Contemporary Hypnosis (1999)
Vol. 16, No. 3, pp. 182–186

DISCUSSION COMMENTARY

THE QUEST FOR HYPNOSIS: WHAT IS IT?

John G. Watkins

University of Montana, USA

Ever since it was discovered that human beings could evince unusual and sometimes startling behaviours after they had been submitted to a ritual, called 'an induction', the human race has been fascinated with trying to discover the essence and 'whys' of the phenomenon called 'hypnosis'. The number of experimental and clinical papers devoted to this quest has been legion.

Dr Barber, from his years of experience with hypnosis (stage performer, scientific researcher and clinical therapist), including a comprehensive review of the relevant literature, has proposed a theoretical approach to this problem which expands our vision and at the same time narrows our focus. He suggests that 'hypnosis' is not a unitary 'state, system, condition', but that it is multifactorial, that there are several different 'kinds of hypnoses'. I heartily concur with this position (Watkins, 1989). An example is the many differences between phenomena observed in the clinic and those evaluated in the laboratory.

In *laboratory hypnosis* the purpose of the study is the discovery of verifiable knowledge. The procedures are empirical. Standardization and control are paramount. The scientific approach is nomothetic. Subjects, commonly selected from volunteers in a population of (conveniently available) college students, are usually normal individuals – that is, not known to be ill or maladjusted. They are motivated to volunteer by curiosity, academic credit, social pressures and financial rewards, and are recruited to *meet the needs of the researcher*. The 'relationship' between experimenter and subject is *minimized* to avoid influence and contamination. Induction suggestions are verbal and standardized, often recorded. Measurements are objective and quantitative.

In *clinical hypnosis* the purpose is the cure or alleviation of painful symptoms and behavioural maladjustments. The subjects (called 'patients' or 'clients') are drawn from a population of all ages, socioeconomic classes and so on, who come *to meet their own needs*. The approach is ideographic. The 'relationship' between therapist and patient is *maximized* to increase therapeutic understanding and influence. Induction instructions, either verbal or non-verbal, are variable, unstandardized and often altered flexibly to meet individual needs. Evaluations (measurements) are subjective and qualitative.

In *stage hypnosis* the purpose is to entertain. Audience subjects volunteer because of curiosity and social pressures. The essence is the 'control' of the hypnotist over the subject, and the phenomena evoked are those most calculated to astound.

Could anything be more different to describe the conditions under which 'hypnotists' work, even though each uses the same term, 'hypnosis'. No wonder the observations of behaviour, perception, learning, memory and so on, differ.

Barber's typology of good hypnotic subjects

By a comprehensive integration of data derived from all sources, Barber concludes that there are three basic 'types' of good hypnotic responders: the 'fantasy-prone', the 'amnesia-prone' and the 'positively set' individual. The genius of this formulation is that it provides a rationale for explaining the differing conclusions concerning motivation, learning, memory, behaviour and experience reported by different investigators and by experimentalists vs clinicians. They may not be studying the same 'kind' of people. For therapists, this classification suggests the possibility of modifying approach and techniques to suit the type of individual being treated.

The attempt to classify humans into 'types' has a long history, 'introverted vs extroverted', 'internal locus of control vs external locus of control', and many others. Typology, however, has its own problems, namely that it tends to ignore individual differences in the interest of group characterizations. The question is to what extent do we differ group-wise, culture-wise, race-wise, and so on, from each other, as compared to individual-wise? Barber's classification permits both group and individual options to operate. So the question here is: Are his three proposed factors (with three other ancillary ones) the most relevant 'types'?

The research data he quotes strongly support his position (and most clinicians would probably not disagree with them). Furthermore, he rightly notes the 'experimenter bias' among investigators who disagree with one another. These biases need further attention.

Sutcliffe (1961) reported that workers in hypnosis tend to be 'sceptics'or 'believers'. Researchers are more sceptical and critical of phenomena reported. Therapists, with a need to trust their patients, are more likely to be believers. So, here we have a typology of 'hypnotists', rather than of 'subjects'. It raises the question of whether the differences reported in studies are related to differences between types of subjects/patients or to differences between types of hypnotists.

At the end of the paper Barber reports three additional dimensions: the social psychology of the hypnotic experience, the hypnotist (interpersonal relationship) including the qualitative influence of the hypnotist, and the nuances of verbalization, such as meaning, locution and vocal qualities.

With a general, provisional acceptance of Barber's three-dimensional typology, I would like to point to his fifth and sixth dimensions, the hypnotist and interpersonal relationship factors, as badly in need of investigation. But first let us try to agree on just what is 'hypnosis'.

Definition of 'hypnosis' – 1

Most researchers consider it to be either 'an altered state of consciousness' or a 'set of socially motivated behaviours' which inhere *in the subject*. Almost all investigations of hypnosis centre on behaviour or experience observed *in the hypnotic subject*. Few reports, with the exception of Diamond's paper (1984), pay any attention to factors and biases inhering in the experimenters' own selves.

For example, Barber reports that the majority of good subjects (85%) are Type 3: the 'positively set'. This 'finding' comes primarily from academic, experimental researchers, who themselves are 'Type 3', 'positively set', cognitive-behavioural-social theory (non-state) adherents, using objective, cognitive-behavioural measuring instruments (the standardized scales of hypnotic susceptibility, such as the Stanford

(Weitzenhoffer and Hilgard, 1967)), and others. One is reminded here of the astounding Rosenthal studies (1976), so largely ignored and almost forgotten today. Rosenthal found that investigators' theoretical positions, beliefs and 'expectancy effects' could even influence the behaviour of albino rats as well as children in controlled laboratory experiments with 'randomly selected' subjects (Rosenthal and Rubin, 1978). Even double-blind controls in an experiment may be insufficient if an investigator's possible bias is presumably controlled by the use of graduate-student hypnotists from the same academic department. So, objective-cognitive-behavioural-social theory researchers, working primarily with normal college student volunteers, find that only a small minority of good hypnotic subjects are 'fantasy-prone' or 'amnesia-prone'. Hypnotherapists, who treat 'symptoms' by suggestion, may well report the same findings.

However, psychoanalytically oriented therapists, who treat by hypnoanalysis, ego-state therapy or related dissociative-psychodynamic approaches, may hold that Barber's 'fantasy-prone' and 'amnesia-prone' types are much more frequent than reported in this paper.

Ego-state therapy (normal-neurotic) patients, when hypnotized (see Watkins and Watkins, 1997), openly demonstrate multiplicity by manifesting 'covert' ego states overtly – such as are normally seen only in multiple personalities, today termed 'DID, Dissociative Identity Disorders' (Putnam, 1989; Kluft and Fine, 1993).

For example, how does one record the factor of 'hypnosis' when a child state, hypnotically activated (Watkins and Watkins, 1997: 83–7), says, regarding the whole person or conscious 'executive' state: 'I don't normally come out. I'm the one who goes into hypnosis. She [the subject – a clinical psychologist] doesn't know how.'

> Therapist: 'She's the one that can hypnotize other people, but she can't go into hypnosis herself. Is that right?'
> Child state: 'I guess so. I'm not around when she hypnotizes other people.'
> Therapist: 'Will you open your eyes and look at me?'
> Child state: 'No. 'Cause if I do that then she comes back, and I go away.'

Now, who in this case is the 'hypnotic subject', the child ego state or the entire person? Supposing we view such transactions from an entirely different and uncommon conceptualization of 'hypnosis'.

Definition of 'hypnosis' – 2

Let us think of 'hypnosis' observed in the clinic by a sensitive, dynamically oriented therapist as 'an intensive *inter-personal relationship* experience', which inheres in both parties. By intense 'resonance' (Watkins, 1978), the therapist co-feels, co-suffers, co-understands the experience of the patient and thereby transmits a greatly enhanced trust which does not occur in an experimental situation.

Because of this deep-level trust, consciousness changes. Feelings, memories, fantasies and experiences emerge that would not be available in the research situation, where relationship is purposefully minimized, and where the subject (by contractual agreement) is treated as an 'object' to be manipulated by the experimenter. The clinical patient knows this, and a whole area of covert behaviour and experience is not made overt and observable to the neutral, objective laboratory investigator. In intensive therapy this level of 'trust', which is both overt (conscious, verbalizable) and covert (unconscious), may not appear until many sessions of therapist–patient inter-

action. A psychodynamic relationship therapy can be very much like other human relationships, friendship, love, and so on. For example, the behaviours and feelings elicited in a woman receiving flowers from 'Bill', a casual acquaintance, may be very different from those manifested when she receives flowers from 'George', who has stood the test of many close, intimate contacts, and whom she has learned to trust, even though both used the same 'inducing' behaviour.

Likewise, the access to behaviours, memories and so on released by a deeply trusting patient in many hours of a close, maximized relationship therapy with a warm, 'therapeutic self' clinician (Watkins, 1978) may be enormously different in both quality and quantity from those revealed to a 'hypnosis researcher', a stranger with whom at most he or she has had an hour or so of acquaintance, and who has no 'healing' responsibilities.

From this point of view, 'hypnotizability' in therapy is very much a function of relationships; it does not inhere in the subject as simply a fixed trait.

Even in the suggestive and cognitive approaches (which seek verbal 'understanding') the therapist may 'loan' the client only his/her cerebrum. In the psychodynamic, ego-state treatment described above, the therapist 'loans' his/her whole 'self', the entire personhood, with all affective, perceptual, motoric, visceral – *and cognitive* – components. It seeks full experiential change in the patient. How does one compare 'hypnosis' in the one with 'hypnosis' in the other?

My criticism here is not with Barber or the impressive amount of data by researchers in the field, but is rather with the nature of 'empirical' research itself, which in its effort to mechanize and objectify the subject may destroy the very nature of what a person, a human being, does and experiences in a bipolar relationship, whether it be 'hypnosis' or some other term applied to an area of human behaviour.

Do I believe in empirical research? Definitely, yes. But it must become much more sophisticated and involve the observing and classifying of the behaviour, feelings, attitudes, beliefs and ideological position *of the investigator* as well as the subject. If 'hypnosis' is bipolar, a hypnotist–subject relationship, then all interactions between the two in a research study, from the moment of contact in a recruiting speech or message to a class of potential subject volunteers, should include an audiovisual recording of all contacts. This makes it possible for another researcher to observe, listen to and study every word, every nuance of expression, and every postural or gestural movement of the original investigator. Such data are never available in journal-published research reports, even though Barber lists them.

Most significant would be identical studies replicated in two different universities (with comparable populations) by two different investigators, one a psychodynamically oriented, 'altered state of consciousness', neodissociative believer regarding hypnosis with his or her graduate student assistants, mentored in his classes (such as might have characterized Hilgard's laboratory). The other would be a behavioural-cognitive-social theory, motivational, 'positive set' believer with his graduate assistants (such as might have characterized Spanos' laboratory). Each, with microscopic eyes, would then scrutinize and evaluate the recordings of the other in a search for contextual investigator influence and biases.

Perhaps then will we really discover the 'true' essence of 'hypnosis'. In the meantime, Barber's three-dimensional theory is an excellent contribution, and if implemented can certainly draw therapists and researchers with different conceptual theories closer together.

References

Diamond MJ. It takes two to tango: some thoughts on the neglected importance of the hypnotist in an interactive hypnotherapeutic relationship. American Journal of Clinical Hypnosis 1984; 27: 3–13.

Kluft RP, Fine CG. Clinical Perspectives on Multiple Personality Disorder. Washington, DC/London: American Psychiatric Press, 1993.

Putnam FW. Diagnosis and Treatment of Multiple Personality Disorder. New York/London: Guilford Press, 1989.

Rosenthal R. Experimental Effects in Behavioral Research. New York: Holt, Rinehart & Winston, 1976.

Rosenthal R, Rubin DB. Interpersonal expectancy effects: the first 345 studies. The Behavioral and Brain Sciences 1978; 3: 377–86.

Sutcliffe JP. 'Credulous' and 'skeptical' views of hypnotic performance. Journal of Abnormal and Social Psychology 1961; 62: 189–200.

Watkins JG. The Therapeutic Self. New York: Human Sciences Press, 1978.

Watkins JG. Hypnotic hypermnesia and forensic hypnosis. A cross examination. American Journal of Clinical Hypnosis 1989; 32: 71–93.

Watkins JG, Watkins HH. Ego States: Theory and Therapy. New York: WW Norton, 1997.

Weitzenhoffer AM, Hilgard ER. Revised Stanford Profile Scales of Hypnotic Susceptibility, Forms I and II. Palo Alto, CA: Consulting Psychologists Press, 1967.

Address for correspondence:
John G. Watkins
413 Evans Street,
Missoula,
Montana 59801, USA