AN INTERVIEW WITH ANTONIO CAPAFONS

ANTONIO CAPAFONS, PHD
MARK P. JENSEN, PHD

ABSTRACT

This article summarizes the key points of a conversation between Mark P. Jensen and Antonio Capafons, in which Dr Capafons discussed his views of hypnosis and the techniques he uses to help patients learn to use hypnosis for increasing self-control over habits, anxiety, and pain management. Dr Capafons points out that the concept of hypnosis has important cultural determinants, and that a traditional model of hypnosis where the patient lies down with his or her eyes closed and passively receives suggestions from the clinician may not always be the most appropriate or effective approach. Rather, clinicians may find that a more active waking hypnosis can help patients to more easily apply hypnotic skills in their everyday life. Dr Capafons describes a number of techniques for assessing and shaping motivation and expectancies about hypnotic responding, as well as some hypnotic strategies for dealing with patients who might be struggling with self-hypnosis.

Key words: waking hypnosis, hypnosis techniques, motivation, expectancies, cultural factors

INTRODUCTION

Dr Capafons became interested in hypnosis when he was studying the factors that predicted treatment success for obesity reduction. As he read more about hypnosis, he began collaborating with a clinician and colleague, Salvador Amigó, to develop a unique approach to hypnosis and how it could be used in therapy. Normally, hypnotic subjects are asked to close their eyes and become very passive, and are then given hypnotic suggestions. Dr Amigó's view was that this limited the work of the therapist. Instead, Dr Amigó suggested, clients could be hypnotized with their eyes open and hypnotic work could occur while the client was actively engaged with the therapist. Dr Amigó and Dr Capafons developed a model of therapy—emotional self-regulation therapy—that incorporated using hypnotic suggestions in this way (see Capafons, 1999a).

Dr Capafons later discovered that this approach—using hypnosis with clients who are alert—was similar to that of W. R. Wells (Wells, 1924), who first described 'waking hypnosis'. He determined that this model could have some advantages over the more passive relaxation hypnosis. For example, it might be more acceptable to clients because with their eyes open they might feel more comfortable and more in control. It also seemed to Dr Capafons that hypnosis could be induced more quickly using this method, possibly making hypnosis more efficient and effective.

Over the years, Dr Capafons has continued to develop a model of waking hypnosis, which he calls the Valencia model. The general thrust of this model is to increase the efficiency of hypnosis by making the process very pleasant, playful, and amusing, while at the same time giving clients a set of skills that they can incorporate into their daily life as a general coping and self-control skill while alert, awake, and engaged (Capafons, 1999b; 2004a; 2004b; Alarcón & Capafons, 2006; Capafons & Mendoza, 2009; 2010; Lopes-Pires et al., 2009).

Mark Jensen: *How do you view hypnosis?*

Antonio Capafons: *HYPNOSIS HAS CULTURAL DETERMINANTS*

Hypnosis is a label associated with a set of ceremonies and interactions that differ somewhat from one culture to another, and also differ over time. So what 'hypnosis' is today is not the same as what it was 100 years ago, nor is it what it will be 100 years from now. It is not exactly the same in Spain as it is in Norway or Japan.

What makes one interaction 'hypnotic' and another not depends on the cultural context. If the particular interaction in question happens to be viewed as 'hypnotic' by the individuals involved, then those interactions are hypnotic. Of course, hypnosis around the world does have a number of common factors, because the culture that contributes to the definition of hypnosis is also an international one.

If a therapist suggests to his or her client that the client's arm is '. . . very, very light, light, light, light, . . . and in a few moments you will feel your arm lifting . . . all by itself . . .', many people in Spain—indeed, people in many parts of the world—would view this interaction as 'hypnosis'. But not every person or every culture would recognize this interaction as hypnosis. Only when the hypnotist and subject agree that a specific interaction is hypnosis does it become hypnosis.

A client was once referred to me for urinary urgency. I began the treatment by using an eyes open/eyes closed induction: 'Open, open your eyes . . . now close the eyes, they are relaxing . . . now open them, and you still feel relaxed . . . and now close the eyes . . .' After ten minutes of this I asked him to describe his experience. Even though he appeared very relaxed and responded to my suggestions, he said, 'I don't feel hypnotized, not at all.' 'Why?' I asked. 'Because you did not use a watch to hypnotize me. So I wasn't hypnotized.' So I took out my pocket watch, and said, 'Now, please look, look at the watch.' He immediately felt very, very hypnotized. So, in his view, the eyes open/eyes closed induction was not 'hypnosis', while a pocket watch induction was.

One common cultural understanding is that, with hypnosis, subjects display non-volitional behaviours; or at least experience a subset of their behaviours as non-volitional. A significant part of the Valencia model of hypnosis is to teach patients to use this aspect of hypnosis to paradoxically get more control over their behaviour. So, for example, smokers sometimes say, 'I smoke automatically. Sometimes I find that my arm and my hand work together, on their own, to take the cigarette out. And then I am smoking before I know it.' What they are doing is an automatic act, an automatized 'response set'. For such patients, we can first teach them to experience arm paralysis, and then get control over this through self-suggestions. Then the patient can learn to use suggestions to paralyse his or her arm just before he or she normally would have used that arm to get a cigarette. The arm seems to be paralysed on its own, but the patient is the one who made the decision to use hypnosis to experience paralysis; ultimately, then, it is the patient who is in control.

Of course, arm paralysis in this instance is a fiction. The client knows and I know that he or she can, in fact, move the arm whenever he or she wants. It is a fiction, but we teach patients to learn to believe in and experience such fiction to achieve their goals.

Also, in the Valencia model, we do not use the concept of trance or alterations in consciousness to understand the effects of hypnosis. Because hypnosis involves the extensive use of language, it can be difficult to distinguish it from psychotherapy and other psychological interventions. With all of these interventions, we are using words to help clients alter their experience. Moreover, hypnosis is effective because of the same factors that influence all behaviour—expectancies, beliefs, motivation, and self-talk. What sets hypnosis apart from general psychotherapy is one's cultural understanding. When a culture defines a certain set of interactions as hypnosis and another set of interactions as psychotherapy, then those interactions *are* hypnosis and psychotherapy, respectively.

WAKING HYPNOSIS

The standard view of hypnosis, at least for many people in the field, is that in order to be hypnotized, you need to sit with the eyes closed and feel 'relaxed'. It is like going to a cathedral or a church to get in touch with God. I close my eyes, I'm thinking, relaxing, I am alone. This approach to hypnosis is not necessarily bad. It can be very good as a way to give people a chance for meditation and self-reflection. But it is not the only way to view hypnosis.

One can also experience a focused awareness with one's eyes open, and when one is with others and communicating. I tell pa-

tients, 'You don't need to be at home and only focusing on internal reactions, closing your eyes and being silent, to use hypnosis.' With waking hypnosis, in fact, it is just the opposite. With waking hypnosis you can speak, feel alert, and feel activated. The patient with a social phobia might ask me, 'So I can go to a party and use waking hypnosis during the party, while interacting with others, without appearing to be in a trance? To feel relaxed with my eyes wide open?' 'Yes,' I would tell this patient, 'You can do that.'

I teach my clients to use waking hypnosis as a coping strategy. This also fits very well with the culture of Spain; Valencia in particular. In Valencia, where I live and work, there is a lot of sand, beautiful beaches, and a climate that is excellent; about sixty degrees on average during the year. People here spend a lot of time outdoors. We go outside and into the streets to walk and talk.

HYPNOSIS IS NOT DISSOCIATION, BUT CONTROL OVER ASSOCIATIONS

Some people view hypnosis as necessarily involving dissociation. In fact, there are some theories of hypnosis that use dissociation as a central concept. But, in fact, parts of the brain are always dissociated, whether someone is 'hypnotized' or not. We are constantly doing more than one thing, and sometimes many things, at the same time. Hypnosis does not cause dissociation—dissociation is a natural state of the brain. What hypnosis does is give you better control over associations. So hypnosis is not a disassociated state; it is control over the state of associations and dissociations.

MJ: What kinds of problems do you use hypnosis for?

AC: I mostly use hypnosis for habit control (e.g. helping smokers become non-smokers), phobia/anxiety management, and pain control.

MJ: What do you seek to understand about or observe in clients as you develop your hypnosis treatments and interventions?

AC: In the Valencia model, we use exercises to evaluate attitudes towards hypnosis, because attitudes and expectancies are the best predictors of response to hypnotic treatments.

ASSESSING MOTIVATION FOR RESPONDING TO HYPNOSIS

A common method in the Valencia model for assessing patient motivation for hypnosis is as follows. First, I ask the patient to stand straight up, with his or her feet close together. Swaying is the normal response to this stance, so I suggest that the client will sway. And then I watch what happens. Because swaying is the natural

response, if they do *not* sway, that means that they are actively resisting the suggestion.

I ask them, 'Okay, what is the problem? What is happening with you?' They might say, 'I don't believe that I will sway,' or 'I don't like the idea of swaying,' or 'I'm not sure.' In this case, I might assess whether the problem might be a lack of trust in me. I will stand behind them, perhaps far behind them, and say, 'Okay, I need to know if I can support you. You can hear my voice, right? Now listen closely. Am I far away, or am I close to you so that I can support you? If you were to fall back, could I catch you from this distance?' They will say, 'No, that is too far.'

I then suggest that they close their eyes, and then I move far to the right or left, but still behind them. I'll ask, 'How about this distance? Could I support you from here?' And the patient will say, 'No.' I say, 'No? So you do have control over whether or not I am able to support you or not because my voice tells you if I am close enough. It is not *what* I say that determines this, but how it sounds to your ears. You have control over that. So if you close your eyes, and I say "Please, fall back," only when you know that you are safe will you do so; and then you will fall back.' And then I stand right behind them and say, 'Please fall back.' Most patients will fall back at this point, and of course I catch them and support them.

Then I repeat the exercise, but instead of telling the patient 'Please fall back,' I *suggest* to them, 'Please, feel as if you are losing your balance, and feel a force pushing or pulling you towards me . . . feel as if you are falling backwards . . .' If they do not fall back, then there are clearly trust issues that would likely interfere with hypnosis treatment. Why with hypnosis and not with me as therapist? Because they allow themselves to fall back when listening to an instruction, but not when they listen to a suggestion. Therefore, it is not the therapist but the narrative (suggestion vs. instruction) which is being used. I might elect, at this point, not to use hypnosis with this particular patient—at least until and if those trust issues are resolved. This is a good exercise not only for assessing motivation and readiness for hypnosis, but also for preparing the patient for the hypnosis process, and for responding to suggestions.

Here is another example for assessing readiness for hypnosis. I ask the patient to push their wrists together '. . . very hard. Push hard for 30 seconds. Now let them come apart about six inches . . . and relax them, and allow them to drift back together, on their own.' In this situation, the natural thing is for the wrists to drift back together—automatically, and without any apparent volitional control. If I do this, and the patient's hands do *not* drift back together, then he or she must be actively preventing this from happening. This calls into question, yet again, this client's readiness to use hypnosis. For most patients, though, the hands come together. And this teaches them something about instigation and something about non-volitional behaviour.

MJ: What are the key elements of effective hypnosis?

AC: *SELECT APPROPRIATE PATIENTS*

I think that there are two kinds of patients that hypnosis does not work for. First, there is the patient who has very negative views about hypnosis—they do not think that it will help them, or they might be frightened of it. These patients usually simply refuse hypnosis when it is offered. They do not have adequate motivation. But since I am a psychologist, I have many tools at my disposal—hypnosis is just one of those tools and I do not have to use it to effectively help my clients. So it is fine to not insist that I use hypnosis with every patient.

The second type of patient is the one who has unrealistic views of hypnosis and what it can do. They might say, 'I want hypnosis because it will take away all of my cravings for smoking all of the time and forever—I know that with hypnosis I will never want to smoke ever again. I am sure that you can do this for me.' Or, 'I want you to hypnotize me into a past life so that I can discover who I really am.' Or, 'I want you to hypnotize me and cure me of my cancer.' Although these patients are very motivated, their unrealistic views of hypnosis can get in the way of its efficacy—because they expect too much, they are bound to get disappointed, and then risk losing the treatment gains that are in fact possible (they can experience a nocebo effect).

In order for hypnosis to be most effective, the patient needs to both be motivated and to have realistic beliefs about what can be accomplished. There are patients who may have inappropriate views of hypnosis, but those views are flexible. For these patients, a single session or part of a session may be all that is needed to address their misunderstandings.

To facilitate this, I usually administer the client version of the Valencia scale of attitudes and beliefs about hypnosis (Capafons et al., 2008). I take a close look at their responses to understand if they have realistic or unrealistic views of hypnosis, and the extent to which those views might interfere with treatment efficacy. If they can be addressed with some basic information, I provide this. If this adequately addresses any concerns or inappropriate beliefs that they have about hypnosis, I then offer treatment with hypnosis.

RAPPORT

Once you select the appropriate patients, you need rapport. Without rapport, all we provide is lay hypnosis.

MJ: What are factors that, although they may not be essential, make hypnosis more effective?

AC: *TAILOR THE HYPNOTIC INDUCTION TO THE EXPECTANCIES OF THE PATIENT*

It is often helpful to tailor the hypnotic induction so that it matches the particular expectations and beliefs that the patient has about hypnosis. You can use direct suggestions, guided suggestions, or even stories and metaphors. All of these can work, but one will probably work better than the others with any one patient. The patient I described earlier who believed that 'hypnosis' only occurred when the clinician used a pocket watch for the induction is a good example of this.

MJ: Are there specific techniques or exercises that you have found particularly useful that you use routinely in many or most cases, or in particular situations?

AC: *TEACHING PATIENTS ABOUT HYPNOSIS USING THE CHEVREUL'S PENDULUM ILLUSION*

One strategy we commonly use for teaching patients about hypnosis and its effects is the pendulum. The exercise goes like this. First, you give the patient a pendulum on a string—about 43 centimetres of string for a weight of 50 grammes (about 17 inches long and a weight of 12 ounces; although the important thing is the proportion, i.e. a wet tea bag can be used) and you suggest that they allow their brain to make the pendulum go in a circular motion. Ask them to simply allow their brain to do this without them trying at all; all they have to do is let this happen while watching the pendulum. Patients are often very surprised to see the pendulum start to comply with the suggested motion. On the one hand, they know that they are making this happen because they can see it with their own eyes. On the other hand, their brain is doing it 'automatically', apparently without their volitional control. This is one way to teach people how their brain is able to self-regulate bodily responses outside of awareness.

USING HYPNOSIS AND RESPONSE TO HYPNOSIS TO ENHANCE SELF-EFFICACY

In the Valencia model, we have developed a number of specific hypnotic techniques to help patients address their presenting problems. One underlying theme of many of these exercises is to teach a set of skills which patients can use to address a number of different problems. For example, I commonly first teach the patient to experience arm paralysis through rapid self-hypnosis (RSH) (Capafons, 1998; 2004a), a self-hypnotic induction method of the Valencia model of waking hypnosis. RSH is a very flexible and structured method which is used for 'instigating' reactions that help clients to experience arm heaviness and paralysis, or a sort of dissociation (a verbatim script of RSH can be found in Capafons, 1998; 2004a as a reaction that confirms to the patient that they are already hypnotized.

When the patient is experiencing the paralysis, I introduce the notion that if the client is able to notice his or her arm being heavy and paralysed (or a very light levitation, depending on the patient's preferences), perhaps he or she can do more things than he or she thought about the primary presenting problem. I ask, 'What has changed so that you feel the arm is paralysed?'

If the client says, 'I don't know,' I would ask, 'Well, what is different now, compared to before?' My goal is to gently guide the patient to understand that it is their brain that has created the experience of paralysis—and that this is direct evidence that they have learned an ability to get more control over their brain. As a result, they are looking at their arm from a new perspective; implicit in this observation is that they may be able to view their presenting problem from a new perspective.

The patient might say, 'Well, my arm is paralysed like I see when people use hypnosis on TV.' But I want him or her to understand that they can use hypnosis to enhance self-control. So I say, 'Ah, yes. But it was *you* that instructed your brain to give you this experience.' It is just the opposite that people usually think of hypno-

sis, because the standard model of hypnosis is that it undermines self-control by encouraging passivity. In the Valencia model, we enhance self-control.

GENERALIZING THE SKILLS OF SELF-HYPNOSIS

A significant aspect of the Valencia model is to teach basic self-control skills with simple exercises, and then encourage the patient to generalize these skills to address their presenting problem and any other problems in their lives. I often start by placing my fingers (ring and middle fingers) in front of the patient's eyes, just at his or her eye level. Then, I say, 'Tell me where you are looking and what you see.' Usually, they say that they can see my fingers. I then invite them to broaden their view. 'You see my fingers. So you can see my right finger, my left finger. You can see things on the level of your eyes. Now be aware of what is above my fingers and below my fingers at the same time. You can see everything. You can see what you are looking at directly, but you can also see what is around my fingers, in your peripheral vision. You can see the light, the window. You can see the brilliant colours. You see the different hues and shades of the colours; you can see everything. You are aware of your brain feeling more activated and more under your control. And you can feel a very strong sense of well-being.' With this exercise, the patient may not feel 'relaxed', but they often feel very good. In fact, patients sometimes say that they feel as if they have had a stimulant.

Importantly, the patient also feels under control. He or she can see everything—the eyes are wide open. I might then suggest arm paralysis, or even that they experience their feet as being stuck to the floor. And when they experience that, I say, 'Now, what about the pain? If you can say to your brain, "Now my feet are stuck to the floor", can you also say to your brain, "My pain can be reduced, or I can understand my pain differently, so that it does not bother me so much"?' If they are unsure, I say, 'Well, let's do an experiment. Go ahead and allow the brain to make the pain feel different.' If they resist, I don't fight them. I just go with it, perhaps saying, 'Okay. Before we move to your pain, what about feeling with a sense of tenderness or a sense of happiness?' I suggest a shift from biological and musculoskeletal reactions to emotional reactions. Of course, I encourage them to do this with their eyes open. Learning to do this with their eyes open is a very good idea, because it means they may be more likely to be able to use these skills in their day-to-day life. We don't just sit around all day reclining with our eyes closed. Most of us are active during the day—driving, walking, working, doing household chores. Learning to get control over the brain so that the patient can feel less pain or more emotionally calm in his or her day-to-day life means that patients can take what they learn out of the office, and use the skills that they learn every day.

And I teach them this in parts. First, I teach them to feel activated, hypnotized, and in control. Then, I teach them to get control over feelings of paralysis. Next, I teach them control over emotions. And then, finally . . . why not control over the presenting problem? We move to this possibility, all the while helping the patient to feel active and engaging him or her in conversation. Yet the patients often say, 'I feel hypnotized', even though it is just the opposite of traditional relaxation hypnosis.

Interestingly, patients often apply the skills that they learn with these exercises to many different problems—not just the presenting one. A mother might comment, 'I have learned how to use self-hypnosis to be able to reduce compulsive eating, but I also use it for helping to control my anxiety or frustration, to feel more calm and focused throughout the day. So when my kids make me feel angry, I can use self-hypnosis when I'm ironing or something else for feeling calm.' In the Valencia model, we specifically teach and encourage this generalization.

WORKING WITH PATIENTS WHO MAY BE STRUGGLING WITH HYPNOSIS

Let us say you are working with a patient to teach him or her hypnosis, but they are having a difficult time learning arm paralysis or arm heaviness. In fact, let us say that they tell you that they think it is stupid to even try. I tell them, 'How is this stupid? Because you tell your brain, "My arm will be very heavy," and because you then allow the brain to create that sensation? Well, maybe that is a little stupid. But let's try another experiment. See this pen (or pencil, or whatever)? Look at this pen and say to your brain, "This is very interesting object. This object is more interesting than life itself." ' The client might say, again, 'This is stupid.'

So I say, 'But it is also stupid to dissociate your arm. Could you try this with me?' At this point, the client usually agrees. I say, 'So now activate your brain, and say to yourself, "In a few minutes, perhaps seconds, the more I look at this pen, the more I will like it." Just let it happen. Find all kinds of things to enjoy about the pen; but please don't interfere with the self-hypnotic mechanism of the brain. Allow it to happen.'

At this point, many of these patients start to be amused by the exercise. I say, 'Okay. Now, in a few minutes, turn it around. Tell your brain to say that you dislike the pen—that it is horrible.' I tell them that they do not lose anything by trying this; I approach it like an amusing experiment. Many patients are able to use this exercise to experience different emotions about the same object. When they do, I ask them to describe to me their theory about how this is possible—to really feel completely different emotions about the same object in a matter of minutes. 'How is it that you are able to change your feelings about the pen? Is it possible that it is because you are able to get control over your mind?' Most patients agree at this point—they have experienced this change directly, and there is really no other reasonable explanation other than the fact that they are using their control over their brain to change their emotions. Then I say, 'Now, perhaps you can change your mind about your problem using hypnosis. Using your thoughts, your imagination, your expectancies.' At this point, many patients say that this helps them understand the goals of the treatment, and that success is possible. I never directly tell patients, 'The way that you think about the problem and your life can improve or worsen your problem.' I use exercises so that the patient can discover this for himself or herself.

We are building self-efficacy for change. The patient notices how he or she can alter his or her experience, just by using the imagination. Yes, I agree with the patient who says that arm levitation and dissociation in and of themselves are stupid. But I also help them to see that if they can learn to use their brain to change their experi-

ence with respect to their arm (or pen), then perhaps they can learn to do the same thing with a presenting problem that may not be as stupid.

'I can't control my anger,' another client might say, 'I am always arguing with my wife.' Well, perhaps if this patient can learn to paralyse and unparalyse his arm, maybe he can learn to get unstuck in the relationship. It is personal discipline—and learning how to tell your brain what you want to experience.

USE THE D'ZURILLA TECHNIQUE FOR PROBLEM SOLVING

For problem solving, we often use hypnosis combined with the D'Zurilla technique of interpersonal problem solving (D'Zurilla & Goldfried, 1971). It is a five-step technique. In the first step, you recognize the problem and develop appropriate attitudes towards the problem (i.e. to have problems is normal; I have to make an effort to solve problems). In the second step, the problem is defined and formulated. In the third step, you generate alternative solutions, as many as you can, without judging or assessing them. Step four involves evaluating those solutions, after anticipating and valuing the probable consequences. This step also involves making decisions and choosing the best solution(s), and their combination. Finally, in step five it is necessary to activate all the solutions and alternatives, so that the patient can evaluate if the plan works.

Hypnosis can be particularly helpful for the third step. Following an induction, you can ask the client to imagine and create different points of view about the problem, so that different solutions will come to him or her. In the original technique, you have the client simply write down every possible idea or solution, no matter how silly or stupid it seems. The hope is that if the idea pool of solutions is large enough, the client will eventually generate one that will be useful.

Specifically, after an induction, I suggest, '. . . and then you can see a screen, and when you do, you will see solutions on that screen. Just look at the screen, you can close your eyes, and you can see it. Let many possible solutions appear . . .'

From an Ericksonian perspective, the patient is allowing his or her unconscious mind to come up with a number of solutions. But I don't like the term 'unconscious mind'. We do not have one unconscious mind. The unconscious mind is really just a metaphor for the many cognitive processes that occur out of our awareness.

USING 'AGE REGRESSION' AS A RESOURCE FOR COPING WITH A PROBLEM TODAY

A lot of therapists use 'hypnotic regression', and I think that this technique can be very effective. But I put the term in quotation marks, because I don't believe (and research supports this conclusion, see Nash, 1987) that the client is really regressing to a previous time.

When using this technique with smokers, I might ask, 'Do you remember your first cigarette?' Every smoker normally does. Then I ask, 'Do you remember when you didn't smoke?' Clients can usually remember this as well. So I say, 'Okay, now we are going to use hypnotic regression. You and I both know that when we think back to a previous time, we don't really go back in time. You are still you, right here, right now. But this can be a way for you to focus your attention and to reflect on your

past. So it is not completely necessary that you regress to the time you actually had your first cigarette. What is important, though, is that you remember and experience what it felt like. Okay? So, now, let's go back. Please light that cigarette. Inhale . . . Good. What is that like?' Usually, the patient says, 'Ugh. That's horrible' or 'Yuck, that tastes bad!' I say, 'Okay. Now bring that reaction, those feelings, up to the present day. What do you feel in your mouth, right now?'

Usually, the client does not have a good taste or feeling in his or her mouth. So I ask, 'Do you want to increase that reaction? You told me before that if, with hypnosis, you could get more in touch with the feeling that smoking is bad for you, you will consider the possibility really of stopping smoking.' If the patient agrees, I then say, 'Okay. Now take your cigarette . . . and breathe in, but please not to your lungs . . . breathe into the stomach.' They usually say, 'It's horrible. Yuck.' I say, 'Just like your first cigarette.'

We can use age regression to help with other aspects of the smoking habit as well. I ask clients if they can recall feeling very happy and satisfied during a time in their life when they were not smoking. If they can, we use hypnosis to recreate those feelings, and link them to being a non-smoker. I also ask if they can recall a time when they handled a significant problem without smoking, and we can then use hypnosis to recreate and emphasize the good feeling that went along with that; linking that ability to problem solve with being a non-smoker. If the patient is older, say in middle age, I might suggest that they keep in mind that the moment they become a non-smoker, they will become younger. Their body will become healthier and healthier—just as if they are growing younger and younger.

Although this strategy is a type of age regression, it is not at all the same as reliving being in the womb, or getting in touch with a past life, or attempting to recall a special trauma that is hidden in the patient's unconscious mind. Rather, it is one way of recreating something that the client already has clearly in his or her mind, and to bring the recollection into the foreground to help with the problem today.

MJ: Anything else?

AC: *SUGGESTIBILITY OR HYPNOTIZABILITY IS NOT IMPORTANT OR NECESSARY FOR GOOD OUTCOMES*

There is a view by some in the hypnosis community that hypnotic suggestibility is important; that clients who are not 'hypnotizable' won't benefit from hypnotic treatment. I don't think that this is an accurate or helpful view. The key processes underlying hypnosis are motivation and self-efficacy, rather than inherent suggestibility. I have already discussed strategies to enhance self-efficacy. We have also recently created some structured exercises to facilitate motivation, as 'motivational questions'. Recently, Mendoza and myself published a book chapter in which we describe what those motivational questions are. Insofar (as in the Valenica model of waking hypnosis) that the suggestions are given while clients keep their eyes open, it is possible to conduct several practice exercises in which clients start realizing that a series of stimuli (pencils, watches, or any object even imaginary ones) can provoke reactions that in a *natural* way they would otherwise never provoke (Capafons & Mendoza, 2009).

These exercises start asking the clients to self-hypnotize. Then, reactions of heaviness and lightness are suggested to be evoked and associated to seeing or touching different objects. Next, these suggestions are reversed; that is, if it has been suggested that seeing a ballpoint pen will generate heaviness, to reverse the suggestion means that the ballpoint pen will evoke lightness later. By using Clark Hull's (1933) terminology the therapist explains to the client that these exercises are useful to facilitate homoaction (the improvement of the responses through practice) and heteroaction (the improvement of the performance in difficult suggestions by practising other less complicated exercises). In this way, clients understand that responding to suggestions is also a matter of practice and learning that facilitates the use of self-hypnosis as a technique to promote coping skills. Clients also learn that they are developing their own ability to respond to hypnotic suggestions that is based on a type of mental discipline.

These exercises also allow for asking the following *motivational questions* (Capafons & Mendoza, 2009: 247–248):

- Do you think that there is any objective reason by which seeing or touching those objects would generate heaviness or lightness? Answer: No
- Do you think that the way you think, or imagine, as well as your attitude has favoured those reactions? Answer: Yes.
- Do you think that the objects evoke the reactions that you have experienced because of the meaning that you have associated to those objects? Answer: Yes.
- Do you think that the magnitude and implications of your problem partially depend on your way of thinking—of imagining—and on your attitude towards it? In other words, do you think that your problem depends on the meaning that you have associated with it? Answer: Yes.
- Do you think that changing your way of thinking and imagining, and your attitude towards the problem, can help you solve the problem? Answer: Yes.
- Do you think that hypnosis can help you manage better your thoughts and your imagination, and to develop and maintain a more useful attitude towards your problem? Answer: Yes.

Usually, clients respond adequately to the questions, which then leads them to change the *meaning* of their symptoms. At this point, the symptoms are no longer perceived as being out of their control. On the contrary, they are modulated, determined, and/or maintained by the patient's attitude and understanding of the problem. In this way, self-hypnosis can be viewed as an adjunctive tool that helps to increase self-control and self-regulation.

In summary, to enhance motivation and self-efficacy, you can use very simple suggestions, such as sway suggestions, the pendulum technique, or similar. Nearly everyone can respond to these suggestions. Once a client believes that the techniques will be helpful and is motivated to respond, he or she will then respond positively to hypnotic treatment.

As I have described, in the Valencia model we start by creating simple reactions to classic hypnotic suggestions, like arm paralysis. We practise these responses, and

then ask the client if he or she wants to keep learning additional responses, or begin to use the skills and apply them to addressing the presenting problem. But other clients may need or want more time—that is fine. Once the patient starts to respond, he or she may be very surprised, and an excitement and curiosity about using hypnosis for the problem can grow very quickly.

So in my view hypnotic suggestibility does not predict outcome very well. Much more important is the flexibility and skills of the therapist for adjusting the inductions and suggestions to the needs and skills of the patient. When you are in a relationship with somebody who is pacing with you, matching you, and tailoring the inductions and suggestions for you, good things happen.

MAKE TREATMENT FUN

We say in Spain that everything we enjoy is a sin. The Catholic Church has a confessional box for a reason; it is impossible to be perfect. Because everything we enjoy is a sin, we will all eventually sin. The effort to avoid everything we like to do is just too much. Say a client seeks therapy because he or she wants to lose weight. And to do that, of course, he or she will need to change eating and exercise habits. Even the thought of eating less or different foods (or both) and exercise can be distressing and feel like 'work'. I think that hypnosis can make this process easier. So I try to keep the 'fun' and humour in hypnosis. I think that this can help make the changes, and the therapy needed to facilitate those changes, much more tolerable. If the treatment process is pleasant, and if the client feels he or she can assert more self-control, the whole process seems less burdensome—and it will therefore be more effective.

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Correspondence to Antonio Capafons, Facultat de Psicologia, Avda. Blasco Ibáñez 21, 46010 Valencia, Spain
Email: Antonio Capafons (antonio.capafons@uv.es)
Phone: +34 96 386 4393
Fax: +34 96 386 4669

Correspondence to Mark P. Jensen, Professor and Vice Chair, Department of Rehabilitation Medicine, Box 356490, University of Washington, Seattle, WA 98195-6490, USA
Email: Mark P. Jensen (mjensen@u.washington.edu)
Phone: +1 206 543 3185
Fax: +1 206 897 4881