Commentary

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I appreciate being asked to comment on the paper “Hypnosis, Hypnotizability and Treatment.” I view this document as a clear and reliable display of antiquated, confused, foggy notions perpetuated by so many current practitioners of clinical. (Please note that what follows does in no way refer to those who are consistent in using valid and reliable measurement in their clinical practice or research).

First of all, hypnosis can be defined based on current neurological and psychological findings that have studied hypnotic phenomena, the ability to concentrate, and attention styles (Spiegel, 2007). We now know beyond clinical observations that hypnosis can be defined as attentive and receptive concentration or, to put it another way, as a form of controlled imagination. It is not sleep. The subject does not “awaken” from trance. The hypnotist does not project onto the subject – instead a natural neuro-circuitry is activated when trance occurs. Hypnosis is not a susceptibility – it is rather a capacity, or sometimes even a talent.

Erickson asserted that “almost everyone” is hypnotizable, but he did not measure. For example, patients with severe mental disorders like schizophrenia, primary depression, or severe obsessive compulsive disorders, cannot maintain the necessary ribbon of concentration long enough to experience and maintain trance as a controlled and reversible state. When measurement is used only about 80% of the population is hypnotizable. Because the Stanford Scale uses individual items which do not have a continuous flow, those with mental disease can respond to some items and score a few points on the scale. But this is not the same as the low score of a mentally intact person who is hypnotizable at the low end of the spectrum. The Hypnotic Induction Profile (HIP) clearly differentiates these two low scoring groups identifying those who are hypnotizable from those who are not.

Three essential features occur in varying combinations which reflect low, mid-range, or high hypnotizability when trance occurs. These features are – absorption, dissociation and suggestibility. If any one of these variables is missing, there is no hypnosis (Spiegel & Spiegel, 1978; 2004).

Hypnosis, per se, is not therapy. It is always, at best, an adjunct to a primary treatment strategy devised by the therapist, or it can occur spontaneously as wish fulfillment, daydreaming, or a coping strategy under stressful conditions.
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Hypnosis can also be an adjunct to a wrong or inappropriate strategy or thus cause harm to the patient and even perpetuate illness behavior.

There is a constellation of four factors which need to be taken into account: one, who is the person; two, what is the nature of the problem; three, does the issue fall into the expertise of the practitioner; and four, what strategies would combine the resources of the person and the nature of the problem to produce a therapeutic result. Some of these factors are overlooked when the emphasis is on induction procedures rather than examining the resources of the person. There are in practice a large variety of induction techniques. Many of them are unnecessarily too complicated and too long for the person and the problem. Sometimes, in our educational programs in the hypnosis societies and in our literature, treatment strategies are fused and confused as induction ceremonies. Many patients can be instructed into a trance in about 10 to 30 seconds and then the focus can be appropriately on the treatment strategy.

As to the four cases:

Case 1

The 5-minute induction ceremony is too long - especially with a “high” – 20 seconds is an adequate period. Many clinical biological syndromes have a normal continuous sequence of spontaneous recovery, if it is not interrupted by inept strategies or intrusive advice. The bleeding cessation here could well have been a completion of a natural sequence, as the author acknowledged. But, sometimes an inept strategy can interfere with healing. To the author’s credit the strategy of an imagined suture allowed the healing sequence to occur in a timely manner and the patient felt mastery over the process.

Case 2

How does the therapist know that this patient was not hypnotizable? No measure was done. She was instructed to use the “tension technique” to finally take control. This kind of illness behavior can easily be corrected with this tension strategy, even without hypnosis.

Case 3

Again, no measurement was done. She was clearly uncooperative, even defiant. She may have stopped smoking, but only temporarily, going back to smoking just to defy the therapist. After all, most of the population who stop smoking does so without formal hypnotic ceremonies. Some of this group may experience spontaneous hypnosis to facilitate the goal without even being aware of it.

Case 4

At last, this patient was measured, and she scored as a “high.” Note that as a “high” she went into trance even before the induction ceremony. Although she was a “high” with motivation, the strategy was inappropriate. Instead of
focusing only on a negative perspective on cigarettes being “nasty,” the better strategy should have been positive with focus upon respecting and protecting her body from the poison of smoking.

Note that when instructed to alleviate pain involving her finger nails, she responded to an appropriate positive treatment strategy: “Let the pain drain out of your fingers and fall onto the floor.” This positive new perspective, with a motivated highly hypnotizable patient can readily affect control, even without a formal induction ceremony.

To summarize over 60 years of clinical experience and research, there is ample evidence that formal measurement with an appropriate scale provides clinically useful information that relates to outcome (Spiegel & Spiegel, 2004; Spiegel, 2007). For example, when the Hypnotic Induction Profile is used to measure hypnotizability (it takes only 5 to 10 minutes), four levels of information become evident:

1) trance capacity – high, mid-range, low;
2) personality processing style;
3) placement on a health-illness continuum;
4) which strategy is appropriate, given the data from 1 -3 (Spiegel, 2007).

The frank and utter candor of this paper provides an occasion to encourage relinquishing antiquated notions about hypnosis and promotes a better clinical application with updated knowledge and rationality. Someone once put it this way. “If you can measure, it is science. Everything else is poetry.” While many who use hypnosis professionally take pride in their “poetry,” there are many occasions when this approach does an injustice to the patient. There is such a thing as bad poetry.

References