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Dr. Milling's work is a "must have" for practitioners looking to both better understand the underpinnings of hypnosis and to use hypnotic interventions with their clients. He has assembled a stellar team of leaders in the field who relay complex material in a way that allows readers to bring the science and efficacy of hypnosis to their patients. Bravo!

—Guy H. Montgomery, PhD, Past President, Society of Psychological Hypnosis (Division 30) of the American Psychological Association

This book includes some of the world's most authoritative authors providing clear, articulate support and instruction for the evidence-based use of clinical hypnosis. This should be on the bookshelf of students and experienced practitioners alike. Simply excellent!

—Eric K. Willmarth, PhD, Chair, Department of Applied Psychophysiology, College of Integrative Medicine and Health Sciences, Saybrook University, Pasadena, CA, United States; Past-President, American Society of Clinical Hypnosis, Society for Clinical and Experimental Hypnosis, and American Psychological Association Division 30: Society of Psychological Hypnosis

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1 AN INTRODUCTION TO THE PRACTICE OF CLINICAL HYPNOSIS

STEVEN JAY LYNN AND JOSEPH P. GREEN

We have devoted much of our careers to the study and clinical practice of hypnosis, not because hypnosis is an arcane or exotic method practiced by those with special powers of influence, or because we witnessed demonstrations of mind-boggling alterations of consciousness as dramatized in the media, or because we sought "quick fixes" in assisting our clients in embracing more fulfilling lives. Rather, the reason for our ongoing fascination with hypnosis is that it has opened doors for us in grappling with the mysteries of consciousness, the power of words in transforming our patients' lives, and how we could leverage a cost-effective, efficient method to harness their personal resources. More specifically, we have found hypnosis to be an efficacious means of modifying thoughts, feelings, and behaviors via suggestions; a vehicle to shift people's expectancies and models of themselves and the world; a method to evoke novel possibilities of thinking, feeling, doing, and circumventing ingrained and maladaptive habits; and a path to investigating the pliability of consciousness and a variety of psychological phenomena in the laboratory.

Hypnosis has come a long way since it inspired our curiosity many years ago. Today, hypnosis has carved out well-earned territory in the landscape of psychological science and clinical practice. Researchers probe intriguing

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hypnotic phenomena in laboratories across the world and share their findings with a wide audience via the most competitive and respected journals. These publications showcase contributions providing ample empirical rationales for practitioners to bring hypnosis into the purview of their interventions.

This volume underscores both how easy-to-implement hypnotic techniques can supplement science-based clinical interventions and how clinicians can use hypnosis with the assurance that it boasts a strong empirical foundation to guide their practice. We write this chapter in the hope that we will engage readers in new adventures in researching or threading hypnosis into their clinical endeavors, and that it will reinvigorate and inform researchers and practitioners already familiar with hypnosis.

ON THE NATURE OF HYPNOSIS

The following section of the chapter presents an overview of the definition of hypnosis and major theories of hypnotic responding.

Defining Hypnosis

Hypnosis falls within a broader domain of phenomena related to suggestion and suggestibility that encompasses waking imaginative suggestions, responses to cues and suggestions in forensic contexts, and placebo effects (Halligan & Oakley, 2014; Hilgard, 1973; Kihlstrom, 2008). Yet hypnosis occupies a unique niche within this broad conceptual space due to sociocultural views of hypnosis, the context in which it unfolds, and the procedures used to elicit hypnotic phenomena.

Comparisons between hypnosis and mindfulness and relaxation are not uncommon. Although it is accurate to say that relaxation and mindfulness can be achieved or guided via suggestion, hypnosis cannot be reduced to either. For example, people respond to hypnotic suggestions while wide awake and exercising on a stationary bicycle in which they experience a physiologically aroused rather than a relaxed state (see Bányai, 2018). Unlike hypnosis, mindfulness practice calls for observing the flow of consciousness with an accepting, nonjudgmental attitude. Not surprisingly, mindfulness practitioners display superior metacognition (Lush et al., 2016), whereas the opposite generally holds for highly suggestible individuals (Dienes et al., 2016). Still, mindfulness and hypnotic suggestions can be combined in clinical interventions (see Green & Lynn, 2019; Lynn et al., 2016; Raz & Lifshitz, 2016).

This idea that clinical hypnosis is tightly bound to the expectational and situational context in which it is practiced aligns most closely with the definition

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of hypnosis advanced decades ago by the Hypnosis Division (30) of the American Psychological Association (Kirsch, 1994b; based on Kihlstrom, 1985). This definition construes hypnosis as a process or procedure in which suggestions for imaginative experiences are provided for alterations in sensations, perceptions, thoughts, memories, or behaviors. In this light, what transpires during hypnosis depends very much on how the situation in which suggestions are embedded is presented to the participant (i.e., as hypnosis) and/or how people interpret the context (i.e., as "hypnotic").

Indeed, many hypnotic proceedings can be described in terms of multiple overlapping and often continuous elements that establish the context as clinical hypnosis. More specifically, prior to hypnosis, the hypnotist, in what we will refer to as prehypnotic communications, will set the stage for hypnosis by explicitly presenting the context as hypnosis and inculcate positive expectancies. A hypnotic induction follows, which is comprised of suggestions that further demarcate the context as hypnosis and precede specific suggestions for research or therapeutic purposes. In clinical situations, these suggestions are often developed in concert with the participant. Where the induction and suggestions begin and end is often a "strained, arbitrary, and artificial distinction" (Lynn et al., 2017, p. 371). It is the incredible diversity of creative suggestions utilized to alter subjective experiences in innumerable, targeted, and highly individualized ways that often lends appeal to hypnosis for clinicians and patients alike. Finally, hypnosis is terminated and a discussion of the experience ensues. In clinical hypnosis, these phases often merge seamlessly into a smooth conversational stream, and suggestions can be delivered formally (e.g., scripted) or interspersed more informally, with eyes open or closed.

The APA definition of hypnosis (Kirsch, 1994b), which emphasizes contextual and procedural aspects of hypnosis, (a) implies tremendous latitude in suggestions that come under the umbrella of hypnosis, (b) delineates a semblance of boundaries between what is "hypnotic" and what is "not hypnotic," (c) does not depend on the instantiation of a "trance" or special state of consciousness, and (d) facilitates scientific investigations insofar as empirical comparisons can be drawn across conditions that are "hypnotic" or "nonhypnotic." This definition of hypnosis is also conducive to studies using standardized scales that assess individual differences in hypnotic responding—variously referred to as hypnotic responsiveness, hypnotic susceptibility, hypnotizability, and hypnotic suggestibility—in contexts that are unambiguously defined as hypnotic. If the situation is neither defined nor perceived as such, then questions can arise concerning whether established test norms apply (and interpretation is possible) when valid and reliable scales of hypnotic responsiveness are used for clinical or research purposes.

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A decade after the first definition was promulgated, the Executive Committee of the APA Division of Psychological Hypnosis (Green, Barabasz, et al., 2005) revised the definition to acknowledge that the "hypnotic induction is an extended initial suggestion for using one's imagination, and may contain further elaborations of the introduction" (p. 262). This aspect of the definition coincides with the fact that in clinical hypnosis there is often no sharp dividing line between the induction and the suggestions that follow.

The definition also took note of the widely used clinical technique of self-hypnosis, described as "the act of administering hypnotic procedures on one's own" (Green, Barabasz, et al., 2005, p. 262). Self-hypnosis, which we consider in greater detail later, can be a viable means of generalizing and maximizing treatment gains apart from the one-on-one hypnosis context and attune participants to their ongoing flow of spontaneous thoughts to steer them in a more positive, adaptive, and goal-directed manner. Self-hypnosis is also a means to illustrate how different psychological conditions can be the product of negative self-suggestions (e.g., I am a failure; I am helpless), which can be countered with self-suggestions.

The revised definition also noted that responsiveness to suggestion can be assessed with standardized scales, that scores can be aggregated into low, medium, and high categories, and that "the salience of evidence for having achieved hypnosis increases with the individual's score" (Green, Barabasz, et al., 2005, p. 263). Using such scales, researchers have determined that approximately 10% to 15% of participants exhibit low hypnotic suggestibility and respond to no or to only a few suggestions, 60% to 80% display moderate (medium) responsiveness, and 10% to 15% exhibit high hypnotic suggestibility and respond to the majority of the suggestions including those for hallucinations or amnesia that involve cognitive and perceptual alterations in consciousness (Terhune et al., 2017).

Most recently, yet another APA task force defined hypnosis as a "state of consciousness involving focused attention and reduced peripheral awareness characterized by an enhanced capacity for response to suggestion" (Elkins et al., 2015, p. 382). Across definitions of hypnosis, there is a strand of agreement that suggestions can alter the spontaneous and situationally activated flow of thoughts, feelings, action tendencies, and behaviors of individuals in situations that are typically defined as hypnosis by an external agent (e.g., clinician, researcher) or construed to be "hypnosis" by the participant.

Theories of Hypnosis

We next turn to major theories of hypnosis that capture important facets of hypnosis germane to clinical practice beyond the definition of hypnosis.

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Psychodynamic Approaches

After Freud rejected hypnosis as a reliable treatment modality, hypnosis receded into the background as a therapeutic intervention until Erika Fromm (Fromm & Nash, 1997), Elgan Baker (1981), and Michael Nash (1997) revived interest in psychodynamic accounts. Psychodynamic theorists have called attention to a strong affective bond that can arise between the hypnotist and participant in a relationship in which fantasy, imagination, primary process mentation, and adaptive regression are important mediators of hypnotic responses and can be leveraged to facilitate emotion regulation and enhanced ego functioning for therapeutic purposes (Fromm & Nash, 1997). Psychodynamic approaches have not been systematically studied in controlled trials in which hypnosis is an adjunct to psychotherapy.

Neodissociation and Cold Control Theory

Dissociation theories of hypnosis address the nonvolitional quality of many hypnotic responses. In 1977, Hilgard argued that suggestion-related automaticity associated with hypnosis was produced by a dissociation of executive monitoring of actions from subsystems of control operational in everyday life (Hilgard, 1977). Hilgard's contentions were inspired by his discovery of the "hidden observer" phenomenon in which he argued the hypnotist uses suggestion to directly access a dissociated/observing aspect of the personality that can objectively report on pain, for example, while not experiencing suffering. Hilgard posited that during hypnosis an amnesic barrier segregates subsystems of control from executive functions. Accordingly, participants experience diminished behavioral control and respond automatically to suggested events. Hilgard's interpretation of the hidden observer stirred substantial controversy, as studies revealed that the nature of the hidden observer (e.g., reporting more vs. less pain) depended on the suggestions or cues inherent in the communications that elicited the seeming personality dissociation (see Green, Page, et al., 2005; Kirsch & Lynn, 1998). Regardless of the explanation for the hidden observer, the phenomenon highlights the ability of suggestion to facilitate a different and potentially more therapeutic perspective on one's experiences and actions (see Lynn et al., 1994).

Another version of dissociation theory—dissociative control theory (see Woody & Sadler, 2008) rejects the existence of the amnesic barrier that Hilgard proposed. Rather, hypnotic suggestions are argued to bypass higher-level executive voluntary control and access lower, more autonomous or involuntary levels of control. According to this view, this state of affairs creates the opportunity for the hypnotist to directly activate behaviors via suggestion that are consistent with therapeutic goals and to instantiate more adaptive coping responses.

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Evidence indicates that much behavior in hypnotic and nonhypnotic contexts is executed on an automatic basis with little or no conscious control (see Kirsch & Lynn, 1998), that hypnosis is associated with a disruption of executive monitoring or metacognition, and that hypnosis may further automatize mental processes and behaviors (see Dienes & Perner, 2007; Lynn & Green, 2011; Kirsch & Lynn, 1999; Terhune et al., 2017). Because suggestions are conveyed in the context of hypnosis, participants are likely to attribute the involuntary "feel" of suggestions to the hypnotist or to the influence of hypnosis more globally (Dienes & Perner, 2007; Kirsch & Lynn, 1999; Martin & Pacherie, 2019).

While not explicitly a dissociation theory, but more rightly labeled a cognitive theory, *cold control theory* (Barnier et al., 2008; Dienes & Hutton, 2013; Dienes & Perner, 2007) argues that normal executive control during hypnosis is not compromised, but a lack of access to higher order thoughts (metacognitive states regarding one's mental representations) related to intentions degrades the everyday sense of agency. This view is consistent with testable claims that hypnotic responsiveness may be enhanced when monitoring and planning executive functions are decoupled from executive control (Jamieson & Sheehan, 2004; Lynn & Green, 2011). Research supports an important role for degraded metacognition in highly suggestible individuals, although the variables (e.g., eye closure, relaxation, focus on bodily sensations, expectancies, attributions of control to the hypnotist) linked with this finding have yet to be researched systematically (see Terhune et al., 2017).

There exists scant disagreement among theorists that highly suggestible individuals often experience hypnotic suggestions as "involuntary happenings." Yet involuntariness reports vary as a function of whether participants expect or are instructed that they will experience hypnotic responses as involuntary (Lynn et al., 1984), which is facilitated by the fact that hypnotic responses are often experienced as partly voluntary and partly involuntary, and many actions in both hypnotic and nonhypnotic situations are not deliberated prior to their execution (Kirsch & Lynn, 1999).

The Sociocognitve Model

The idea that expectancies modulate or mediate the subjective experience of hypnosis and corresponding behaviors is a cornerstone of the sociocognitive perspective. The *sociocognitive model* (SCM) is an open, evidence-based model that seeks to identify social and cognitive variables that stand in a functional relation with hypnotic responsiveness. This perspective locates hypnosis within a wide network of interacting variables that encompass beliefs, attitudes, expectancies, motivation, and ability to experience nonhypnotic imaginative suggestions. The SCM is also known as the cognitive

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behavioral model of hypnosis and is compatible with cognitive-behavioral psychotherapies that prioritize the influence of expectancies, cognitions, beliefs, and imaginings on behaviors and emotions. Kirsch, Montgomery et al.'s (1995) now classic meta-analysis revealed that the average client receiving cognitive-behavioral hypnotherapy exhibited greater improvement than at least 70% of clients receiving nonhypnotic cognitive-behavioral treatment.

The perspective has its roots in the early writings of Theodore Sarbin and T. X. Barber and their students William C. Coe, and Nicholas Spanos and John Chaves, respectively, and the later work of Irving Kirsch, Steven Jay Lynn, and Graham Wagstaff. These theorists vociferously challenged the existence of a special hypnotic state or trance and instead featured participants' often unconscious enactment of the social role of a hypnotized subject, "believed in imaginings," and the strategic, goal-directed nature of hypnotic responding (Coe & Sarbin, 1991; Lynn et al., 2008; Sarbin & Coe, 1972; Spanos, 1991; Wagstaff. 1991). The SCM has also highlighted the important role of imaginative suggestions, which can elicit profound changes in behavior and experience regardless of whether they are presented in a hypnotic or nonhypnotic context.

The SCM views hypnosis as a form of top-down regulation in which mental representations, including expectations, attitudes, and beliefs about hypnosis, cascade downstream to override or modulate perception, physiology, and behavior (see Terhune et al., 2017; see also Kirsch & Lynn 1998; Lynn et al., 1991; Spanos, 1986). Because hypnosis is widely viewed as a potent means of altering consciousness, in a therapeutic situation, positive expectancies can potentially enhance treatment outcomes. In fact, Kirsch has argued that hypnosis acts as a nondeceptive placebo, bolstering positive response expectancies that have a self-confirming nature (Kirsch, 1994a, response set theory; see also Kirsch & Lynn,1999).

According to *response set theory* (Kirsch & Lynn, 1998, 1999), much of what occurs during hypnosis is perceived as automatic, because actions, planned or unplanned, are viewed as initiated automatically at the time of activation by response sets (expectations and intentions). Hypnosis primes people to view the hypnotist or hypnosis as the source of their nonvolitional responses because of dominant cultural views that hypnotic responses are not self-initiated.

The SCM finds support in research showing that (a) expectancies, attitudes, beliefs, motivation, goal-directed fantasies and imaginings, and responsiveness to waking imaginative suggestions account for significant variability in hypnotic suggestibility (Barber, 1969; Barber et al., 1974; Lynn et al., 2010; Spanos, 1986, 1991) and that (b) hypnotic suggestibility can be substantially increased via social learning training programs (Gorassini & Spanos, 1986)

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that modify these mediating variables (e.g., enhance positive attitudes and expectancies, increase motivation and suggestion-directed imagining). Gfeller and Gorassini (2010) described how elements of such training programs can be exported to hypnotherapies to optimize treatment gains.

Phenomenological/Interactive Theories

Clinicians often use hypnosis to alter consciousness in meaningful and significant respects. Martin Orne (1959) was one of the first modern theorists to underscore the importance of subjective experiences and subtle as well as dramatic changes in cognitions and affects in hypnotic contexts in which individuals are especially sensitive to social and suggested cues and experimental demands (i.e., demand characteristics). More recently, researchers have documented profound changes in the experience of agency and perceptions of the self in responses to suggestions ranging from audio and visual hallucinations and to convincing out-of-body experiences, feelings of paralysis, and even delusions of a sex change (Connors et al., 2012; Noble & McConkey, 1995; Polito et al., 2014). These sorts of suggestions are experienced most compellingly on the part of highly suggestible individuals.

Phenomenological/interactive theories (like sociocognitive perspectives), view hypnotic responses as the by-product of multiple interacting variables (e.g., person, situation, rapport; McConkey, 1991; Nadon et al., 1987; Sheehan, 1991). However, in contrast with the SCM, they focus more on (a) differences between hypnotic and nonhypnotic waking behavior and the particular cognitive commitment people display to respond to suggestions in hypnotic situations (Sheehan, 1991) and (b) the meaning that participants ascribe to the hypnotist's communications that can activate highly diverse and idiosyncratic responses both within and across hypnotic sessions (McConkey, 1991; Sheehan & McConkey, 1982). Clinicians often encounter highly "individual" responses that are seemingly unrelated to the literal content of suggestions delivered, but nevertheless are emotionally salient, personally meaningful, and potentially worthy of exploration.

Ericksonian Hypnosis

Milton H. Erickson is widely regarded as the progenitor of modern clinical hypnosis. Erickson (Erickson et al., 1976; Haley, 1985) pioneered ingenious brief and strategic hypnotic approaches that used paradox, metaphors, analogies, indirect and permissive suggestions, and teaching stories to advantage. He appreciated the importance of creating positive expectancies for change and the automatic nature of thoughts and behaviors, antedating contemporary discussions of automaticity in hypnosis and everyday life. However, he is best known for his *utilization approach* that anticipated

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contemporary acceptance-based third wave approaches in championing radical acceptance of his patients and utilizing their innate resources and talents to foment change.

Rather than viewing hypnosis as a dissociative process, Erickson understood hypnosis as quite the opposite: an associative process that capitalized on shifting spontaneous and suggestion-related associations toward the realization of personal goals. As Erickson et al. (1976) wrote, "[M]ost people do not know that most mental processes are autonomous. . . . Hypnotic suggestions come into play when the therapist's directives have a significant effect on facilitating the expression of that flow in one direction or another" (p. 58).

Many of Erickson's creative stratagems and methods continue to be popular among clinicians and are promulgated in the recent writings of Stephen and Carol Lankton (2015), Michael Yapko (2018), and Jeffrey Zeig (2014). These authors have advocated effectively for tapping participants' acknowledged and unrecognized or underutilized personal resources, strengths, and motivations.

Ericksonian hypnotherapy (the addition of Ericksonian methods to psychotherapy) has not been investigated in controlled trials. However, many of his innovative techniques (e.g., paradoxical interventions, reframing) are grounded in principles of cognitive and behavioral change supported by research in social, clinical, and cognitive psychology (Lynn & Hallquist, 2004; Lynn & Sherman, 2000).

Psychophysiological Approaches

Elucidating the psychophysiological moderators and mediators of suggestions in hypnotic and nonhypnotic contexts promises to yield important insights across competing theoretical perspectives. Hypnotic responses, like all complex human behaviors and experiences that call for the deployment of attention and personal resources, will be reflected in cognitive, affective, and social domains and ultimately in the physiology of the participant. For the past three decades, researchers have been hot on the trail of the correlates and antecedents of hypnotic responsiveness. Evidence to date supports the idea that hypnosis and individual differences in responsiveness are associated with top-down regulation of lower brain structures and anterior cingulate, prefrontal, and parietal cortices (see Terhune et al., 2017).

Nevertheless, the ability to identify a unique psychophysiological state and the roles of different brain mechanisms reliably associated with hypnosis has so far proven elusive. This is probably the case because the subjective experience of hypnosis, including the experience of involuntariness and the reported "depth" of hypnosis, often vary substantially within a hypnotic session

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(Cardeña, 2005; Cardeña et al., 2013) and in response to some suggestions but not others (Terhune et al., 2017). Even highly responsive people pass some suggestions but not others and different suggestions access different abilities, implying that multiple suggestion-related abilities underlie hypnotic responsiveness (Barnier et al., 2008; Woody et al., 2005). These different abilities likely reflect different neural correlates or antecedents of hypnotic responsivity. Thus, participants can be informed that even some highly responsive individuals discover that their experiences vary over the course of the session in interesting ways and that after the hypnosis they will have an opportunity to share what seemed to work best.

Psychophysiological research has borne fruit in an important respect: Studies have documented that hypnotic phenomena are "genuine" in that the effects of suggestions, such as a visual hallucination, for example (e.g., hallucinating an object), can be indexed by corresponding changes in physiology (e.g., visual cortex) among highly hypnotizable participants (Kosslyn et al., 2000; Szechtman et al., 1998). We have found it useful to share these sorts of findings with participants, which lend credibility to hypnosis as a means to effect change on multiple personal levels.

CONSIDERING INDIVIDUAL DIFFERENCES: DETERMINANTS OF HYPNOTIC RESPONSIVENESS

In the chapters that follow, readers will appreciate that hypnosis can be a potent instrument in affecting personal change. A burgeoning literature based on qualitative and meta-analytic findings documents the promise of hypnosis in treating medical and psychological conditions as diverse as irritable bowel syndrome, depression, and anxiety (see Terhune et al., 2017).

Yet individuals vary in their responses to hypnotic interventions. A keen awareness of potential individual differences in hypnotic responsiveness (e.g., alternative terms: hypnotic suggestibility, hypnotizability, hypnotic susceptibility) is prerequisite to optimizing the participants' experience of hypnosis. In fact, individual differences are the rule rather than the exception in hypnotic situations. Clinicians can benefit greatly from knowledge of the determinants of hypnotic responsiveness. Lynn et al. (2019) recently presented evidence pertaining to individual differences that we summarize here.

People who respond highly to hypnotic suggestions are likely to:

1. Expect they will respond to suggestions, be motivated to respond, and have the ability to respond to nonhypnotic as well as hypnotic imaginative suggestions. Expectancies consistently predict hypnotic responsiveness. Kirsch,

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Silva et al. (1995) reported that response expectancy was the strongest predictor of hypnotic responsiveness among a pool of potential predictors including absorption, fantasy proneness, and personal motivation. Braffman and Kirsch (1999) found that the combination of expectancy, motivation, and nonhypnotic imaginative suggestibility accounted for slightly more than half the variance (i.e., 53%) in hypnotic responsiveness. Practitioners should keep in mind that while expectancies affect hypnotic suggestibility, responsiveness to suggestions in turn affect expectancies on a reciprocal and ongoing basis (Benham et al., 2006).

2. Become absorbed in suggestions, allocate attentional resources, and actively deploy imaginings to reify suggestion-related experiences that, in turn, bolster response expectancies (Kirsch & Lynn, 1999; Lynn, 1997).

3. Accurately interpret the intent of suggestions with minimal critique of their responses, interfering thoughts, and metacognitive awareness, and evidence a low threshold of response to hypnotic suggestions (Dienes & Perner, 2007; Lynn et al., 1991; Terhune et al., 2017).

4. Adopt "liberal" performance standards; that is, not so stringent or unattainable (e.g., believe a suggested hallucination must be perceived as lifelike in all respects; Lynn et al., 2003) as to dampen positive response expectancies and their belief that they "passed" a suggestion.

5. Experience rapport with the hypnotist (Gfeller et al., 1987; Lynn et al., 1991).

6. Score relatively high on measures of absorption, fantasy-proneness, dissociation, and positive attitudes about hypnosis. The correlations between such measures and hypnotic responsiveness are generally small-to-moderate and can be inflated artificially when measures are administered in the same test context. Although moderate levels of fantasy proneness, absorption, and imagery vividness contribute to the prediction of hypnotic responsiveness, very low levels of imaginative propensity are almost always associated with low responsivity (de Groh, 1989; Spanos, 1991), and strong negative attitudes about hypnosis suppress hypnotic responsiveness (Spanos et al., 1987).

THE PRACTICE OF CLINICAL HYPNOSIS

Clearly, a broad base of empirical knowledge is available to inform clinicians, beginning with the hypnotist sharing information prior to initiating hypnosis, to which we turn next.

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Prehypnotic Information

Often prehypnotic information will flow directly into an induction, although it may be presented at any point in the contact with a participant and affect hypnotic responsiveness ranging from a small to a relatively large extent.

To set the stage for the proceedings, the practitioner typically will have (a) secured information about the participant's past experiences with hypnosis, if any; discussed the purpose and goals of the session; and solicited and/or reviewed potential suggestions with the participant; (b) attempted to instill positive attitudes, beliefs, and expectancies about hypnosis; (c) ascertained participant expectancies and knowledge about hypnosis and corrected myths and misconceptions; and (d) responded to questions. Mistaken beliefs include that people cannot resist or oppose suggestions, that they relinquish their willpower to the hypnotist, respond like an automaton, develop amnesia for what occurs and lose touch with their surroundings, not "come out of" hypnosis, and are gullible or of low intelligence (see Green et al., 2006; Lynn et al., 2010). Another myth of concern is that hypnosis increases the accuracy of memories. In fact, hypnosis is not a reliable method for improving memory and should not be used to retrieve relatively recent memories or excavate childhood memories, as hypnosis increases the risk of false memories and unwarranted confidence in memories independent of their veracity (Lynn et al., 2015).

The hypnotist would do well to actively encourage absorption and imaginal involvement in suggestions, enlist the cooperation of participants, and strive to cultivate a positive rapport. In engaging in these activities, clinicians will encourage a motivated cognitive commitment or preparedness to respond to suggestions that reflects response sets associated with highly suggestible individuals (e.g., Sheehan, 1991; Sheehan & McConkey, 1982; Tellegen, 1981).

Hypnosis Protocols: Are There Differences in Hypnotic Inductions?

Hypnotic inductions take many forms. Nevertheless, few if any differences in participant responsiveness exist across hypnotic inductions that vary in their length, whether suggestions are ordered from easy to difficult or vice versa; whether they are worded in permissive versus authoritative terms; or whether they call for relaxation or an alert–awake state of mind (Lynn et al., 2017; Terhune & Cardeña, 2016). Still, individuals we have treated have generally responded very favorably to the sorts of suggestions contained in the sample induction below.

The following example of a generic hypnotic induction via suggestions for eye fixation and closure combines multiple elements of calmness,

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feeling at ease, relaxation and attention to sensations and breathing, enhanced receptivity and ability to access personal resources, self-compassion and acceptance, and deepening of hypnotic experiences. These sorts of suggestions pave the way for treatment of a variety of conditions and for more tailored suggestions that follow the induction. The sample induction also includes reference to self-hypnosis, which is a useful method in itself and as a post-hypnotic method to enhance and maintain treatment gains. Readers will note that the suggestions in the sample induction are generally very permissive and neither authoritative (e.g., You *will* experience ___) nor particularly directive. Rather, they imply considerable latitude in responding in order to fulfill the task demands of the suggestions.

A Sample Hypnotic Induction Protocol

"Let's begin by you looking at the spot where the wall and ceiling meet. Just find that corner spot and stare at it for a little while. A spot of your choosing, actually any spot will do . . . as we begin hypnosis together, working together to help you discover all that you can learn in your hypnosis, what you can achieve . . . just continue looking at your spot.

Now, as you do so, it would be perfectly natural after a while for your eyelids to begin to become a bit heavy and tired from staring, and especially so as you pay attention to this happening, noticing it, directing your attention to the natural heaviness. Perhaps this sense of heaviness begins to be accompanied by a welcome release of tension you might have accumulated during the day as your body gets more comfortable and as you begin to unwind and relax and release as you notice the tiredness of your eyes . . . and the more you experience this heaviness . . . and as you discover just how heavy and tired you feel your eyes become . . . they can close easily and comfortably. In doing this, you can discover how bringing your attention to what I'm saying will help you to experience what is suggested.

But you don't need to focus on that right now. There's lots of time to go deeper into your experience . . . just the right level of hypnosis that is comfortable for you. Comfortable and at ease. Nothing to bother, nothing to disturb. As you listen to my voice and feel more calm, at ease, peaceful, perhaps even in synch with your breathing, perhaps you can also appreciate the value of taking a deep breath, a deep breath . . . how releasing it would be to let go of some of the tension accumulated in the natural course of daily life. Try it now, take a deep breath in. And let it go. Again, deep breath in . . . and out.

As you now pay some attention to your breathing—you may notice many sensations associated with your breathing. You may notice how

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your shoulders rise . . . and fall with each breath that you take. Or, how your chest expands . . . and then relaxes with each breath. Breathe in what you need. And, breathe out what you don't. Your body knows what to do . . . here and now . . . just being in the moment, breathing with ease, enjoying the comfort of just being in the moment with nothing to bother, nothing to disturb as you go deeper into hypnosis . . . exactly to the extent that's right for you. And you don't even have to think about it. Nothing more, nothing less, calm and at ease, perhaps noticing how some of the heaviness or maybe another feeling . . . perhaps warmth . . . is making its way through your body, easy, easy going . . . just let it happen if you wish. Or just maybe it's a cool sensation of comfort and calm . . . and, you know, some people even experience a certain lightness of being as they release and relax. As you go deeper, just as deep as you would like to go, you may discover that you feel more receptive, open, letting your experiences happen easy and effortlessly, while in the background of your awareness all the while knowing it's you who shape your experiences as you listen to the sound of my voice.

After all, hypnosis is really self-hypnosis; it is you who has the experience of calm and ease . . . you who thinks and imagines along with what I suggest . . . you who experiences suggestions . . . you who owns and can embrace your experiences . . . and it is you who after our time today can continue to experience suggestions . . . suited to you . . . to set your mind and intentions and plans to best achieve your goals.

IF EYES HAVE NOT CLOSED:

As you continue to go deeper and deeper into your hypnosis, into an open and receptive state of mind, just continue to hear my voice and think about what I share with you. You've done well to concentrate on the spot on the wall and listen to the sound of my voice going with you, but there is no need to stare at that spot any longer. Just let your eyes comfortably close. Please close your eyes now.

AFTER EYES HAVE CLOSED:

While you focused on your breathing and observed your body getting acquainted with what hypnosis is like for you, you closed your eyes, allowing for an internal focus and the presence of being to explore a bit what it would be like to be even more absorbed in your thoughts, feelings, and experiences . . . receptive . . . and focused on what I suggest as you draw upon a lifetime of learnings . . . joining in with the idea, images, and experiences that unfold, to encounter new possibilities of becoming . . . of being present . . . to develop compassion for yourself, empathy for yourself, loving-kindness toward yourself . . . opening yourself up to the excitement of self-discovery . . . open to new possibilities for creating the person you

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are capable of being . . . becoming . . . as you go just as deep as you wish . . . as you continue to hear my voice that will go with you . . . and you think about, imagine, and experience suggestions (for: insert purpose of suggestions) in your own unique way . . . with an openness to what is most helpful and what you need (insert goal or experience).

Now let's see; what if you were to go even deeper, enjoying the experience of thoughts, feelings, images, and intentions all coming together, merging in new or creative ways to achieve your goals? Yet bringing your lifetime of experiences with you . . . as you explore the depth of awareness and understanding needed to get in touch with your resources at a level you might not fully comprehend consciously . . . but these resources are gifts for yourself . . . to yourself . . . to be accessed during our hypnosis today and afterward with self-hypnotic techniques. I will share these with you. Wouldn't that be nice?"

Deepening the Experience of Hypnosis

Throughout the hypnotic induction and interspersed among suggestions, it is common for the hypnotist, as in the sample induction, to suggest that the client experience deeper, perhaps more intense, salient, or expansive feelings of relaxation, being at ease, or other suggested or desired states as stipulated by the participant in advance or developed "on the spot" at the judgment of the hypnotist. Such deepening suggestions can encourage refocusing or intensifying efforts to more fully experience any desired therapeutic state or suggested event (see Lynn et al., 2010). Deepening suggestions may also assist participants in experiencing suggestion-related phenomena that they might have previously struggled with or not fully achieved (Lynn & Kirsch, 2006).

Deepening suggestions may be accompanied by counts (e.g., ". . . with each count you will feel yourself going deeper and deeper into hypnosis . . . 1 . . . deeper, 2 deeper and deeper . . . 3 . . ."), such as counting breaths, simply "going deeper" with each count; waves breaking on the shore; steps toward a special place with properties of enhanced experience specified (e.g., relaxation, wisdom, insight, access to resources), and so forth. Yet another induction with deepening suggestions pivots around walking down a magnificent spiral staircase. The participant imagines the staircase first and reports how many steps they will descend until they reach the bottom. With each step down, the hypnotist suggests that they experience a deeper state of hypnosis and say aloud the step number (e.g., 1, 2, 3 . . .) in tandem with lifting an index finger to mark their progress (see Lynn & Kirsch, 2006, for another staircase induction).

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Nevertheless, counting is not a requirement. Below is a short example of a suggestion to experience a deeper, more intensified level of hypnosis that does not rely on counting.

"As you become more familiar with your hypnosis, you may wish to go even deeper into hypnosis, deeper and deeper as you find a level that is just right for you. You may find yourself going deeper and deeper into hypnosis, your hypnosis . . . to a place within yourself, where you feel safe and secure. A place where you become increasingly aware of the possibilities within you, the potential for change, growth, confidence, empowerment, and the realization that you can live the life that you want to live. The life you choose to live . . . a life consistent with your values, your goals, and your intentions. Wouldn't it be nice to go just as deep into your hypnosis as you want to go. Deeply relaxed . . . calm and at ease. You can be deeply hypnotized but can still clearly hear what I am saying. Take a few minutes to do this, now. After a while, I will ask if you are ready to move forward and experience your hypnosis on an even deeper level?"

Another type of induction with deepening suggestions includes imagery focused on participants imagining their right or left hand rising off the resting surface, being lifted up gradually by brightly colored helium-filled balloons. As the hand rises, the person receives suggestions to experience deeper and deeper hypnosis and that when their hand moves upward and touches their face, they will experience a very deep level of hypnosis and feel even more relaxed when the hand returns to the resting surface.

The Diversity of Hypnotic Suggestions

What is more important in determining therapy outcome than the use of a particular induction or the deepening method is likely the salience of specific suggestions and their congruence with the goals and aims of the therapy enterprise, alongside the participants' beliefs, attitudes, expectancies, and ability to respond to suggestions in the context of hypnosis.

Hypnotic suggestions constrain the vast reservoir of spontaneous involuntary thoughts, fantasies, imaginings, and inchoate associations that mark much of our mental life and channels them in therapeutic directions to transform maladaptive beliefs, thoughts, and action tendencies into more adaptive schemas and goal-directed behaviors (see Lynn et al., 2019).

Hypnotic suggestions are different from instructions and lack their coercive quality (Terhune et al., 2017). Suggestions are typically verbal communications, but they can be nonverbal as well, explicit or implicit, imply a passive or automatic response or a deliberate conscious response, delivered in a

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permissive or an authoritative manner, or contain rich suggestion-related imagery or minimal imagery, affording substantial flexibility on the part of the hypnotist in crafting suggestions. In clinical contexts, suggestions often unwind in a reciprocal manner in which participant responses influence hypnotist interventions on a recursive unfolding basis.

Clinicians can titrate to some extent whether suggestions are experienced as mostly voluntary or not by modifying suggestion wording and participant expectancies (see Lynn et al., 1994). For example, involuntariness reports are related to suggestions worded in a traditional direct-authoritative manner. When suggestions are worded more permissively (e.g., You may begin to experience lightness in your hand vs. You will experience your hand getting lighter), responses are typically perceived as more voluntary (see Lynn et al., 1993). Clinicians can modify suggestions to accord with participant preferences to address concerns about relinquishing control during hypnosis. More permissive suggestions typically do not compromise behavioral responses to suggestions relative to authoritative suggestions (Lynn et al., 1993).

Practitioners can be reassured that many of the suggestions used for therapeutic purposes (e.g., relaxation, imagining events, imaginative rehearsal, ego strengthening) are not particularly challenging, demanding, or difficult to pass, other than by those considered "low hypnotizable" (Barber, 1985). Montgomery et al. (2011) reported that hypnotic ability accounts for only 6% of the variability in treatment outcomes in clinical care settings, although hypnotic responsiveness is still a statistically significant predictor of clinical utility.

These sorts of findings are consistent with our experience that it is often not necessary to conduct a formal assessment of hypnotic responsiveness for clinical purposes. Nevertheless, in rare and exceptional cases, such as when hypnosis is considered as a substitute for an anesthetic (i.e., due to prior allergic/anaphylactic response) for a dental extraction, it is prudent to determine that the candidate for hypnosis responds successfully to analgesia suggestions in advance of any procedure as well as to test for high levels of hypnotic responsiveness based on a standardized scale.

It is often obvious that some participants are especially low in hypnotic responsiveness when an actual induction is attempted, and in this case formal assessment of hypnotic responsiveness is not likely to yield incrementally useful information. However, some of these same individuals will both respond successfully to imaginative suggestions administered in a nonhypnotic context and express openness to this alternative. Fortunately, much can be accomplished with nonhypnotic imaginative suggestions, as hypnosis confers only a small advantage in responsiveness—on average approximately 1.5 suggestions out of a total of 12 suggestions (Kirsch & Lynn, 1995).

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Self-Hypnosis and Posthypnotic Suggestions

Suggestions can be administered either by another person (i.e., heterohypnosis) or self-administered (i.e., self-hypnosis). The practitioner can legitimately convey the idea that all hypnosis can be considered "self-hypnosis." After all, it is the participant who chooses whether to respond to suggestions or squelch the response, actively participate during the session, and imagine the suggested state of affairs; similar to the reference to self-hypnosis in the sample induction in which it is emphasized that it is the client who is "doing the work." Self-hypnosis can be a powerful and portable tool to (a) instate new cognitive-affective-behavioral responses or (b) to challenge or replace existing negative self-suggestions that are at the core of diverse manifestations of psychopathology, including depression and anxiety (e.g., "I'm worthless," "I'll make a fool of myself at the party"), with more positive, goal-directed, self-administered suggestions in everyday life (see Lynn & Kirsch, 2006).

Sometimes self-hypnosis is administered in the absence of a prior hypnotic induction. That is, from the outset, the therapist contextualizes the situation as self-hypnosis. More commonly, self-hypnosis can be utilized on a posthypnotic basis after an initial session in which the hypnotist induces hypnotic responses. When this occurs, the suggestion to engage in self-hypnosis after the session is a good example of a posthypnotic suggestion: A suggestion to engage in a mental or behavioral activity following hypnosis (Barnier & McConkey, 1999). Posthypnotic suggestions often prime certain responses in certain circumstances. For example, Hammond (1992) recommends the following format for posthypnotic suggestions: "When I feel _____, I will _____." Many different cues can be attached to posthypnotic suggestions that include visual cues (e.g., "When I see a person smoking, I will remind myself that smoking is bad for my health"), sounds ("Whenever I hear _____ on the radio, I will list five reasons to not smoke"), thoughts ("When I think I need to smoke, I will have an image of myself as a nonsmoker"), and physical sensations and emotions ("When I feel an urge to smoke, I will tell myself that the urge will pass"). Each of these suggestions can be anchored with a sense of strength and resolve to resist any urge to smoke, as we describe in Chapter 7.

Characterizing hypnotic experiences as self-generated can encourage participants to create and embellish their own suggestions tailored to their specific needs and goals. The brief script below expands on the metaphor of Lynn and Kirsch (2006), which links self-hypnosis skills with the common experience of riding a bicycle.

"Remember when you first learned to ride a bike? If you were like me, you might have been a little scared, uncertain of what to do, and lacking

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confidence that you could master the task. You might have been concerned that you would fail. Maybe you feared that you'd not be able to experience the thrill of coasting along on your bike, with the cool breeze blowing through your hair, joining in the fun with your friends or family members or just riding around yourself.

But you did learn. You could do it, and you did do it. And, after a little practice, you learned that not only could you ride, but you could do so without much effort, even without much thinking. You just jumped on your bike and took off. You let your mind and body work together to do all the things needed to maintain your balance, steer the bike, going from place to place, at your own pace, in control, and enjoying the ride. Soon, you were able to move in the direction that you wanted to move.

Isn't it amazing that you were in such control—doing all the things you needed to do—yet the act of riding a bike was easy, effortless, and seemingly automatic. You didn't have to think about controlling the bike. It became so effortless, right? Your mind and body working together to achieve a goal. Without effort, without stress, easy and effortless.

It's the same with hypnosis. You are in control and you go in the direction you choose. You imagine along with the suggestion, to respond or to make suggestions seem real. It's your choice, your decision, your work. And, just like riding a bike, it gets easier with time. Easier and easier with time and practice.

Given this understanding that you are the one making things happen, you are the one creating your experiences, you can see how all hypnosis is, in fact, self-hypnosis. After a little practice listening to me guiding you with my suggestions, you will gain confidence that you can give yourself suggestions, and create your own suggestions. The beauty of this realization is that you can personalize suggestions that are just right for you, as you know best what you need, what you want, and what works best for you."

CONCLUSION

Hypnosis affords clinicians with a brief, efficient, and cost-effective methodology to alleviate or address a wide range of psychological conditions and disorders. Clinicians of diverse stripe should consider adding hypnosis to their repertoire of evidence-based interventions as a potential catalyst of treatment effects. Self-hypnosis and posthypnotic suggestions can be utilized to maximize the transfer and generalization of treatment gains outside the hypnotic context. The chapters that follow provide substantial

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documentation of the salutary effects of hypnosis, along with guidance to facilitate the use of hypnosis in a wide range of clinical contexts. After reading this volume, it is our hope that readers will share our fascination with hypnosis and integrate it into their clinical work to explore how it can impact the lives of their patients and assist them in achieving their goals.

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