Editorial:
How Do We Specify and Research the Skill Sets of Therapeutic Hypnosis?

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This is the first issue of the Journal published during my term as editor. I am thankful to have been selected as Editor and look forward to serving the American Society of Clinical Hypnosis (ASCH) in this capacity for the next several years. Thurman Mott, the interim Editor, deserves a great deal of gratitude from the Society for his repeated devotion to the Journal and his dedication transitioning through difficult times. He generously made himself available to me, freely offering advice and information. Former Editors Melvin Gravitz and Ed Frischholz also have offered their assistance and expertise, and I cannot thank them enough. Finally, I would like to acknowledge Cory Hammond for ably serving in the role of Associate Editor for the International Review of Literature for the Journal. For 18 years, Dr. Hammond wrote concise abstracts of articles on hypnosis that appeared in other journals. The Review section of the Journal has been of great value to ASCH members. Dr. Hammond's work composing these reviews requires continuous, meticulous, and painstaking effort. On behalf of the membership of ASCH and readers of the Journal, I want to express our deep and enduring gratitude to Dr. Hammond for his years of exemplary service. For this issue Dr. Hammond graciously agreed to train Dr. Ian Wickramasekera II as his replacement.

I acquired the position on April 1, 2005, and due to the dedicated work of everyone on the current masthead, the ASCH Executive Committee, and all the authors who have worked hard to create, and resubmit material in a timely fashion, the Journal is once again under way.
The American Journal of Clinical Hypnosis (AJCH), has been, and will continue to be, a distinguished and respected source for health care professionals seeking information on clinical, theoretical, and empirical research on the nature and utilization of hypnosis. My experience teaching hypnosis and brief therapy in various venues around the world has given rise to a broad vision for the Journal. I see it as an instrument for integrating hypnosis into the mainstream of health care. I seek to promote a wider range of health care professionals in learning about how the applications of hypnosis; patient/therapist interaction; research on hypnosis that improves our understanding of human functioning; and developing specific treatment protocols using hypnosis that will benefit client and patient care and improve the efficiency and efficacy of their professional efforts.

Manuscripts that advance the science and art of therapeutic hypnosis by specifying interventions and clarifying treatment protocols will receive priority over those that do not. For example, the term “hypnotic technique” is too ambiguous and needs to be specified. We will favor submissions that help the health care community better delineate and articulate what we actually do with clients. If an intervention is considered a “hypnotic technique,” what makes it so? Is it due to a fostering of suggestibility? Is it due to increasing internal absorption? If so, how can one specify the skill sets of therapeutic hypnosis and how are they measured and learned? Let us define these skill sets or interventions in a manner that is clinically replicable, tied to theory, and clear to researchers who wish to engage in empirical validation.

The skills we use in treatment are communications and observation skills. I believe this is the time to begin to discriminate and define both the empirical aspects of social and therapeutic communication and the observable or measurable responses that these communications elicit. For instance, if the telling of a story intended to be therapeutic (a so called “therapeutic metaphor”) results in the listener becoming less animated, having increased muscle lassitude, slowing his or her blink, swallow, and breathing reflexes, and producing pupil dilation, these observable signs need to be included in manuscripts. And, apropos to the earlier point, does this mean that therapeutic metaphor is a “hypnotic technique”? If so, why?

The same attention to detail should apply to types of suggestion, retrieved experiences, associational sequences, various health care contexts, client and patient backgrounds and goals, etc. We are long past the days when it is sufficient to say that the experimental group of client’s phobias, depression, asthma, pain, or whatever, were treated with “hypnotherapy.” We want to involve dentists, anthropologists, surgeons, consulting psychologists, sociologists, clinical social workers, neuroscientists, and professors in any of these fields to take hypnosis seriously or become interested in hypnosis. To accomplish this we need to further reduce the mythology surrounding hypnosis by careful observation of subjects, greater specificity of interventions used, and the development and testing of broader theories of human experience.

I would like to see a reduction of generalized statements like “hypnotic interventions” when it is possible to specify more precisely the particular procedures or protocols used. Such specification ought to use well described skill sets such as paradoxical intention; use of various specific language forms including direct and indirect suggestion; confusion; purposeful ambiguity; metaphor; and matching body language and so on. Authors can specify communications and intervention protocols used in
their clinical and research studies, and the observable behaviors displayed by their subjects that guided the choices they made. Thus, their work will be replicable and will be generalizable to the mainstream of successful health care.

Another of my concerns, which may surprise some readers, is that I will require clarification of articles that are submitted replete with terms such as “Ericksonian approach,” “Ericksonian concepts,” “Ericksonian therapy,” or “Ericksonian hypnosis.” I do not believe that there is any such thing as “Ericksonian hypnosis.” It is a term that has been carelessly used to indicate that a trainer or practitioner favors influences derived from Milton Erickson. Having personally observed Dr. Erickson during a period of five years, and having studied hypnosis research since his passing in 1980, I still wonder whether or not there are measurable differences in the therapeutic hypnosis he created compared with anyone else. This is a question that still requires empirical investigation. It is certainly true that the way in which Erickson conceptualized hypnosis; his timing; his choice of interventions in the sessions; how he introduced hypnosis; and his manner of induction was often different than that done by his contemporaries. But authors cannot simply say that they used an Ericksonian approach unless it is important for clarifying a manuscript. And then, authors need to define what they mean by saying “an Ericksonian approach” and provide reference citations from acceptable literature such as Erickson’s own writings. For example, one concept for dealing with an individual pertains to such well-known therapeutic wisdom as “speaking the client’s language,” or in other ways attempting to develop empathy by understanding the problem from the clients’ framework. It is inappropriate and ambiguous for articles to label these as “Ericksonian concepts” (1901-1980)—they can be found in the work of Carl Rogers (1902-1987) and before him those earlier pioneers of seeing problems from the client’s point of view like Phineas Pinel (1745-1826) at Salpetriere Hospital and later Hippolyte Bernheim (1835-1919) and so many others!

I have two major goals for the Journal. The first goal is making it a vehicle for unification. The AJCH can be a vehicle for the unification of many activities of its sponsor the ASCH. AJCH needs to strive for a unification of theory and practice. Articles that address theory also need to explain the ramifications of such theory in practice. Articles that address theory or clinical practice need to define the research that needs to be done to support them.

A second goal for the Journal is to unite practitioners of non-hypnotic health care with those who use hypnosis. There is much to be gained by this union. The skill sets of successful practitioners of hypnosis are phenomenal. How can we specify and research the skill sets of therapeutic hypnosis more precisely? The understanding of how words and tone alone change clients with pain during surgery, paralysis of limbs, dental anxiety, sexual dysfunctions, and so on, seems to border on the miraculous. Yet, we need to explain these verbal skill sets in greater detail so they can be replicated in the research laboratory as well as the clinic. I am certain that all psychotherapists, pediatricians, family therapists, surgeons, dentists, forensic psychologists and psychiatrists, and other health care professionals can improve the outcomes of their treatments through the acquisition of hypnotic skill sets. Journal submissions need to address these issues. These are the ways that the AJCH will bridge the gaps between mainstream health care professionals and the otherwise circumscribed membership of the ASCH. Finally, I believe we will advance AJCH such that “…the student, the
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experimenter and the clinician, wherever located, find readily at hand the aid and the inspiration of others similarly interested, and thus effect an exchange and a development of knowledge for himself [sic] and for others.¹” Let us continue to forge our way into the mainstream.

Please feel free to contact me with your thoughts and suggestions.

¹ This statement was taken from the first Editorial of AJCH (Vol. 1, No. 1, pg. 1) written by the founder of ASCH and first Editor of AJCH, Milton H. Erickson, M.D.