Contemporary Hypnosis (2004)
Vol. 21, No. 4, 2004 pp. 187–201

CLINICAL APPLICATIONS OF 'WAKING' HYPNOSIS FROM A COGNITIVE-BEHAVIOURAL PERSPECTIVE: FROM EFFICACY TO EFFICIENCY

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Abstract

This article reviews several essential components for use in the practice of hypnosis from a cognitive-behavioural perspective. These include a cognitive-behavioural introduction, which presents hypnosis to the client as a voluntary, self-controlled process. Then, a set of practical tasks is presented for assessing suggestibility as well as collaboration and attitudes toward hypnosis. The author provides a description of rapid self-hypnosis and instruction as to its implementation, and advocates the use of metaphors designed to facilitate a client's understanding of hypnosis. The article then introduces 'waking' hypnosis as an efficient, adaptable, and pleasurable alternative to other forms of hypnosis, and discusses its implications in terms of the socio-cognitive perspective of hypnosis.

Key words: alert hypnotic induction, cognitive-behavioural, self-hypnosis, suggestibility

The 'waking'-hypnosis therapeutic model of the Valencia group: searching for efficiency

The fact that hypnotic induction methods are so called by pure convention does not mean that they are not important in using hypnosis in clinical practice (Lynn, Rhue and Weekes, 1990; Kirsch, 1998). In fact, empirical evidence indicates that a great part of the efficiency of a therapeutic programme complemented by hypnosis depends on its induction methods (Capafons, 2001b). However, the induction methods will be more or less efficient, in part based on the explanations given to clients about hypnosis and the expectancies that clients draw from such explanations (Lynn, Nash, Rhue, Frauman and Sweeney, 1984). In order to achieve good rapport and to realize a cognitive-behavioural vision of hypnosis, three procedures may be implemented as part of the Valencia Model of Waking Hypnosis: a cognitive-behavioural introduction to hypnosis; a clinical assessment of hypnotic suggestibility; and a metaphor for hypnosis. The induction methods used in this model (rapid self-hypnosis and waking-alert hypnosis, (the latter also known as alert-hand hypnosis; Cardeña, Alarcón, Capafons and Bayot, 1998) become especially important within the general context from which the introduction, assessment and metaphor are performed. The final underlying idea is that individuals can activate the suggestive processes typical of hypnosis across a radically different behavioural topography (appearance, activity, open eyes, etc.) to that normally seen (Capafons, 1999).

A cognitive-behavioural introduction to hypnosis

I initiate the introduction to hypnosis from a cognitive-behavioural standpoint (Capafons and Amigó, 1993a; Capafons, 2001a), which is a more elaborate version of Coe's original idea (1980), and which was extended by Kirsch (1994). In implementing this introduction, it is important to transmit several ideas to the clients:

- The responses to the suggestions are acts committed by the clients and therefore they are not dependent on any power that the therapist might have; therapists only *help* the clients to experience the suggested responses.
- Such acts are automatic but voluntary, given that clients are the ones who do or do not initiate them.
- What happens during hypnosis depends mainly on clients' utilization of certain resources. The resources that are activated are similar to the many other acts in everyday life.
- Hypnosis implies reactions in everyday life, which can be activated or deactivated at will at any given moment.
- From this point of view, hypnosis is seen as a form of self-control, even if less conscious effort is required on behalf of clients to regulate certain behaviours.
- To be hypnotized does not imply entering into a trance or altered state of consciousness but rather involves preparing the mind for setting off the resources which, in everyday life, also lead us to activate responses that we perceive as automatic.

The above-mentioned ideas are based on experimental research into hypnosis from a cognitive-behavioural perspective. The proposal that the acts committed in hypnosis are voluntary but automatic (Capafons and Amigó, 1993b; Capafons, 2001a), is the fundamental conclusion obtained from the work of Kirsch and Lynn (1998), and Lynn (1997): the responses to hypnotic suggestion are intentional but also automatic. Automatism means less volitional effort and less consumption of attentional resources. In no way does it mean that persons involved do not make any effort or consume any attentional resources. At the very least, people will evoke a response in a context that would not normally elicit it. In this sense, what occurs in hypnosis is a controlled but automatic process. Finally, the introduction that we propose is also based on the dramaturgical theory of hypnosis and Sarbin's concept self-deception (Coe and Sarbin, 1991; Gorassini, 1999) and on the theories of goal directed and rule governed behaviour as well as on the misattribution theory proposed by Spanos (Spanos and Coe, 1992; Spanos, 1996).

To carry out the cognitive-behavioural presentation, clients are given a pocket watch with a chain, or anything that can be used as a pendulum. The therapist explains (and indeed serves as a model for) the exercise that they are going to carry out. With the dominant arm stretched out in front of them, the therapist holds the pendulum between their thumb and forefinger. At this moment, the therapist asks the watch to perform circular movements or oscillations. When the therapist has finished the exercise, they ask the clients to do it in more or less the following way:

> Therapist: Now stretch out your arm and allow the pendulum to come to rest completely still. Very good. Now ask the watch to move in some direction or other, to trace circles or move from left to right or backwards and forwards. Ask it whatever you wish but do not ask it to defy gravity and move up towards the ceiling. That particular one never

works when I try it, and if it did work I would probably die of shock. So what have you asked the watch? [The client answers and the watch moves] Ah! Fantastic! I can see you are quite good at this. Why do you think the watch moved?

Client: I don't know. It just moved by itself. It's incredible. Maybe I moved it without realizing it.

T: Yes, it's fun isn't it? OK, let's try it again but this time I want you to watch your hand very closely [the watch moves]. Can you notice anything?

C: I think I notice very minute movements in my hand. But I'm not doing it on purpose!

T: Exactly! Do you know what this pendulum is?

C: Well, of course I do, it's a pendulum.

T: OK, I guess that's obvious. But in this case it works as an amplifier, which amplifies the almost unnoticeable movements of your hand at the end of the pendulum and for that reason you can see the movements. If we were to shorten the chain that suspends the watch [the therapist holds the pendulum near the watch end of the chain], it would hardly move at all regardless of what we ask it to do [the therapist demonstrates the idea]. Well, hypnosis, in a way, is like that. Whenever you hear my voice (or indeed your own voice) suggesting things to you your brain will send 'orders' to the organs involved in the response which you experience, and you will do things in order to experience these responses. Generally, they will be so subtle that you will not even notice them and you will experience them as if they happened by themselves, as if they just happen. OK? But remember, it is always you who triggers the things that happen. It is also you who puts an end to them. Let's do another exercise. Stretch out your arm and ask the watch to move in a specific direction [the watch moves]. Now, I want you to think that what you are doing is really nonsense, just a stupid game, that you are in fact being ridiculous... or just think of something urgent that you have to do at home or at work [the watch usually comes to a stand still]. Can you see what happens? If you don't move your hand the watch will stop moving. This is what we call interference. The word interference usually has negative connotations: interference impedes us from watching the television, or from using our mobile phone. If someone interferes, then they obstruct us in our attempts to achieve some goal or other. However, in my case, interference is something positive: you have shown me that you are an active person and that you control what occurs in hypnosis at any given moment. If there is anything that you do not like or if you think that anything is inappropriate, you can interfere with it and stop it. When a person is hypnotized s/he does not lose control. The reactions that person experiences are automatic (you asked the watch to move, you did not ask your hand to move the watch, however, your brain understood the instruction and activated the hand movements by itself), but voluntary, given that you yourself initiated and detained the response once you thought that it was ridiculous, or once it stopped interesting you. Talking itself is a voluntary act, I can stop when I wish [the therapist stops talking for a few moments], but I do not have to search for the words in order to talk, they just jump out without having to think of them. In this way talking is automatic. If I had to speak to you in a different language that was not so familiar to me, I would have to think about many of my words, i.e. it would be something voluntary but not automatic. Hypnosis is like that, you will experience voluntary but automatic responses. Do you understand?

C: Yes I think so. It's just like walking, voluntary but automatic at the same time, right?

T: Precisely! But let us try another exercise. Stretch out your arm and ask the watch to move but this time ask it as if your life depended on it, ask it impatiently and demandingly. Ask it now! [The client does so but the watch does not move]. You see, this is another form of interference. If you wish to experience something and you are waiting on it, demanding impatiently that it occur, then it most probably will not happen. It is just like when you try to remember something that is on the tip of your tongue, the more you try to remember it the more blank your mind goes. Have you ever had anything like that happen to you?

C: Yes, many times. I think I am getting the hang of what it means to be hypnotized.

T: Excellent! Just a moment ago I mentioned that, for me, interference is something positive. Nevertheless, there are interferences that would be inappropriate. Do you know what they are?
C: No. I don't know what you mean.
T: I mean that if at any moment you feel unhappy or do not agree with any of the suggestions or with any of the things we do to help overcome the problem which has brought you here, and you do not communicate this to me but instead keep silent, this would be an inappropriate interference. This would not be positive, as it would imply a break in our communication. If this were to happen, then both you and I would be wasting our time here. Do you understand?
C: Yes, yes I believe so.
T: There is still one more thing, which I would like to ask you: if you wished to interfere with the suggestions or the therapy how do you think you might do it?
C: Well, I don't know, I don't think I will interfere.
T: Probably not, but try now to imagine what you would do in such a case.
C: I suppose I would think of something else, perhaps not follow the instructions or not offer any ideas about looking for solutions.
T: I see. I am going to ask a favour of you. If you discover that you are doing one of the things that you have just described, please tell me right away. Otherwise our communication will be broken, you will lose confidence in me and I will not be able to help you. As I said before in this case we would both be wasting our time. OK?
C: All right, I'll give it a try.
T: Good, now I would like to explain something else. I know that you have understood what to expect from hypnosis but I would still like to us to agree on one more thing. I assure you that all the time that we spend here talking about this will be time saved in the future, if we can overcome all possible misunderstandings. Tell me, have you ever seen a horror movie?
C: Yes.
T: Do they frighten you? Do you notice anything about yourself?
C: Yes I get scared. I notice tension, fear...
T: Your heart beats faster perhaps, your hands sweat and you feel a sense of danger?
C: Yes, sometimes, even though I like the movie, I look away from the most terrifying scenes.
T: Perfect. Now try to imagine that I am an extra-terrestrial, and that I am observing you while you watch the movie. Do you think that I could believe it possible that you should be frightened by something that you know is not real but is actually a fantasy, a lie? Don't you think that I should believe that you were not very intelligent?
C: Well if you look at it like that [laughter], then I guess so.
T: But really it's not like that. The cinema is an art form. You know that there is a director, actors, cameras, a scriptwriter, etc., and you know that everything is just a story. Right?
C: Yes of course [laughter].
T: In other words, you voluntarily choose not to think of the fact that it is all a fantasy, and you become involved in the story that is being told. You unconsciously 'forget' that behind the scenes there is a whole team who has recorded the movie and that all you see are the effects of a few lights reflecting consecutive stills on the screen. All things considered, it is actually a great effort, given that you must 'forget' something that is obvious.
C: Exactly, but it doesn't take much effort unless of course the movie is really badly made.
T: Precisely. So what happens when you watch an interesting movie is that you experience enriching, intense, automatic reactions. In spite of the fact that you know everything is false, you let yourself go along with the director's proposals and thus you experience intense emotions. You may even experience certain behaviours, a sudden start for example, covering your eyes, crying etc., is that right?
C: Yes, generally.
T: Well, hypnosis works in a similar way. Sometimes I will be the director of the movie

(directing the hypnotic suggestions) and at other times you will be the director (self-hypnosis). I will propose that you experience certain things, which deep down you will know are not true (for example that you cannot lift your arm or that you forget something) because if you allow things to happen (just as in the cinema) then they will happen. Sometimes these reactions can be very intense but they will always be under your control. In fact, what do you or indeed other people do when they don't want to see certain sequences of a horror movie?

C: I look away, or I leave my seat, sometimes I cover my face with my hands and I look out from between my fingers. Some people actually leave the cinema. Sometimes I think that it is all a lie and I distance myself from the plot.

T: That's right. Don't you think that these behaviours are like interferences?

C: Well, now that you mention it, I guess they are.

T: Going to the cinema is a voluntary act, just like 'forgetting' that all is fantasy and paying attention to what happens on screen. The reactions that you experience are automatic, just like the fear, happiness or pity generated by the images. All of these reactions however are under your control. All you have to do is avoid going to the movies or stop paying attention to the director's proposals. You can even get up and leave the theatre. OK, well hypnosis is just like a story or a film. What happens in hypnosis is voluntary and automatic at the same time. You may wish not to initiate the processes to experience certain reactions, or you may wish to interfere in it. It depends on you. If you like the proposed script, you can experience enriching intense sensations and reactions, which will help you to overcome the problem you have told me about. If you decide that the story does not interest you, just don't listen to it, but do not forget to tell me. OK?

C: Yes, OK. I never thought that hypnosis worked that way. I think that now I know why I sometimes get a sense that I do things almost without wanting to but without losing control.

T: Perfect. If you wish we can begin with a few exercises that will give us information about your current level of responding to hypnotic suggestions.

C: OK. I am looking forward to experiencing what it is like to be hypnotized.

As you can see, the introduction that we propose links hypnosis to everyday life. In the same fashion, it demystifies the belief that people susceptible to hypnosis are ignorant, stupid, or mentally ill, that hypnosis is dangerous to hypnotized individuals, or that it involves an altered state of consciousness (in which a person can become trapped, Capafons, 1998b). Moreover, our introduction conceptualizes hypnosis as a form of self-control, something that generally impedes dependence of the patients on the therapist and also reduces any fear that the individuals might have about losing control. In this way, it is much more probable that clients decide to move on to the process of hypnotic suggestibility assessment without reluctance and with more adequate beliefs and expectancies about hypnosis. Recent research shows that the presentation reduces attrition much more than a trance presentation, when people reluctant to be hypnotized are selected, and they are offered to be hypnotized (Capafons, Selma, Cabañas, Espejo, Alarcón, Mendoza and Natkin, in preparation). This is convergent with the results of a study by Lynn, Vanderhoff, Shindler and Stafford (2002), although they used a different trance explanation in which lack of control was emphasized.

Nevertheless, other recent data show that when a self-hypnosis induction is offered, there are no differences between trance and cognitive-behavioural presentation in the power to change negative attitudes towards hypnosis (Capafons, Cabañas, Alarcón, Espejo, Mendoza, Chaves and Monje, submitted). Perhaps the key factor here is that clients think that under hypnosis control is retained by the person, and self-hypnosis fosters such a belief.

Clinical assessment of hypnotic suggestibility

The assessment of hypnotic suggestibility in applied clinical practice continues to be an issue of some controversy. Some authors believe that to this end, the application of psychometric scales should be included as a further aspect of the general assessment of the client (Council, 1998). Others believe that such an assessment is of little utility given that hypnotic suggestibility can be modified (Chaves, 1996), and that the provision of failure-experiences in terms of being hypnotized (a very probable occurrence when using the habitual scales) at the beginning of the therapy is not very advisable (Capafons and Amigó, 1993b; Capafons, 2001a). In my case, the initial assessment is done outside the hypnotic context, as a form of assessing clients' *collaboration* with, and *confidence* in, the therapist and indeed the hypnosis itself. After having proposed the use of hypnosis to the clients, demythologized the possible risks and dangers of hypnosis (Capafons, 1998b), and carried out the cognitive-behavioural introduction described above, my activity is systematically guided towards confirming to the clients that such dangers do not exist and that it is highly probable that they will be able to respond successfully to the therapeutic suggestions. Therefore, in my opinion, what one really assesses here are clients' attitudes towards the hypnosis and the therapist. This attitude is the most consistent predictor of successful treatment in programmes that include hypnosis as their complement (Schoenberger, 2000), and may be compared to the concept of generalized implementation intention proposed by Lynn (1997) and Kirsch and Lynn (1998), or cognitive response motivation. As Wagstaff (1998) states, the improvement of expectancies and attitudes towards hypnosis is probably the key to increasing the effectiveness of therapies based on the use of hypnosis.

The assessment exercises are carried out without previous hypnotic induction (Capafons, 2001a), the reason for this being the high correlation between hypnotic and waking suggestion responses (approximately 64% of the variance: Hilgard, 1965; Kirsch, 1997) and because the intention is that the clients start to become familiar with 'waking' hypnosis. On the other hand, any failure that may occur can be attributed to the lack of training, practice or correction in the hypnotic induction exercises (Capafons, 2001a). To be specific, we begin with postural sway, which involves using both direct and repetitive suggestions (Hull, 1933). The clients should have their eyes closed and their feet together, a position that is important since it, in itself, provokes swaying. If, after having listened to the therapist's suggestion, the clients sway gently, then they are not interfering or blocking reactions, given that this movement is *to be expected without any intervention from the suggestion*. If the clients sway ostensibly, we assume that they are collaborating and experiencing the effect of the suggestion (the clients possess response expectancies which prepare for the automatic activation of the response: Kirsch and Lynn, 1998; Kirsch, 1999). If the clients do not sway at all, then it is highly probable that they are resisting. In this case we can ask them why this is happening: if it is because of their fears, reluctances, scepticism, etc. In addition, we tell the clients that everyone sways slightly in this exercise unless s/he blocks the instruction.

In the next exercise, the 'falling back exercise', (Hilgard, 1965; Capafons, 2001a) one can appreciate even more the *confidence* that the clients have in their therapists, given that the therapists are the ones to catch the clients. If the clients avoid falling, we should ask for and assess the motives behind their lack of confidence. If the clients allow themselves to fall backwards, we may conclude that they are confident and collaborative. If they also state that they felt unbalanced, then we assume that the clients have experienced the subjective reaction suggested.

Certain clients, however, show a preference or need to use their imaginations in order to notice the suggested reactions (Barber, 1999). Thus, another exercise can be implemented in which reactions are suggested by way of a metaphor. The patients are asked to imagine that the therapist is holding a rather powerful magnet in his or her right hand and that this magnet is being passed around the clients' heads, which feel attracted by the magnet. At a given moment, the therapist indicates that the magnet is moving to the left and drawing the patients' bodies with it, then to the right, then forwards, then backwards (the postural sway movements). Finally, the magnet draws the patients so strongly backwards that they lose their balance and fall (into the supporting hands of the therapist). If we observe and/or the clients report more elaborate responses on application of the magnet metaphor, we conclude that the clients work better using their imaginations. After that, we carry out a trick exercise (Weitzenhoffer, 1989), by way of which we assess a greater degree of confidence on the part of the clients. The clients are asked to roll up their eyes and then they are instructed to close their eyelids without lowering their eyes. The clients are then told to attempt to raise their eyelids without moving their eyes from this position and that they will not be able to do so (challenge exercise). If the clients do not open their eyes, we ask them how they feel and explain the trick (i.e. it is virtually impossible to raise one's eyelids whilst maintaining your eyes in this position). If the clients open their eyes, they are then asked about any reluctance they are feeling and we assess whether or not they understood the instructions. If the clients opened their eyes because they were afraid, the hypnotic suggestibility assessment is detained and the possible causes of lack of confidence are addressed. If these difficulties are overcome, the exercise is repeated to explain that they have been tricked.

Nevertheless, at this point it is made clear to the patients that tricks will always be explained and that they will be used as a part of the treatment in order to improve upon the responses to the suggestions, thus converting them into prompts for the suggested responses. At times, it is difficult for the clients to roll up their eyes and hold them there with their eyelids closed. In this case, we can ask the clients to look at a given point on the ceiling, obliging them to lift their gaze and then to lower their eyelids without moving their eyes from that point.

Finally, a motor challenge is given to the patients (hand clasping). If the clients respond appropriately and do not become startled, then the mechanism behind the exercise is explained and they are told that there is a very high probability that they will respond well to the therapeutic suggestions given that the clients have activated the tension response in their hands and have not interfered with it. In fact, the correlation of these motor exercises of primary suggestibility with hypnotic suggestibility is very high (Eysenck, 1989), although it depends on the explanations that are given to the participants (Gheorghiu, 1989). However, if patients fail the challenge, they are then asked if they felt tension in their fingers or as if their hands were stuck together. If they did, they are asked for the reasons that led them to separate their hands. If clients report having done so as a result of a fear of losing voluntary control, then the trick is explained to them, as is the importance of experiencing the tension without interfering. If the patients did not experience any kind of reaction, then the exercise is repeated using imagination techniques (strong glue which sticks the hands together, etc.). If all fails, the patients are told that they are not in hypnosis and that with some practice they will be able to perform the exercise whilst in hypnosis.

In summary, the hypnotic suggestibility assessment that we propose is standardized somewhat, but it does give us a lot of information about the attitudes and collaboration of

the patient regarding therapy. Likewise, it allows the therapist to transmit messages such as the following:

- The responses to the suggestions depend more on the confidence that the clients have in the therapist and in the hypnosis than on any kind of trait that the clients may possess.
- The responses to the suggestions can be *learned*, and a non-response to some of the suggestions should not be considered a failure.
- Tricks or prompts can always be used to allow the activation of the desired responses in order to evoke these using the suggestions at a later date.
- Finally, the suggestion that hypnosis is self-control is once again brought up, as is the idea that non-responsiveness to the hypnosis presents us with a problem that is no more than that of learning how to gain more self-control.

Therefore, the therapist transmits the idea to patients that there is always a solution to the problems that may arise and that finding that solution depends mostly on them. This will increase response expectancies and the clients' involvement with the treatment, while at the same time providing a robust sense of personal control. This will most likely affect the responses to the suggestions (Lynn, Rhue and Weekes, 1990; Kirsch and Lynn, 1998). For that reason, the method of assessment that we propose is the development of a strong rapport and therapeutic relationship.

Rapid self-hypnosis

Once all of the above has been carried out, the clients are invited to initiate their hypnotic experience using self-hypnosis (or indeed, if the patients have been hypnotized using other methods, to initiate their experience with this kind of hypnosis). In this way, any residual lack of confidence that the clients still may be showing is tempered by labelling the situation 'self-hypnosis'. Moreover, using this method, the concept of hypnosis is reaffirmed as a self-control skill (Katz, 1978; Capafons, 1998a, 1998b). Self-hypnosis, like other psychological procedures, is a potent way of altering personal reactions, even at a physiological level, as has been demonstrated elegantly by Gruzelier, Levy, Williams and Henderson (2001) and Egner and Gruzelier (2003).

In rapid self-hypnosis, the patients are told that they will be shown some exercises which together form a method of self-hypnosis which can be carried out very quickly, with eyes open, in a disguised fashion. This induction method (described in detail by Capafons, 1998a, 1998b) is closely linked to the hypnotic suggestibility exercises carried out earlier (falling backwards and hand clasping). Since these exercises have already been performed by the client, they have experience with these methods, as well as the expectation that they will prove effective.

Rapid self-hypnosis is made up of three separate steps: 1) hand clasping, 2) falling backwards, and 3) a challenge suggestion ('confirmation' exercise). The client is told that the exercises are designed to *activate the brain* so that it can work in a rapid and effective manner. Just as in Kroger and Fezler (1976), appeals to sensory/emotional recall can be made: individuals responding to the suggestions evoke (or reproduce) reactions which are already stored in their brains, in the absence of the stimuli with which they were originally associated. Therefore the hand clasping, the falling backwards and the challenge exercise are forms of activating our brain so that it can respond effectively, just as was explained in the cognitive-behavioural introduction. Specifically, rapid self-hypnosis

begins by showing clients how to perform the hand clasping exercise. They should join hands without interlocking their fingers. Then, they should take a deep breath and exhale slowly while clasping their hands gently together. Without releasing the pressure on their hands, the clients should take a further deep breath and exhale once again, this time tensing their hands a little more. Finally, the clients exhale and clasps hands for a third time, allowing their hands to fall abruptly onto their laps. Subsequently, the clients learn to fall backwards, beginning by sitting comfortably in chairs. Then, the clients distance themselves approximately 10 cm from the back of the chairs and allow themselves to fall abruptly backwards onto it. This exercise promotes a comfortable feeling as well as a brief and faint sensation of paralysis (useful for relaxation and the next challenge suggestion).

Once the patients have practised both exercises separately, they then combine the two. First, they find a comfortable position in the chairs into which they will later fall backwards. Then the clients lean forward in the chairs and with arms stretched out, join their hands and put pressure on them whilst carrying out the three exhalations. Then they allow themselves to fall abruptly backwards while at the same time allowing their hands to fall down onto their laps in the same abrupt manner. At this point the therapist suggests heaviness and relaxation (already prompted in the previous exercises) as well as a greater activation and widening of the mind. Finally, the therapist suggests that one of the client's hands is very heavy and stuck to their leg so that later they can suggest that the more they attempt to separate them, the heavier and more stuck the hand will become. In this way, the more the clients try to lift their hands, the more difficult it is for them. This suggestion is carried out whilst reminding the clients of the content of the cognitive-behavioural introduction: the proposed reaction is fictional; however it can be experienced *as if* it were real, thus readdressing Sarbin's role enactment theory (Sarbin and Coe, 1972).

In the beginning, the clients may experience these exercises with their eyes closed. Soon, however, they will be able to do them with their eyes open, shortening the prominence of the movements until they are almost unnoticeable. The clients will adopt a natural position leaning forward in the chair as if they were paying attention to something; the hands will join in a disguised way, arms bent with the elbows resting on whatever surface is available (a desk, the legs, the armrests of the chair, etc.). The exhalations and the hand clasping will be carried out in a disguised fashion, adopting an appropriate facial expression according to the situation (interest, great surprise, concentration, etc.). Finally, the falling backwards is disguised, so that it looks like the clients have simply changed their position in the chair. With their eyes open and talking normally, the clients 'evoke' the heavy sensation in their hands and suggest the challenge exercise to themselves. At this point, the clients are told that their brains are now ready to respond to the therapist's suggestion (or, in the subsequent sessions, the clients' suggestions), whatever the nature of the suggestions may be, including of course, those of activation, alertness, mind expansion and openness, etc. In other words, the clients stop being relaxed and become activated, thus being able to experience the suggested therapeutic reactions (i.e. to feel indifference towards certain foods, happiness and well-being, analgesia, etc.) and to carry out their daily tasks simultaneously.

This disguised form of self-hypnosis becomes shorter and better disguised with practice. If the clients are capable of reproducing extreme heaviness in the arm, with very little practice they can concentrate on the arm (with the eyes open and without interrupting the flow of the everyday task being carried out) and self-suggest that the arm is

heavy and immobile, at least as if the arm were not theirs (dissociation of the arm). The clients are now in self-hypnosis and can be given the therapeutic suggestions. In other words, rapid self-hypnosis has been reduced to a single instruction of reproducing a sensation, which, given that it requires neither overt exercises nor the closing of the eyes nor the adoption of a relaxation posture, goes unnoticed by any other individuals present. In this way, the clients are using 'waking' hypnosis, to which they have gained access by fading the relaxation exercises and the traditional hypnotic appearance (eyes closed, relaxation, numbness, etc.). In their everyday life, clients only need to activate the dissociation of the arm in order to give themselves therapeutic suggestions. On the other hand, if they wish, they can use the rapid self-hypnosis exercises to achieve quick but intense relaxation.

Research carried out by our group (Martínez-Tendero, Capafons, Weber and Cardeña, 2001), shows that rapid self-hypnosis is perceived as pleasant, as well as easy to learn, understand and utilize. Moreover, it is shown to be just as 'powerful' as other forms of self-hypnosis (Spiegel and Spiegel, 1978) and hetero-hypnosis when it comes to fostering test suggestions. Other research has shown that a large number of people experience the reactions suggested by the method of induction (relaxation, heaviness, challenge exercise), and also experience this method as being pleasant (Reig, Capafons, Bayot and Bustillo, 2001). In addition, the results of Reig et al. indicate that the arm dissociation variant of rapid self-hypnosis is perceived as even more pleasant, and that it promotes more responses to the suggestions than the falling backwards and hand-clasping variant. In other words, both the long and the short versions of rapid self-hypnosis are well received by participants and, after a few days practice of the above exercises, the power and pleasantness of the technique is increased by using arm dissociation.

A metaphor for attitudinal consolidation

Once the client has experienced hypnosis (in this case through self-hypnosis), we trigger another resource (a metaphor) that is designed to help the patients consolidate the following ideas: hypnosis is not dangerous, does not imply a lack of effort or perseverance to achieve a change in behaviour, and is an important instrument, albeit only as a helping agent in the treatment to be activated (hypnosis as a complement/adjunctive to the chosen treatment). The metaphor also helps to endorse a less esoteric and more scientific and natural view of hypnosis, based on ordinary and well-known processes. This will help the clients understand the commonality between hypnotic and 'normal' behaviours.

This metaphor, which has been published previously by Capafons, Alarcón and Hemmings (1999), will not be replicated here due to its length. It involves clients as the main characters in an adventure story in a jungle, who confront various difficult situations and overcome them with their own effort, creativity and adequate use of a multipurpose tool. In sum, the metaphor is intended to be a didactic aid that allows the clients to consolidate and remember information about hypnosis (Porush, 1987). All of the metaphor's intended aims are thought to contribute towards activating expectations of self-efficacy (Callow and Benson, 1990) and appropriate response expectancies, which in turn foster and facilitate therapeutic success. Research by Capafons et al. (1999), shows that after hearing the metaphor whilst in hypnosis, the majority of volunteers change their opinions with respect to hypnosis, accepting it with greater confidence.

The role of hetero-hypnosis

As we have indicated, our model of therapeutic intervention using hypnosis is based on

the creation of positive attitudes towards hypnosis itself as well as on the use of waking suggestion. All of that, however, is oriented around self-hypnosis, depending on the clients and their particular problems. In this way, the clients must carry out a series of exercises in order to acquire self-hypnosis skills under almost any circumstances, which will then enable them to become the main agents responsible for their own psychotherapy. In order to do this, the therapist can hypnotize the clients with the aim of reinforcing the efficacy of the self-suggestions that the clients administer to themselves using self-hypnosis. In the 'waking' hypnosis model, alert or active-alert methods are used, which encourage the clients to keep their eyes open, adopt a normal everyday appearance of activated individuals and even to maintain pleasant conversations with the therapist (as is the case in rapid self-hypnosis). Normally, the suggestions given by the therapist in that context include those which indicate that rapid self-hypnosis will be effective in allowing the activation of the clients' resources, that the reactions to be evoked really will be evoked, etc. In other words, the therapist declares that the clients will be successful in modulating, regulating and producing therapeutic change. Put yet another way, rapid self-hypnosis is the axis around which hetero-hypnosis will turn.

As has been indicated here, various methods of alert hypnosis exist (Vingoe, 1973; Barabasz and Barabasz, 1996; Wark, 1998), and it is sometimes labelled hyperempiria (Gibbons, 1979). In general, such methods usually include relaxation and eye closing. Probably the most researched and well known of these methods was created by Bányai (Bányai and Hilgard, 1976; Bányai, Zseni and Túry, 1993). This method, however, may be problematic since it requires an ergonomic bicycle, or a spacious room in which the patients can walk around and activate themselves (which may well be incompatible with patients who suffer from cardiovascular problems or indeed with the preferences of certain patients; Capafons, 1998a). A preferable alert method may be waking-alert hypnosis (or alert hand hypnosis; Capafons, 1998a) that I designed, in which clients are required to perform only a gentle physical exercise (hand movement) that emphasizes keeping the eyes open, general activation and even walking whilst remaining 'hypnotized'. Waking-alert hypnosis is a method of hetero-hypnosis (Capafons, 1998a). In fact, according to research carried out with the waking-alert method, the pleasantness factor that participants experience whilst in hypnosis and even the responses to the test suggestions are increased (Cardeña et al., 1998). The waking-alert method leads to less attrition, is more pleasant and also more 'powerful' when it comes to fostering responses to the test suggestions (Alarcón, Capafons, Bayot and Cardeña, 1999) than Bányai's method.

In hypnotizing clients using this method, the clients must first carry out a few brief exercises so that they can understand the reactions they will later experience (Cardeña et al., 1998). In this way, reactions of stress or anxiety can be avoided (Ludwig and Lyle, 1964). The clients are then asked to move their dominant hands up and down until this movement seems automatic. When the clients indicate that this objective has been achieved, it is suggested that their hearts pump more blood in order to keep the hands moving, therefore their heartbeat and breathing rate become faster. Then it is suggested that the augmented heartbeat and breathing rate activate the brain (which will be more alert) as well as the muscles of the body. When the clients feel activated, it is suggested that they stand up and walk around whilst remaining active, alert and hypnotized. Some suggestions can then be given in order to confirm that the brain is now *receptive*, activated and ready to respond to the therapeutic suggestions. In this case, the therapeutic suggestions are generally geared towards reinforcing the clients' and the rapid self-hypnosis's efficacy in order to foster therapeutic change. Nevertheless, on other occasions, clients show a marked interest in receiving suggestions from the therapist. In

this case, their preference is respected so that once again the 'control' can be gradually passed back to the client.

Conclusion

'Waking' hypnosis and the concrete methods for using it that have been described here are founded on the basic principles proposed by Wells (1924) more than seventy years ago (Capafons, 1999). The fundamental characteristics of all of these techniques are that the clients can respond to the suggestions while:

- remaining active;
- keeping their eyes open;
- maintaining a conversation with the therapist; and
- experiencing a robust sense of control.

Moreover, all of the above-mentioned methods of suggestion management have been described by participants as pleasant, enjoyable and useful. They lack none of the efficacy attributed to other forms of hypnotic suggestion management, and have even surpassed other methods. However, perhaps the common denominator in all of these methods is their empirical backing. All methods that we have proposed above are derived from cognitive-behavioural or socio-cognitive conceptions of hypnosis (being, at the same time, permeable enough to incorporate the ideas and methods of other schools that fit with such conceptions), and have been empirically validated. Waking suggestion, according to our approximation of it, is not just an effective complement to therapeutic intervention, but also appears to be efficient. It is pleasantly received by both client and therapist (Mendoza, 2000), and is very flexible when it comes to adapting to the preferences, needs and problems that the clients bring to the therapeutic arena. In this sense, it would appear that 'waking' hypnosis can certainly be considered efficient based on Seligman's definition (1995; 1996) of efficiency. At a time when hypnosis is not widely embraced by the general public, we (Capafons, 2002) are in agreement with Lynn and Fite (1998) that the socio-cognitive views of hypnosis will probably gain widespread acceptance, and that clinicians will become better informed of the experimental literature. Without mentioning the terms 'trance' or 'altered state of consciousness', we have managed to get both client and therapist to enjoy suggestion, whilst maintaining beliefs in keeping with the experimental literature on modern hypnosis.

Paradoxically, these results validate and confirm old concepts:

- 'waking' hypnosis is just as effective and efficient as hypnosis by relaxation;
- almost everyone can be hypnotized to some degree or be trained to be hypnotized; and
- hypnotic responses imply that the clients trigger certain resources that are not qualitatively different to those triggered in order to provoke non-hypnotic behaviour.

Only time will tell if Lynn and Fite's (1998) prediction that socio-cognitive points of view will meet widespread acceptance is correct. Our view is that this should be so if we, as clinical psychologists, can find useful and efficient therapeutic alternatives in such approximations. Perhaps other psychotherapeutic approximations can find common ground in our proposals, a prospect that would mean not only the acceptance of the socio-cognitive points of view but also its mutual enrichment and integration.

Acknowledgements

My thanks to Irving Kirsch and Yael Nitkin-Kaner for their helpful comments and corrections to the manuscript. Translated into English by Martin Hemmings.

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