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Hypnosis
for Behavioral Health
A Guide to Expanding
Your Professional Practice

David B. Reid, PsyD
For Melissa.

On August 18, 1990 I was deeply consumed by an irresistible hypnotic trance that continues to this day thanks to your patience, love, and selfless support.
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Preface

Patience and tranquility of mind contribute more to cure our distempers as the whole art of medicine.
— WOLFGANG AMADEUS MOZART (1787)

Despite 14 years of clinical experience treating behavioral health concerns, I felt frustrated and ineffective as the emotionally fragile man sat across from me, his arms folded across his chest, his watering eyes scanning the room for a box of tissues. Witnessing his internal struggle to resist further emotional deterioration, my mind consciously ran through a mental Rolodex of numerous therapeutic interventions at my disposal: cognitive therapy, rational emotive techniques, progressive muscle relaxation, reassuring client-centered comments. I even pondered the feasibility of strategic therapy; throw a double bind his way to snap him out of his panic. And there was always the option of continued silence.

Unexpectedly unresponsive, my confidence momentarily shaken, I was at a loss for words or ideas. I was sliding down a slippery Freudian slope with my panicked patient deteriorating before my eyes.

Without clear intention, I found myself explaining the “fight or flight” response first espoused by Walter Cannon (1915). I told the distressed man about the primitive, automatic, inborn response that prepares the body to “fight” or “flee” when survival is threatened. I gave him the Cliff Notes version of how the body’s natural defense mechanism is hardwired into our brains to protect us from harm. I explained how his panic attacks were the manifestation of his fight-or-flight system running amuck. His body was doing what it was supposed to do when it was frightened; unfortunately, it didn’t know the difference between real and imagined fear. His body was overheating and trying desperately to get his attention. Like that annoying cell phone commercial: His body was saying, “Can you hear me now?”

“So what can I do about it?” he asked, wiping tears from his cheeks.

“Your sympathetic nervous system has taken over at a time when it doesn’t need to,” I told him. “We need to get your autonomic nervous system back in control.”

More psychobabble from me as far as he was concerned.
His predictable question followed: “And how do I do that?”

It was then that I recalled looking through a brochure I received earlier that week offering a workshop on “Ericksonian Hypnosis.” It mentioned something about helping people access their innate, natural abilities to overcome panic and anxiety. Sounded credible, not like that “quack-like-a-duck” silliness that many think of when it comes to hypnosis. The brochure was still on my desk. I needed the continuing education credits and the course seemed like it would be entertaining, if nothing else.

I handed the brochure to my patient, told him I planned to take the course, and if he was willing, we could put trance work to the test. Given the severity of his panic attacks, which interfered with his ability to function as a fire fighter, he was willing to try anything that offered any hope of symptom relief. Just the thought of feeling better brightened his mood.

The seminar started two weeks later in Hilton Head, South Carolina. I admit, at first, I was skeptical. Though I consider myself an open-minded person, I maintained my preconceived and stereotyped notion of hypnosis. When the instructor informed us that this was “an experiential workshop where you will be helping people go into trance, and where you will experience trance yourself,” I immediately pictured myself in a hooded cape, Obi Wan Kenobi hovering beside me, offering words of encouragement: “Use the force, use the force.” I found the image a bit humorous and without complete awareness, started laughing out loud. This, of course, caught the attention of the instructor who, respectful as can be, asked if something was wrong. I shook my head, and apologized. But that wasn’t to be the end of it. He knew it, and I knew it.

Noticing the empty seats to my left and right, he realized I was alone and whatever just happened, happened in my head.

He offered another opportunity for me to share: “Are you sure about that?” And with that question, heads turned and all eyes in the room were on me.

Use the force, the voice echoed. I chuckled again. The instructor laughed in turn, though still not privy to my inside joke. Just then a small wave of nervous laughter rolled through the room. The spotlight was on me, the stage was mine whether I wanted it or not. There was no turning back now.

“Okay,” I started. “When you mentioned we’d be putting each other in trance today, I just pictured myself in a hooded robe with Obi Wan Kenobi encouraging me use the force. You know, ‘May the force be with you,’” I said as I waved my hands through the air making a light saber whoosh sound just for effect.

“Perfect,” he exclaimed and quickly settled the now-amused group like only a seasoned lecturer can. “Don’t you see how perfect that is?”
I wasn’t sure if the question was rhetorical, but I answered anyway, “Not really.”

“What you just experienced was a perfect example of how we mindlessly go in and out of trance every day. You pictured something in your mind. Created it yourself and the image generated a spontaneous reaction. In your case, laughter. Certainly, you had no intention of laughing out loud in the middle of a seminar for no reason, right?”

I nodded.

“So what you did was summon a thought, a memory, something in your data bank. And you had such a connection to it that it caused you to react as if it was really happening right now. That is trance.”

The room was silent. After allowing us to digest the thought, he said, “And what’s even better, you generated laughter from the rest of the group.”

“That’s because they were picturing me in a bathrobe talking to Obi Wan Kenobi,” I offered.

“Before that,” he said. “Before you said anything. When I asked if you were sure you were okay, you kinda laughed, then I laughed, then a few others laughed. You hadn’t said anything. All of that, in a way, was a group-generated trance experience.”

How any of this was going to help my patient back home, I wasn’t sure at the time, but after three days of intensive training in Ericksonian Hypnosis eloquently presented by the ever-engaging and charismatic Bill O’Hanlon, I was a believer. I found the force!

Since that workshop, I have employed hypnosis on a nearly daily basis in my private practice. Though I certainly do not uphold hypnosis as the panacea for all psychological ills, it offers any mental health practitioner with an alternative intervention that may otherwise be unavailable or simply discarded. Like having another tool in the shed, it may be the first one selected, or perhaps a second or third choice if other tools don’t do the job. I like to think of hypnosis as an adjustable power tool with various and sundry drill bits and adaptable screwdriver heads. It can be used to repair or build a number of things, but it’s useless if a hammer is called for.

*Hypnosis for Behavioral Health: A Guide to Expanding Your Professional Practice* is a source guide offering mental health providers with eclectic and innovative behavioral and naturalistic interventions that can be individually tailored and applied to help others manage unwanted symptoms and enhance desired skills and abilities. This book does not require any background in clinical hypnosis in order to benefit the practicing clinician, though employing it as “stand-alone” text will by no means enable you to become a proficient hypnotherapist.

It is my intention to introduce you to the complex, intriguing, and ever-fascinating world of hypnosis. Case studies, hypnosis scripts, and
examples of individualized treatment plans are referenced throughout the book to facilitate your knowledge and understanding of hypnotic concepts. All case studies presented are partial transcripts of recorded sessions with my clients. Personal identifying information including names (with the exception of the Case of Brennan), ages, professions, and at times gender have been changed to protect the privacy and anonymity of my clients. Although published references are cited throughout to support an understanding of the efficacy of hypnosis for treating various clinical concerns and improving performance, this book intentionally does not include an exhaustive review of hypnosis literature. Rather, this text serves as a useful guidebook for clinicians desiring to enhance their therapeutic skills and expand their clinical practice using hypnosis.

It should be understood that it is only with years of consistent practice, education, clinical supervision, and a commitment to utilizing hypnosis in clinical practice that one becomes truly skilled. Like any over-learned behavior that eventually becomes natural and proficient, you must practice, practice, practice. Consider it a suggestion, albeit an overtly conscious one.

It is also my expectation and hope that this book promotes a number of unexplored avenues in your clinical, and perhaps personal, life as well. The more comfortable and familiar you become with hypnotic techniques, the more you will appreciate the seemingly limitless abilities and vast resources of the unconscious mind. For this reason, I encourage you to become familiar with your own unconscious processes by facilitating trance on a regular basis either with the assistance of another therapist or through self-hypnosis. Becoming personally familiar with trance experiences, such as the eye-roll technique (see Chapter 6), alert- or waking-trance (described throughout), and hand and arm levitation (see Chapter 4), and the Chevreul pendulum (see Chapter 4), promotes a “feel” of the techniques allowing you to more easily replicate them with your clients. Furthermore, regular use of hypnosis can help you achieve your personal goals while facilitating a variety of experiences that you can use therapeutically with your clients.

Like any text devoted to the practice of clinical hypnosis, this book is no substitute for experiential training and supervision that is available through academic institutions or privately sponsored continuing education workshops. You are therefore highly encouraged to seek pragmatic learning opportunities through seminars or direct supervision to supplement what you learn from reading this book.

_Hypnosis for Behavioral Health_ includes case histories and excerpts from actual hypnosis sessions that allow you to “see” the interventions applied in pragmatic and strategic ways, adding depth and substance to the subject matter. Throughout this book, suggested activities provided at the conclusion of most chapters and experiential “exercises”
embedded within chapters are provided to prompt active participation in your learning experience. From the identification of the presenting problem, to the reclassification of the problem into terms that allow for the selection and application of an appropriate hypnotic intervention, you will learn to generate and implement individualized treatment plans for your clients.

For some, hypnosis is perceived as a means of controlling others, albeit with the best of intentions in mind to assist willing clients while avoiding harm. Traditionally, hypnosis has fallen into one of two schools of thought: (1) all control resides with the hypnotist who guides and directly suggests that the client have specific experiences, feelings, and responses during trance, and (2) scripted, non-individualized interventions that are tailored to resolve a specific presenting problem. Though both approaches have produced positive effects, they are quite limited and are likely to be met more frequently with failure than success.

Thanks to the innovative, insightful, and pioneering work of the late Milton Erickson, MD, hypnosis has evolved beyond the limitations of the “traditional” approaches mentioned above. Trusting and relying upon an individual’s creativity, resourcefulness, and unique innate abilities to promote trance states and facilitate a process of healing, Erickson altered the conceptual framework of hypnosis, essentially moving it beyond an experience of blind allegiance to a controlling therapist where “failed” experiences were readily attributed to a resistant or non-hypnotizable subject.

The term “Ericksonian Hypnosis,” which has been referenced twice earlier, has been criticized and challenged for being “a convenient way of referring to an approach to change that is uniquely Erickson’s” (Lankton, 2008, p. 468). Stephen Lankton, current editor-in-chief of the American Journal of Clinical Hypnosis, studied with Dr. Erickson for five years, authored or co-authored seven books on hypnosis and psychotherapy, and for nearly 30 years promoted Erickson’s work and maintains that the proper phase ought to be an “Ericksonian approach to change and hypnosis.” Though Lankton himself utilized the term Ericksonian Hypnosis (see Lankton & Lankton, 2008; Lankton, 2004; Zeig & Lankton, 1988) in several of his own publications, I tend to agree with his most recent opinion, and therefore employ a version of his suggested term throughout this book when referring to Dr. Erickson’s applied hypnotic techniques and interventions.

As you can readily infer from the above paragraph, Hypnosis for Behavioral Health relies heavily upon the techniques espoused by Milton Erickson and his protégés as it is my contention that they offer clients a comfortable, naturalistic, non-intrusive, permissive means of accessing inner resources and abilities. Rather than rely upon the therapist to “cure” or “heal” through robotic scripts (i.e., outside-in approach), Erickson’s approach to hypnosis respects individual differences and enables each person to facilitate healing and personal growth from within (i.e., an
inside-out approach). While I make efforts to include the perspectives and opinions of so-called Ericksonian detractors when appropriate, I do so conservatively and selectively. It is not my intention to uncritically espouse Erickson’s teachings or those of his follower’s; however, the techniques offered in this book are largely influenced by Erickson and as such are heavily emphasized and personally preferred. Just as there are disagreements in the field of psychotherapy, there are clinicians who align themselves predominantly with one model of hypnosis while being openly critical of other models. Having said this, I encourage you to broaden your horizons by reading and learning as much as you can about clinical hypnosis. In the end, it will be up to you to employ hypnotic strategies and interventions that are personally meaningful, comfortable, and effective.

Those familiar with Bill O’Hanlon’s terms “solution-oriented therapy” and “solution-oriented hypnosis” may question my use of the term “solution-enhanced hypnosis” throughout this text. While possibly seen as simply a matter of semantics, I believe the latter term more accurately reflects the hypnotic processes since it involves the positive exploitation and identification of existing and/or potential solutions. When employing hypnotic techniques, as therapists, we not only “orient” treatment toward the identification of solutions, but also enhance the solutions themselves.

It is an understatement to say that hypnosis is a controversial subject. Chances are, since you selected this text to read or simply review, you already possess an open-minded curiosity about hypnosis and are not seeking unequivocal evidence to support its clinical utility. Or, perhaps like me, before participating in Bill O’Hanlon’s three-day seminar, you need to see it to believe it. If so, I suggest you consider a slight alteration to that point of view and consider Bill’s perspective that perhaps you will see it when you believe it.

A few final notes. Rather than refer to people as exclusively male (as tradition entails) and in an effort to avoid a visually awkward blending of genders (e.g., he/she or even worse, s/he), I intersperse both male and female pronouns throughout the book. Also within the case studies, examples, and hypnotic scripts provided, all italicized words were emphasized and spoken as the client exhaled while bold face words were spoken or emphasized when the client inhaled. As you will see in Chapter 3 and beyond, this intervention can function as a very nice means of maintaining an appropriate rhythm during the hypnosis session in addition to facilitating and enhancing your client’s trance and ideomotor responses.

It is my hope that Hypnosis for Behavioral Health will serve as a valuable reference tool for expanding your clinical practice. There are plenty of informative and insightful textbooks on hypnosis included in Appendix B of this book and I encourage you to read and learn from all of them.
Reading in and of itself, of course, is no substitute for practicing techniques. After all, no Major League pitcher ever won the Cy Young Award by sitting in the stands.

REFERENCES


Acknowledgments

There are few accomplishments in life that are attained without the assistance or support of others. Authoring a book is no exception, despite the isolation during early morning hours holed up in a cramped office with the company of only a laptop computer and a lukewarm cup of coffee. Though it is my name alone that appears above the title of this book, the creation of this text was by no means a solo project. With this in mind, I would like to personally acknowledge and thank a number of individuals who have directly and indirectly contributed to and influenced my personal and professional development that culminated in the publication of this book.

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As any published author appreciates, one's completed work is only as good as an editor deems it to be. This author is privileged to have an editor who has been supportive, encouraging, and patient, despite my repeated challenges with meeting promised deadlines. Thank you, Nancy Hale. It has truly been a pleasure working with you.

To my children Kailey and Brennan, I love you more than words could ever convey, and I thank you for allowing me to selfishly pursue my goal of writing this book while you selflessly put your own needs on hold.

Finally, I want to express my unending gratitude and appreciation to my wife Melissa who has been, and remains, the greatest blessing bestowed upon me.
Section I: Hypnosis and Trance

*Man cannot persist long in a conscious state; he must throw himself back into the unconscious, for his root lives there.*

— Goethe (1807)

*Conversation with Friedrich Wilhelm Riemer, May 17, 1807.*
The Phenomenology of Hypnosis

A life lived of choice is a life of conscious action. A life lived of chance is a life of unconscious creation.
— Neale Donald Walsh (2005)

Do you recall your initial reaction or thoughts upon hearing the word hypnosis? What image or images came to mind? Did you picture a shiny gold watch swaying back and forth before a pair of vacant eyes? Perhaps mind control or even brainwashing was considered? Or maybe some secret ability to magically probe the unconscious mind and unearth buried skeletons haunting neurotic personalities? A kind of subconscious dumpster diving, if you will.

Answers to the questions posed above, silly as they may be, are important to consider as your initial reaction to hypnosis could serve as a valuable reference when introducing your clients to one of the most—if not the most—misunderstood psychotherapeutic interventions available to mental health professionals.

Hypnosis has a recurring history of acceptance and rejection dating back to the time of Mesmer over 200 years ago. Hypnosis has also been a troublesome word for some since it tends to elicit an aura of intrigue and mystery. It tends to conjure a variety of creepy, if not chilling, images of costumed performers standing on stages casting spells upon small crowds of people who blindly succumb to irresistible suggestions.

The motion picture industry alone, through its perseverative portrayal of hypnosis as omnipotent and deceptive mind control, continues to perpetuate public mistrust and suspiciousness of something that warrants little, if any, fear. Though hypnosis promoted Fred Astaire’s love life and enhanced his dancing skills in Carefree (1938), it framed
an innocent woman in *Whirlpool* (1949) and facilitated espionage in *The Manchurian Candidate* (1962). It was portrayed as powerfully malicious in *The Silence of the Lambs* (1991), where a sociopathic psychiatrist, Dr. Hannibal “The Cannibal” Lecter, persuades a detested fellow inmate to commit suicide, and does so while separated by several layers of brick and glass. Sadly, even children’s animation (i.e., *Jungle Book* [1967], *Robin Hood* [1973]) has been a less than innocent participant when it comes to the exploitation of hypnosis through its cartoon images.

For others, hypnosis is a welcomed opportunity to relieve emotional discomfort, physical pain, sleepless nights, and anxiety. Still others may tune into the resources of the subconscious mind to improve athletic performance, or ignite dormant motivation propelling successful endeavors and outcomes.

As a hypnotherapist, you will no doubt encounter the occasional “Doubting Thomas” who refuses to believe it until he sees it. And there are those who, predominantly due to fear of the unknown or simply out of ignorance, will resist any opportunity to benefit from hypnosis. Though fortunately representing a minority of clients, you are also likely to encounter the occasional unyielding individual who is convinced that hypnosis opens the should-be-sealed portal to a weak mind, unwittingly allowing undesirable spirits and demons to slip through and possess their vulnerable soul.

In general, it has fortunately been my experience that when individuals are reasonably motivated to change unwanted behaviors and are fairly open-minded and relatively trusting, hypnosis is eagerly embraced and appreciated. For many, hypnosis is a fascinating topic of discussion. If you care to put this to the test, leave any hypnosis textbook lying around and see how long it takes for someone within eyeshot to either peruse the book or initiate a conversation on the subject. Be forewarned: they may challenge you to hypnotize them!

**WHAT HYPNOSIS IS AND IS NOT**

With its mystique, affiliated power, and mystery, hypnosis intrigues some while frightening others. How can there be such opposing views and opinions? What is this process we call hypnosis? How can it be relevant to a clinical practice dedicated to relieving human suffering? And how does one learn the skills to apply hypnosis in everyday clinical practice? These questions (and others) serve as the basis for this text and the answers to these queries will become evident as you explore each chapter. First, let’s start with the term “hypnosis.”
Hypnosis has no single, agreed-upon definition (Yapko, 2003; Lynn & Rhue, 1991). The Society of Psychological Hypnosis (Division 30 of the American Psychological Association) offers the following widely cited and generalized definition (1993):

Hypnosis is a procedure during which a health professional or researcher suggests that a client, patient, or subject experience[s] changes in sensations, perceptions, thoughts, or behavior.

This broad definition reasonably depicts the relationship between the doer and the receiver of hypnosis, defines the context of the process itself, yet it is limited as there is much more involved with hypnotic phenomena than that identified by the Society of Psychological Hypnosis. Given the complexity of hypnosis, a single sentence definition may never suffice. Further, establishing a universally agreed upon definition is nearly unfathomable since it is the very process of hypnosis (i.e., the intermingling and synthesis of the give and take among provider, receiver, and context of the technique) that generates disagreement among the “experts” in the field.

Bill O’Hanlon, prolific author and student of Dr. Milton Erickson, conveyed hypnosis as an inside-out process (i.e., coming from the client versus the therapist) identifying trance as “the evocation of involuntary experience” (1992, p. 11). When I treat clients using trance, O’Hanlon’s definition comes to life for me, as I remain ever alert for some involuntary response (e.g., a twitching arm, hand, or leg, spontaneous laughter, a smile) that unequivocally reveals the existence of a trance state.

Doubters and Nonbelievers

As you expand your hypnosis knowledge base, you will no doubt encounter the occasional method skeptic who credits therapeutic dependence—otherwise known as positive transference—as the underlying mechanism responsible for hypnotic symptom relief (Fromm, 1992; Nash, 1991; Nash & Spinier, 1989; Whitehead, Noller, & Sheehan, 2008). According to these critics, it is not trance itself that generates relief, but compliance of the client who desires approval and acceptance from the therapist or simply the role taken by the hypnotist that promotes any observed or reported change.

In response to these critics, some have argued that alleged transference or other, more or less conscious motives including self-fulfilling prophecies or desires to please the therapist, rely on narrow and restrictive theoretical perspectives that pit one conceptual framework against the reported observations and impressions of the client (Yapko, 2003; Barber, 2000). Based on my personal experience working with athletes I concur with the positions espoused by Yapko and Barber, as athletes are
neither motivated to please me, nor looking to book some trance-ticket for a flight into health. I suppose one could argue in these cases, that positive results from hypnosis are due to nothing other than improved confidence or manifestation of a self-fulfilling prophecy that could be accomplished through a number of alternative interventions including a pep talk. Perhaps there is some truth to this supposition; however, hypnosis unlike pep talks, empowers individuals to maintain a sense of personal responsibility and self-control.

Regardless of the empirical data supporting the benefits of hypnosis for clinical and nonclinical matters, the efficacy of the intervention is ultimately for the client and therapist to determine. Some individuals achieve established goals using hypnosis sooner than others. Some may require “booster” sessions over time; others may not. And certainly some clients fail to respond to any hypnotic intervention, no matter the frequency and duration of sessions, or perceived depth of trance.

Failed cases, however, should not lend credence to the theory that hypnosis benefits only weak-minded individuals, or those motivated (consciously or unconsciously) to please their therapist, or desiring some self-fulfilling prophecy. While positive transference and self-fulfilling prophecies may enhance/influence treatment results (as they likely do in any psychotherapeutic context) they do not negate alternative explanations or underlying subconscious processes that account for the therapeutic benefits of hypnosis. After all, some people respond well to ibuprofen; others do not, and still others experience adverse side effects that make taking this medication intolerable or life threatening. Would we conclude from these observations that positive responders do so primarily to please their physician or the manufacturers of ibuprofen? And isn’t it equally preposterous to suggest that pain relief from non-steroidal anti-inflammatory agents is exclusively due to some self-fulfilling prophecy?

Nearly everyone, for better or worse, has some established, though as noted previously, perhaps ill-informed opinion or attitude about hypnosis. One-step quit smoking programs are also prevalent in some communities despite a success rate that is no better than nicotine replacement or nicotinic agonists like varenicline (Spiegel, Frischholz, Fleiss, & Spiegel, 1993). With these rather skewed and stereotyped perceptions receiving greater public exposure than those of clinical hypnosis, it is no wonder people have a jaded understanding, if not fear, of hypnosis.

Mind Control. Do You Mind?

Perhaps the most common myth that I address in my practice concerning hypnosis is the notion that it involves mind control. Of course this misconception is easy to understand if you have ever observed stage hypnosis
in action. In these contrived grand displays, the hypnotist, appearing on stage as some mystical caped crusader eventually casts irresistible spells upon willing audience members who subsequently engage in bizarre and silly behaviors that apparently would never occur under conscious conditions. Ergo, mind control.

To address the myth of mind control and ease my clients’ unwarranted concerns, I inform them that if I could actually control someone’s mind using hypnosis, I would surely put both of my teenage children in trance, offer post-hypnotic suggestions that are immediately obeyed in response to some preordained stimulus or cue (e.g., a snap of my fingers, an uttered word). A single snap for instance would prompt them to clean their bedrooms while two snaps would evoke an automatic, robotic-like obedience to do the dishes without complaint. Imagine the power I could command!

**Immediate Cure-All Results**

At times, some clients seek hypnosis expecting an immediately cure for what ails them. One afternoon, a 40-year, two-pack-per-day smoker with chronic obstructive pulmonary disease (COPD) referred for hypnosis to stop smoking, expected me to put her in a one-time trance, render her subconscious mind at my immediate disposal, suggest she quit smoking immediately, snap my fingers and awaken her from her semi-comatose trance and wish her well in her life as a permanent non-smoker. Contrary to what some believe or hope to be true, hypnosis is not a quick fix. While I have obtained positive results in as little as one, two, or three sessions, effective treatment usually requires adjunct interventions such as cognitive-behavioral therapy, environmental manipulation, family therapy, and at times pharmacotherapy.

Likewise, hypnosis is not a panacea for every emotional, behavioral, or physical disorder that afflicts humans. Marketing hypnosis as such unfortunately only serves to tarnish its reputation as a beneficial therapeutic intervention. An online search of hypnosis through any web browser will readily yield websites promoting downloadable audio hypnosis recordings intended to relieve symptoms associated with nearly every disorder known to man. For instance, some sites that shall remain nameless to avoid any inadvertent advertisement of their foolhardy products, offer farcical applications of hypnosis such as teeth whitening, eye color alteration, unsightly hair removal, generation of wealth, and relief of symptoms associated with degenerative neurological disorders such as Parkinson’s disease and Alzheimer’s dementia. Sad to say, since the audible hypnosis sessions for hair removal failed to deliver satisfactory results, my wife continues to rely on epilation adhesives to eradicate the unsightly unibrow from my face.
HYPONOTIC RESPONSIVENESS

Of the many questions I am asked about hypnosis, one that is frequently repeated concerns the issue of hypnotizability. Over the years, some of my clients have been quite adamant that they cannot be hypnotized and remain convinced that hypnosis would not help them. In these cases, I usually don’t push the matter, as it would likely result in a failed and fruitless endeavor. I simply initiate other therapeutic interventions instead. Does this mean these clients could not be hypnotized? Are there really people who lack whatever innate capacity is needed to go into trance? Well, yes . . . and no.

With rare exception, theoretically, everyone can be hypnotized. Other than individuals with significant neurologic impairment (e.g., mental retardation, severe traumatic brain injury, dementia), or acute intoxication precluding the capacity to engage in sustained focused attention, nearly everyone can experience an intended hypnotic state. Schizophrenics generally make for poor hypnosis candidates, though impaired reality testing or dissociation should not preclude the implementation of hypnosis, since the technique itself involves dissociative states of mind. Anyone who has ever daydreamed, become lost in thought, or engaged in purposeful behavior that was not consciously recalled (other than while inebriated), has been absorbed in a waking state trance of sorts. The primary difference between a waking trance and a hypnotic trance is that the latter is consciously intended and utilized for therapeutic purposes; the former, more spontaneous and subconsciously directed. It should be noted that there are some who maintain the opinion that the terms “trance” and “hypnosis” are not interchangeable and would adamantly disagree with the above statement (see Weitzenhoffer, 2000).

It is true that some individuals, for whatever reason, remain interpersonally guarded, hesitant, or resistant when it comes to hypnotic induction. Fear of the unknown, fear of failure, or lack of trust in the therapist tends to promote the fallacy that an individual cannot be hypnotized. As stated previously, Hypnosis for Behavioral Health, relies heavily upon the insights and ingenuity of Milton Erickson and minimizes these potential impediments by permitting the client to be nervous, distrustful, resistant, and guarded. Through a process called utilization, the therapist employs whatever the client brings to the session to promote trance. In essence, the symptom (resistance) identifies the solution (permissiveness) for promoting trance.

For some, a more realistic fear of hypnosis is that it will expose emotions that would ordinarily be kept suppressed or repressed. Usually, these individuals are generally uncomfortable with expressing emotions, and fear losing control of their feeling states if they were to be hypnotized. Whenever a client expresses hesitation about hypnotic treatment, we should be mindful of their unstated fear of losing control of any
emotional discharge. Gently asking a person about this possible concern could help allay fear about losing control of her emotions and facilitate productive hypnotic intervention.

Karen, a 58-year-old retired school teacher, suffered horribly from a fear of driving on interstate highways after experiencing an episode of vertigo while driving on Interstate 95 over 20 years ago while heading to Florida for a vacation with her family. Ever since this frightening experience, she traveled on secondary roads, scenic routes, and alternate roadways to reach her destination. Over the past 20 years, her inconvenient fear made for long road trips when visiting out-of-town family over the holidays. Unfortunately, this also generated considerable stress for her husband who resented the extended travel time whenever he needed his wife to take the wheel. Though Karen was internally and externally motivated to overcome her fear, traditional therapy including cognitive-behavioral therapy, forced exposure resulting in an immediate pullover onto the shoulder of the highway, and progressive muscle relaxation, were all met with repeated failure. The lack of therapeutic success despite multiple interventions also left her doubtful that anything would help, including hypnosis. Appreciating her limited hope and faith in hypnosis, and knowing that lack of control is rooted in all anxiety, I introduced hypnosis to Karen as a natural, innate skill that she already possessed and could access in her own time and way. Like a child learning to read and write, she just needed some guidance that would allow the skills and abilities within to manifest. By pairing hypnotic techniques with learning, hypnosis effectively stimulated familiar unconscious experiences for Karen thereby allowing her to reframe preconceived obstacles as opportunities.

Individuals suffering from anxiety and depression spend much of their lives in trance (Gilligan, 1987). By recognizing symptoms as manifestations of “negative” or unhealthy trance (unconscious) states that are intended to make the world safer on some level, we can appreciate (and reframe) their purpose. Whether the symptoms involve dissociation, insomnia, fear of failure, smoking, or over-eating, they serve some purpose and can create opportunities for hypnosis intervention. In Chapter 3, I review hypnotic phenomenon in normal and unhealthy/pathological human conditions that will promote a better understanding of naturalistic trance inductions that rely on the traits, behaviors, and idiosyncrasies the client brings into the session. By considering trance as a natural human experience, and individualizing induction for each client, you will begin to appreciate just how “hypnotizable” most people are.

Relaxation, one of many byproducts of hypnosis, has been associated with hypnotic responsiveness. The inability to relax, in particular has been identified as an impediment to hypnosis (Paul, 2011); however, as you will discover in subsequent chapters, one does not need to be relaxed in order to benefit from “alert” or “waking hypnosis.” In these
conditions, with eyes open, athletes are encouraged to focus their attention intensely during physical activity (e.g., running on a treadmill, throwing a baseball, swimming, or riding a stationary bike), and are then exposed to suggestions intended to enhance athletic performance. In other words, they are getting “in the zone.” It, therefore, stands to reason that relaxation is not a necessary prerequisite for hypnosis to be effective.

Pragmatically speaking, relaxation is typically a component or outcome of the hypnotic intervention as it promotes a sense of comfort while reducing the stress and anxiety typically associated with most people’s troubles. Since relaxation tends to be a natural byproduct of hypnosis, acknowledging this experience during trance helps highlight the subjective differences for the client between hypnotic and non-hypnotic (or alert wakefulness) states. In so doing, the therapist reinforces for the client that an altered state of consciousness befitting their expectation has indeed occurred. In essence, relaxation is beneficial for hypnosis, but not essential and sometimes counterproductive.

Some hypnotherapists and clinicians contend that people “possess” varying degrees of hypnotic susceptibility, and even rely upon “suggestibility tests” to determine hypnotic responsiveness in their clients. One such test considered by some to be the gold standard of hypnotizability assessment is the *Stanford Hypnotic Susceptibility Scales* (Forms A, B, and C), co-developed by psychologists André Weitzenhoffer and Ernest Hilgard (1959, 1962).

Interestingly, Weitzenhoffer (2000) maintained that he does not employ hypnotic susceptibility assessments in his clinical practice noting, “apart from scientific reasons . . . there seems to be little reason for it” (p. 276).

I personally find little need to employ suggestibility tests with my clients, however, I appreciate the benefits of such testing when conducting controlled experiments on the utility of hypnosis. Suggestibility test scores, in my opinion, are far less helpful than the observed clinical response elicited from a client during trance. Using formal suggestibility testing in clinical settings may also place an unnecessary burden on a client. Some clients may feel pressure to live up to expectations of being “highly suggestible” while those with lower scores may prematurely decline the opportunity to reap any benefits of hypnosis. Additionally, as you will learn in the following chapter, such testing in some ways undermines the notion that trance is a natural human phenomenon.

It is true that some individuals initiate trance faster and more deeply than others (Yapko, 2003). Factors including expectancy (Kirsch, 2000; Yapko, 1988), age (Hilgard, 1977; Morgan & Hilgard, 1973), phobias (Frankel, 1976), posttraumatic stress disorder (Bliss, 1986), sleep disturbances (Belicki & Belicki, 1986), and a complex combination of four factors: expectations, suggestion, a cognitive element (including relaxation and/or imagery), and dissociation (Evans, 2000) have been shown to
positively affect responsiveness to hypnosis. Though the therapist is not able to directly control variables such as age, phobias, posttraumatic stress disorder (PTSD), or sleep disturbance, the four factors mentioned above can be readily employed and manipulated to promote trance.

**STAGE HYPNOSIS: STAGED FOR ENTERTAINMENT**

Unfortunately for many, stage hypnosis serves as the only or primary reference for understanding hypnosis. When providing hypnosis to your clients you should be prepared to dispel the myths of stage hypnosis that unfortunately tarnish the public’s perception about clinical hypnosis. Stage hypnosis is for entertainment purposes only. As its name implies, it is essentially *staged*. While some may contend that all staged hypnosis is disingenuous (Paul, 2011), I do not take issue with the possibility that some participants are indeed experiencing an altered state of consciousness.

Let’s consider the factors involved in stage hypnosis to determine how hypnotic principles and aspects of human behavior produce the results that are witnessed at the state fair. Unlike hypnosis that occurs in a clinical setting, stage hypnosis involves a series of well-conceived strategies that essentially ensure that the audience members who chose to remain in their seats rather than take the stage, will witness before their very eyes seemingly “normal” people obey a stage hypnotist’s suggestions and engage in foolish, if not embarrassing, behavior. At times, to enhance the perception that trance will indeed occur, the performer will ask only for volunteers who “really want to be hypnotized.” The stage hypnotist can therefore make a number of safe assumptions about the group of volunteers who likely rush the stage, eager to experience trance:

1. They welcome the opportunity to sit in front of a crowd of people and are willing to risk making spectacles of themselves.
2. They are probably willing to perform and behave as directed, though there are exceptions as discussed below.
3. A common character trait of volunteer performers, whether acting in a play, singing, or performing on stage, or wanting to subject oneself to public hypnosis, is an element of exhibitionism. I feel confident saying this as I once volunteered my exhibitionistic self to perform in a number of sideshows at the Renaissance Festival in Crownsville, Maryland. Shy, reserved introverts, in contrast, are not likely to find themselves on stage.
4. While many volunteers are eager to experience the mysterious hypnotic trance, some present with “hidden agendas” or ulterior motives destined to prove that the hypnotist has no power over their mind. Others may selfishly find a chair on stage to prove to themselves that
their personal will is strong and able to resist any and all subconscious suggestions. Knowing that these folks exist, the experienced stage hypnotist presents a number of “suggestibility tests” and gently dismisses those who fail to meet minimum expectations. Prior to initiating his act, the performer informs the participants that, “At any time while in trance, if I touch your shoulder, you will slowly open your eyes, gently arise from your chair, and quietly return to your seat, at which time you can gradually come out of trance.” Such statements presume that the person will be in trance at the time they are touched (dismissed) and remain in some trance state, until they return to their seat. This well-planned strategy allows the stage hypnotist to not only dismiss volunteers who inadequately respond to his suggestions, but also provides the audience with evidence that the people on stage remain in some hypnotic state as they return to their seats.

Suggestibility tests for stage hypnosis are usually rather benign and simple. They generally involve having volunteers engage in focusing techniques followed by specific suggestions intended to evoke certain feelings or behaviors, such as “Your hands are so heavy that you can’t lift them from your lap.” This may be followed by a suggestion that “a bee is buzzing around your head and about to land on your nose.” Those who flinch, scrunch their faces, or even swat at the imaginary insect remain on stage for further suggestibility tests. Non-responders are gently dismissed.

Remaining volunteers who are verbally reinforced for how well they are performing may begin to feel a sense of obligation (transference, if you will) to please the stage hypnotist or the audience. At this point in the show, the volunteers are poised to “obey” suggestions, while the audience is primed for continued entertainment.

Principles of social psychology including conformity (Asch, 1951, 1955), and obedience to authority (Milgram, 1963, 1974) provide an understanding of how individuals can participate in stage hypnosis and experience the desired effect that was strategically planned (and expected) by the performer. In the Asch studies, cited above, research subjects were informed that they were participating in a “visual perception test” and were instructed to determine which of several bars on one card was the same length as the single bar on another card (see Figure 1.1) All participants were to report their answer aloud, one after the other. Unbeknownst to the lone experimental subject, nine other participants in the room were confederates (assistants to Asch) who at times unanimously provided obviously incorrect responses. To Solomon Asch’s surprise, nearly 75% of the experimental subjects conformed to the “obviously erroneous” answers given by the confederate members at least once, and 28% conformed on more than six of the 18 “staged” trials. Essentially, this study reveals how readily people will “cave” to peer-pressure under the right circumstances.
HYPNOSIS: EMPIRICALLY SUPPORTED OR EXPERIMENTAL

For those acculturated to the managed care climate demanding empirical support for clinical interventions, it comes as no surprise that some managed care contracts exclude hypnosis as a reimbursable service. What continues to be astonishing, if not insulting in my opinion, is the classification of hypnosis by some companies as “investigative” or “experimental,” thereby failing to meet the company’s established criteria for medical necessity.

In preparation for this book, I contacted several major managed care companies offering health insurance plans throughout the United States and asked if their plan covered hypnosis for treatment of psychological disorders. While many do, others do not, and those denying coverage consider hypnosis investigative. Interestingly, these same “rejecting” companies enthusiastically provide reimbursement for “rational emotive therapy” and “solution-oriented therapy” for treatment of psychological disorders, yet a literature search on PubMed.gov in October 2011 for peer-reviewed published articles in reputable journals revealed 202 and 324 published articles for these therapeutic interventions, respectively. “Hypnosis” in contrast yielded 12,390 referenced articles.

My quasi-experimental investigation, of course, did not involve a critical examination of the research design or methodology of any of the published studies. Nonetheless, it can be safely assumed that the majority of articles listed on PubMed.gov have undergone some level of peer-review scrutiny before being accepted for publication, as this is a requirement for inclusion on PubMed.gov.

Reimbursement for hypnosis, like other medical and psychological interventions, has been directly and in some ways adversely influenced by managed care demands for empirical studies to qualify treatment procedures as evidence-based practice (EBP). This is not to say that EBP is a horrible thing to be condemned. It isn’t. In fact, it makes sense that any...
proposed clinical intervention, whether it is electroconvulsive therapy (ECT), a frontal lobectomy, emotional freedom techniques, or hypnosis, should undergo repeated, controlled investigation in ways that provide support for its clinical utility. (See Chapter 12 for additional information regarding reimbursement for hypnosis services.) Concerns develop, however, when those in control of health care dollars unnecessarily restrict a provider’s capacity to utilize services that have validated treatment efficacy, consumer satisfaction, and little to no unwanted or adverse side effects.

So what of the controlled studies on hypnosis? Does hypnosis work? Is it an effective therapy? First, let’s consider the terms “hypnosis” and “hypnotherapy.” While potentially offending the “purists” who concretely distinguish these terms—those who define hypnosis as a tool used in conjunction with other interventions (e.g., cognitive-behavioral therapy) versus others who contend hypnotherapy is a therapy in and of itself—I personally find the semantic debate pointless. Defining hypnosis as a therapeutic tool or as therapy has nothing to do with determining the efficacy of the intervention; rather, it is the growing body of evidence that hypnosis, whether it is the primary or adjunctive intervention, positively influences treatment outcome (Lynn & Cardeña, 2007; Mottern, 2010; Thornberry, Schaeffer, Wright, Haley, & Kirsh, 2007; Xu & Cardeña, 2008).

It is nearly indisputable that hypnosis has been applied effectively for the treatment of various clinical conditions too numerous to mention and review at this time. Nonetheless, suffice it to say, as identified in Table 1.1, there is ample empirical support that hypnosis improves a number of psychological and medical conditions whether applied alone or in conjunction with other psychological interventions. Additionally, as referenced in the footnote section of this same table, although a frequent criticism of managed care companies reluctant to reimburse for hypnosis services, not all professionally published reports involve professional reviews or single case studies.

### TABLE 1.1

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>References</th>
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<tr>
<td>Depressive disorders</td>
<td>Alladin (2010)**</td>
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<tr>
<td></td>
<td>Loriedo and Torti (2010)†</td>
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<td></td>
<td>Perfect and Elkins (2010)†</td>
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<td></td>
<td>Yapko (2010)**</td>
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<td>DiClementi, Deffenbaugh, and Jackson (2007)**</td>
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<td></td>
<td>McIntosh (2007)**</td>
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<tr>
<td>Obsessive-compulsive disorder</td>
<td>Meyerson and Konichezky (2010)†</td>
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(continued)
FINAL THOUGHTS

Though some managed care companies continue to consider hypnosis as an investigational intervention lacking empirical support necessary for consideration as an EBP, there is ample evidence from peer-reviewed publications that hypnosis improves treatment outcome. Fortunately, exceptional research on hypnosis continues to be produced, providing additional support for hypnosis treatment of many medical and non-medical conditions. Since this important and valuable research is being published in professional journals in addition to specialized hypnosis journals, it is apparent that there is a growing interest in this fascinating and effective treatment intervention.

Suggestions, if you will:

1. Consider the natural phenomenon associated with trance and identify as many “waking” experiences as you can when you have been
in trance. What does it feel like? How do you know you are in a waking trance? Pay attention to others and notice when they appear to go into trance during complex behavioral activities.

2. If you have an opportunity, visit a county or state fair or Renaissance Festival where there is a stage hypnotist and observe the show. Pay attention to the well-planned strategies of the performer and notice the responsiveness of the volunteers. If you are unable to make a trip to see a live show, you can find one or more videos on YouTube or other Internet websites.

REFERENCES


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