td>Will use in private</td>
<td>6.7</td>
<td>43.3</td>
<td>8.06**</td>
</tr>
<tr>
<td>Will use in public</td>
<td>26.7</td>
<td>40.0</td>
<td>0.80</td>
</tr>
<tr>
<td>Would recommend it</td>
<td>10.0</td>
<td>26.7</td>
<td>2.27</td>
</tr>
<tr>
<td>Felt myself hypnotized</td>
<td>30.0</td>
<td>26.7</td>
<td>0.59</td>
</tr>
</tbody>
</table>

* $p<.05$, ** $p<.01$, *** $p<.001$
One of the motivations for developing the RSH was to create a technique with the efficacy of the self-hypnotic procedure of the HIP, but which could be done with open eyes and not produce the discomfort that the HIP seems to have on a few people. The finding that the RSH was preferred over the HIP in certain areas suggests that this goal may have been achieved. Our study needs to be replicated by independent researchers because the main experimenter was not blind as to the authorship of the RSH and could have inadvertently biased the results; however, our analysis did not show evidence of an “experimenter effect.”

If the results of this study are replicated, it will be important to evaluate if the preference of the RSH over the HIP translates into meaningful clinical effects. Although the actual effectiveness of a procedure will depend on factors such as level of hypnotizability, the specific suggestions used, and non-specific factors, a convenient, comfortable, and easy self-hypnotic procedure may facilitate treatment adherence and, ultimately, have a significant clinical effect. It would also be advisable to develop and evaluate self-hypnotic variants of procedures emphasizing alertness (e.g., Barabasz & Barabasz, 1999), which may be preferable in some circumstances (Capafons, Alarcón, Bayot, 1998). The call for systematic studies of hetero-hypnosis as an empirically supported treatment (e.g., Cardeña, 2000; Kirsch, Capafons, Cardeña & Amigó, 1999) should be accompanied by another call for more systematic studies on the application of self-hypnosis.

References


