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WILL THE FALSE MEMORY DEBATE INCREASE ACCEPTANCE OF THE SOCIOCOGNITIVE MODEL OF HYPNOSIS?

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Wagstaff (1998) proposes that we consider hypnosis not as a special altered state of consciousness but rather as a suggestion in itself – a suggestion that one is 'entering a special state or condition called hypnosis. Consequently anyone who accepts this suggestion will tend to enact the hypnotic role as they understand it. . . . Hypnosis is a term that refers to any instruction or procedures that either explicitly or implicitly conveys to the client/participant that he or she is about to enter, or has entered a special state or condition we call "hypnosis"' (p. 160).

Wagstaff's proposal is entirely consistent with the views of sociocognitive theorists (e.g. Barber, Sarbin, Spanos, Coe, Chaves, Kirsch and Lynn), who hold that hypnosis is a role-governed, expectancy driven, culturally and socially constructed phenomenon. Wagstaff's arguments are reasonable, and the data he marshals to buttress his claims are impressive. Although his definition could be faulted because it is unclear what criteria ought to be used to judge whether a person 'accepts the suggestion that he or she is or has been hypnotized', (p. 161) besides the traditional criteria used to assess hypnotizability, we are in general agreement with Wagstaff's interpretation of the empirical literature, and with the general thrust of his conceptualization of hypnosis. Hence, we would offer the reader little by enunciating minor quibbles with him.

Rather, our sense is that it would be more fruitful to use his paper as the springboard for addressing the following question and its implications: Is there any reason to believe that Wagstaff's ideas will be greeted with acceptance outside the confines of a relatively small group of like-minded, sociocognitively oriented workers in the field? We will speculate that developments on a number of social and political fronts, most notably the emerging false memory debate, imply that sociocognitive models of hypnosis, and by extension Wagstaff's proposals, will receive increasing attention in the future.

Before we opine about future trends, we examine some past developments relevant to the question we posed earlier. While Barber and his colleagues (Barber, 1969; Barber et al., 1974), and Sarbin and Coe (1972) were voicing considerable scepticism regarding traditional 'trance-based' conceptualizations of hypnosis in the 1960s and 1970s, and while the sociocognitive model was taking shape as a viable alternative to traditional ways of thinking about hypnosis, clinical hypnosis was entering a boom period. The surge of interest in Erickson's creative techniques, his description of hypnosis as a natural yet transcendent 'trance-like' state or condition, and the folklore that sprang up around Erickson as a remarkable man who overcame personal adversity and limitations, reinvigorated clinical hypnosis after a fallow period in which Freud's abandonment of hypnosis cast a pall over explorations into hypnotic phenomena and their clinical use. In short, Erickson reignited the historical fascination with hypnosis as a transcendent methodology – one with profound implications for therapeutic intervention.

The seemingly neat fit of hypnotic methods with the movement toward strategic and problem-focused interventions; the advent of the health psychology movement; and the rise in the use of hypnosis in the treatment of dissociative disorders and in the uncovering of past traumas, all propelled clinical hypnosis into the mainstream of clinical psychology. Also spurring the growth of hypnosis was the advent of organized and increasingly influential hypnosis societies and interest groups, which expanded the training and clinical repertoire of many individuals across a variety of professions (see Lynn and Rhue, 1991). As clinical hypnosis emerged as a specialty area within the broader domain of clincial psychology, the notion that hypnosis produces a 'trance' or an altered state of awareness became increasingly entrenched in the clinician's vernacular.

While these developments occurred, academic debates about issues such as whether hypnosis is a suggested state of affairs, a trait, or an altered state of consciousness were marginalized in the process. Technical academic debates did not speak to clinicians focused on the nitty-gritty of making a difference in people's lives.

Our impression is that many clinicians ignored, devalued, or regarded the following findings generated by sociocognitive researchers as part of a debunking enterprise: (a) that hypnosis does not increase suggestibility to any great degree, (b) that hypnotic responses do not reflect an increased tolerance for logical incongruity, (c) that indirect suggestions are no more effective than direct suggestions, (d) that 'literalism' of responding is not a marker of hypnotizability, (e) that there are no unique or reliable physiological markers of hypnosis, (f) that dissociation and hypnotizability are not highly correlated, (g) that hypnotizability is modifiable, (h) that most participants perceive hypnosis as a normal state of focused attention, (i) that so-called 'hidden observers' are suggested phenomena, and (j) that the experience of age-regressed persons does not mirror historical reality (see Kirsch and Lynn, 1998; Lynn and Rhue, 1991; Rhue et al., 1993).

Given the generally chilly reception that sociocognitive views have received, will eminently sensible proposals like Wagstaff's fare any better in the future? Will sociocognitive views meet with more widespread acceptance? We answer this question with a tentative 'Yes'.

It may not be an exaggeration to claim that clinical hypnosis is in a state of crisis in America. Based on conversations with leaders of the two major hypnosis societies, it appears that the membership in these societies has fallen precipitously, in the range of 33% to 45%, over the past five years or so. This dramatic change in the level of involvement in organized hypnosis is probably not entirely attributable to economic pressures on clinicians related to the arguably disastrous effects of managed care.

Rather, our sense is that there is a backlash against hypnosis because of the contentious false memory debate and the attendant threat of litigation against therapists. Relatedly, the use of hypnosis in the treatment of dissociative identity disorder, particularly for purposes of memory recovery, has fallen into disfavour in some circles. Although the literature supports the claim that hypnosis should not be used to recover historically accurate memories in psychotherapy (Lynn et al., 1997), there is no empirical justification to ban the clinical use of hypnosis altogether.

Perhaps the strongest advocacy group to emerge for the responsible use of hypnosis to recover memories is the American Society of Clinical Hypnosis. This group has recently published a set of guidelines for 'clinical hypnosis and memory' that, somewhat ironically, endorses sociocognitive variables as influential determinants of hypnotic in its defence of the use of hypnosis for purposes of memory recovery

(Hammond et al., 1995): none of the long list of authors of this document – Hammond, Garver, Mutter, Crasilneck, Frischholz, Gravitz, Hibler, Olsen, Scheflin, H. Spiegel and Wester – has ever, to our knowledge, heretofore emphasized the relevance of sociocognitive variables to the production of any hypnotic response. Nevertheless, the document consistently refers to expectancies and argues that 'memories may be contaminated and pseudomememories created as a result of uncontrolled social psychological variables and situational demands . . .' (p. 17). The publication further contends that 'Hypnosis itself does not appear to be a significant biasing factor in the creation of pseudomemories' (p. 18) and claims that there is nothing special about hypnosis in that 'the contaminating effects on memory are no more likely to occur from the use of hypnosis than from many nonhypnotic interviewing and interrogative procedures' (p. 22).

Although the ASCH publication arguably scapegoats sociocognitive variables in the creation of hypnotic pseudomemories, it seems but a small step to extend the ASCH guidelines' acknowledgement of the import of social influence and demands to other clinical contexts and hypnotic phenomena. And it is but another small step to credit sociocognitive variables (e.g. expectancies, attitudes and beliefs) with some of the salutary effects of clinical hypnosis.

Of course, it is also important to keep in mind that the ASCH guidelines are far from standing in wholesale agreement with sociocognitive precepts. For instance, they maintain that 'highly hypnotizable individuals are believed to enter trance states spontaneously, without a formal induction . . .' (p. 45). The failure to operationalize trance states and to specify their antecedents and concomitants is entirely antagonistic to sociocognitive models and can wreak havoc in courtrooms where it is necessary to determine whether a subject was 'hypnotized' or not (e.g. when techniques such as guided imagery and relaxation are used).

Wagstaff's proposal that the hypnotic context be defined by the suggestion that one is entering a special state or condition called hypnosis will help the courts to make appropriate decisions about when a situation is 'hypnotic' and when it cannot be so construed. In short, we envision the possibility that the sociocognitive model will become increasingly palatable to clinicians who are faced with defending their use of hypnosis and who feel increasing pressure from managed health care to become knowledgeable about the science as well as the practice of hypnosis.

If clinicians become more avid consumers of the empirical literature, they will encounter substantial documentation for the value of hypnotic interventions. The meta-analysis by Kirsch et al. (1994) concluded that merely labelling cognitive-behavioural procedures as 'hypnotic' had an adventitious effect on clinical outcome. This finding implies that Wagstaff is correct that the mere act of defining procedures as 'hypnotic' affects behaviour. However, Kirsch's analysis and other positive outcome data also imply that clinicians may be drawn increasingly to hypnosis not so much because of the compelling nature of hypnotic phenomena but because of the documented efficacy of procedures that are perceived as 'hypnotic'.

If sociocognitive models are ever to gain the respect they deserve, it is incumbent on workers in the area to do more than critique competing theories of hypnosis. They must also spell out the relevance of sociocognitive models and research to clinical practice and continue to conduct clinically meaningful research. Yet even if these steps are pursued with vigour, it may well be the case that the acceptance of Wagstaff's definition of hypnosis, and sociocognitive models in general, will hinge on social and political factors that lie outside the arena of scientific discourse.

References

Barber TX. Hypnosis: A Scientific Approach. New York: Van Nostrand Reinhold, 1969.
Barber TX, Spanos NP, Chaves JF. Hypnosis, Imagination and Human Potentialities. Elmsford NY: Pergamon Press, 1974.
Hammond DC, Garver RB, Mutter CB, Crasilneck HB, Firschholz E, Gravitz MA, Hibler NS, Olson J, Scheflin A, Spiegel H, Wester W. Clinical Hypnosis and Memory: Guidelines for Clinicians and for Forensic Hypnosis. American Society of Clinical Hypnosis Press, 1995.
Kirsch I, Lynn SJ. Dissociation theories of hypnosis. Psychological Bulletin 1998; 123: 100–115.
Kirsch I, Montgomery G, Sapirstein G. Hypnosis as an adjunct to cognitive behavioral psychotherapy: A meta-analysis. Journal of Consulting and Clinical Psychology 1995; 63: 214–220.
Lynn SJ, Lock T, Myers B, Payne D. Recalling the unrecallable: Should hypnosis be used for memory recovery in psychotherapy? Current Directions in Psychological Science 1997; 6: 79–83.
Lynn SJ, Rhue J, eds. Theories of Hypnosis: Current Models and Perspectives. New York: Guilford Press, 1991.
Rhue J, Lynn SJ, Kirsch I, eds. Handbook of Clinical Hypnosis, Washington, DC: American Psychological Association, 1993.
Sarbin TR, Coe WC. Hypnosis: A Social Psychological Analysis of Influence Communication. New York: Holt Rinehart & Winston, 1972.

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