

American Journal of Clinical Hypnosis
51:1, July 2008

Copyright © 2008 by the American Society of Clinical Hypnosis

HYPNOSIS, HYPNOTIZABILITY AND TREATMENT

Howard Sutchter
Chicago, IL

Abstract

There is broad agreement that a phenomenon we call "hypnosis" exists. However, there is no generally accepted definition of hypnosis. A brief historical overview of the use of hypnosis in healing practices demonstrates how it evolved willy-nilly, and like Topsy, "just grewed" into its current status in medicine, psychiatry, psychology and dentistry. The mechanisms underlying hypnosis and how hypnosis differs from other cognitive states are almost totally unknown. With the exceptions of suggestions for pain control, current concepts of high, medium, low or non-hypnotizability do not reliably predict clinical outcomes for most medical, psychiatric or dental disorders. We do know that it is relatively easy to reliably evaluate hypnotizability, but other than choosing volunteers or subjects who will or will not exhibit traditional hypnotic phenomena, we rarely know what to do with that evaluation with actual clinical patients. Four case studies, representative of many others, chosen retrospectively from a practice that spans 45 years, illustrate how traditional or modern hypnotizability assessment is irrelevant in the clinical setting. Although the four patients differed obviously and vastly in hypnotizability, they all benefited from the use of hypnosis.

Keywords: Hypnosis, hypnotizability and treatment.

Address correspondences and reprint requests to:

Howard Sutchter, DDS, MA
5415 North Sheridan Road, 4311
Chicago, IL 60640

In 1957, when I was in professional school, I asked the customary ignorant and naïve questions: What is hypnosis? Who gets hypnotized? What can you do with it? Now 45 years later, with lots of training and experience, I ask the same, but now profound questions: What is hypnosis? Who gets hypnotized? What can you do with it?

What is Hypnosis?

Usually we know what a phenomenon or object is and there is broad agreement about its nature. For example, from the time of Columbus to the time in the 20th century when Uri Gagarin gazed down on our planet from space, sufficient evidence had accumulated producing almost universal agreement: the earth is round. Evidence about the nature of hypnosis has not evolved to the point where there is such a simple conclusion about its nature.

A brief historical overview of the use of hypnosis in healing practices demonstrates how it evolved into its current status in medicine, psychiatry, and dentistry. While many consider Franz Anton Mesmer as the father of modern hypnosis (Ellenberger, 1970; Gauld, 1992; Hilgard, 1965), the term "hypnotism" was coined by James Braid in the 1840's more than 50 years after Mesmer's original publication (see the translation of Mesmer's early work published in 1948, but originally published in 1766). One thing is clear. Mesmer's mesmerism was not the same thing as Braid's hypnotism and different historical theories about the nature of hypnosis have been summarized by Gauld (1992), Hilgard (1965) and the Spiegel's (1978/2004).

A similar situation still exists today. Many who use "hypnosis" still purport to know what it is. But, the truth is, no one really knows what is going on in the mind and body of a

hypnotized person. Most definitions of hypnosis merely describe the behavior of "hypnotized" people (Araoz, 2005; Barber & Calverley, 1963; Daniel, 2005; Frischholz, 1985; Gauld, 1992; Green, Barabasz, Barrett & Montgomery, 2005; Hammond, 2005; Heap, 2005; Hilgard, 1965; Killeen & Nash, 2003; Kirsch, 2003; Lynn & Rhue, 1991; McConkey, 2005; Mesmer, 1948; Nash, 2005; Perry, 2004; Rossi, 2005; Spiegel & Greenleaf, 2005; Spiegel & Spiegel, 1978; Woody & Sadler, 2005; Yapko, 2005). Deluded by their ability to persuade some people to cooperate in an induction ceremony, too many clinicians and researchers suffer from, what I call a "Humpty Dumpty Complex", that is, hypnosis is what I say it is, nothing more and nothing less.

There is even controversy over whether the administration of an induction produces a hypnotic "state" which is qualitatively different from the normal waking state (Frischholz, 2005a; Frischholz, 2007; Hull, 1933; Kirsch, Mazzoni & Montgomery, 2006; Weitzenhoffer, 1953). Interestingly, a recent attempt to answer this question was undertaken using a poll of hypnosis professionals (Christensen, 2005). Respondents claimed, by a ratio of 4:1, that induction ceremonies produced an identifiable "state" (presumably different from a normal conscious "waking" state). While not surprised by the poll results regarding this issue, I submit that questions such as these cannot be answered on the basis of opinion alone. The issue of whether hypnosis is really different from other methods that also claim to influence thought, behavior and physiology, or is different in name only (e.g., systematic relaxation, guided imagery, meditation, neurolinguistic programming, aspects of yoga, or other mystic rituals) can be answered only by data derived from scientific investigations.

Who gets hypnotized?

Some hypnotists (e.g., Milton Erickson, 1980) have asserted, without defining hypnosis, that almost everyone is hypnotizable if the hypnotist has sufficient skill and patience (Erickson, 1980). This begs the question: if you haven't defined a condition, how can you decide that everybody can achieve it - Erickson differentiated between light, medium, and deep trances. Hence, it seems that Erickson decided that whatever it was he considered to be hypnosis, some people had a little of it, some people had more, and some people had a lot.

History tells us that man may have been experiencing himself in altered states of consciousness for a long time. An early explanation for individual differences in responsivity to hypnotic induction-like procedures began to emerge around the time of Mesmer. For example, Father Gasner, (1727-1779), a contemporary of Mesmer's, and recently considered by some to be the father of modern hypnosis instead of Mesmer (Peter, 2005), treated by the use of exorcism. Here too, like the ancient Egyptian sleep temples, divine intercession was also a likely requirement. Thus, individual differences in responsivity to exorcism could now be attributed to at least two external sources: the skill of the exorcist/healer; and whether or not God chose to intervene in a particular patient. In Mesmer's case, individual differences in the ability to be magnetized were attributed to different amounts of magnetic fluid within the person or external factors such as differences in the size of the magnetic body exerting its effect upon the person.

Clinicians and investigators who came after Mesmer also identified other individual differences in response to mesmeric-like procedures which were considered necessary to make the treatment effective (Gauld, 1992).

For example, the Marquis de Puységur (1751-1825) postulated that "magnetism" and, in addition, "somnambulism" (often accompanied by a "spontaneous amnesia" for the healing procedure) was a necessary component of effective treatment. In contrast, the Abbe Faria (1756-1819), a mesmerist who nevertheless rejected the concept of "animal magnetism," gave "suggestions" during what he called "lucid sleep". He was more a showman than a therapist. Braid (1795-1860) wanted a "hypnotic sleep" and a state of "monoideism" in which the subject, even sometimes whilst apparently wide awake, became susceptible to being influenced and controlled entirely by the suggestions (implicit or explicit) of others upon whom their attention was fixed.

James Esdaile (1808-1859) only sought "Mesmeric sleep," not needing "sleep-walking" or the "somnambulistic" state to perform painless surgery without chemical anesthetics. He delegated hypnotic inductions to assistants who used lots of passes, and had his patients mesmerized for hours each day, sometimes for 10 to 12 days. Patients also usually had "spontaneous amnesia" for the surgery.

Pierre Janet (1859-1947) thought that just being hypnotized per se could bring certain therapeutic benefits. Charcot (1825-1893) and the rest of the Salpetriere school believed that hypnotism was akin to "hysteria" (i.e., a defective nervous system) and that the therapeutic influence of hypnotism needed only suggestion to activate the therapeutic "hysteria". But he thought it was chiefly effective with troubles that depended on "hysteria".

In contrast, A.A. Liebault (1823-1904), father of the Nancy school wanted his patients to be spellbound (i.e., in a state of "charme"). Bernheim (1840-1919) wanted his patients to "sleep" with "closed eyes" and believed that "suggestion" was the necessary process by which hypnosis operated.

SUTCHER

A.W. van Renterghem (1845-1939) and F. van Eeden (1860-1932) were medical partners in the Netherlands. When treating patients, van Renterghem sought a "somnambulistic" state while van Eeden preferred a state of "daze" or "passive lying still with eyes closed." The latter avoided "somnambulism" because he felt it interfered with the healing process. The Dane, Carl Hansen (1833-1897), more a showman than a healer, still considered that he was "magnetizing" or "mesmerizing" his subjects.

Hypnosis is an ephemeral condition difficult to describe. These examples illustrate how experts with a variety of requirements from different countries using different languages further muddied the waters about the nature of hypnosis. For example, how is Liebeult's "Charme" different from van Renterghem's "somnambulistic" state? Without standardization of common terms and descriptors accurately characterizing the nature of hypnosis, agreement is impossible. That is, each early hypnotic practitioner required a specific patient reaction to consider his intervention to be effective. For example, Mesmer and his "crisis;" Esdaille "mesmeric sleep;" Liebeult "Charme;" van Eeden's "daze, etc."

Many contemporary clinicians and researchers, without defining what they are doing, are measuring something. These various measurements may be reliable, but their significance is questionable. There are many different quantitative methods for measuring individual differences in responsivity to hypnosis, such as the Barber Suggestibility Scale (Barber, 1965), the Stanford Hypnotic Susceptibility Scales (Hilgard, 1965; Weitzenhoffer & Hilgard, 1959; Weitzenhoffer & Hilgard, 1962), the Eye Roll Sign and the Induction Score of the Hypnotic Induction Profile (Spiegel & Spiegel, 1978; Spiegel,

Aronson, Fleiss & Haber, 1976), and various self-rating procedures (Frischholz, E.J., Tyron, W.W., Fisher, S., Maruffi, B.L., Vellios, A.T. & Spiegel, H., 1980; Tart, 1979). This makes any kind of standardization problematic because scores on different tests, while internally consistent, do not intercorrelate high enough (range of r 's = .20 - .70) to consider these different methods as interchangeable measures (Frischholz, E.J., Tyron, W.W., Fisher, S., Maruffi, B.L., Vellios, A.T. & Spiegel, H., 1980; Frischholz, E.J. Braun, B.G., Lipman, L.S., & Sachs, R.G., 1992; Ruch, Morgan & Hilgard, 1974). Hence, "some clinical groups may score significantly higher or lower than normal subjects on one type of hypnotizability measure but not on another" (Frischholz, E.J. Braun, B.G., Lipman, L.S., & Sachs, R.G., 1992; p.1521). For example, schizophrenics earn significantly lower scores on the Induction Score of the Hypnotic Induction Profile than different normal comparison groups such as college students or medical patients being treated for their smoking addiction (Frischholz, E.J. Braun, B.G., Lipman, L.S., & Sachs, R.G., 1992; Spiegel, Detrick & Frischholz, 1982). In contrast, no significant differences between schizophrenics and normals were observed on the Stanford Form C Scale (Frischholz, E.J. Braun, B.G., Lipman, L.S., & Sachs, R.G., 1992). Thus, the answer to the question of who gets hypnotized may be more dependent on the type of scale one uses for measuring hypnotizability.

Few agree on anything today. A variety of terms have been proposed: suggestibility, hypnotic suggestibility, imaginative suggestibility, hypnotic susceptibility, hypnotizability, trance capacity or hypnotic responsivity to name a few (Braffman & Kirsch, 1999; Christensen, 2005; Frischholz, 1985; 2005a; Spiegel and Spiegel, 1978; Weitzenhoffer, 1980). Making this

matter even more confusing is that some use different types of descriptive labels while at the same time employing the same assessment method/measurement instrument. In conclusion, while it is conceded that individual differences in responsivity to hypnosis can be reliably measured using the same instrument/method, there is no doubt that there is continuing confusion about how to characterize or interpret an individual's score derived from any one method.

What can you do with Hypnosis?

Both traditional and current measures of hypnotizability seem to be good predictors of stage performance or the selection of subjects for hypnosis research. However, other than predicting subjects/patients most likely to respond positively to hypnotic and non-hypnotic treatments for pain reduction (Appel & Bleiberg, 2005; Frischholz, 2005b; Hilgard & Hilgard, 1975; Katz, Kao, Katz & Spiegel, 1974), traditional or current measures of hypnotizability do not reliably predict outcome of treatment for most medical, psychiatric or dental disorders. Simply putting a number on something does not increase your understanding of anything.

The basic theme of this paper is that although hypnotizability can be easily and reliably assessed, hypnotizability scores do not tell us much about how hypnotizability relates to treatment outcome. Below I illustrate the nature of this problem by first briefly describing some of my own clinical experiences. I present four case examples where the patients differed vastly in their levels of hypnotizability, but nevertheless profited from treatment which this Humpty Dumpty labeled hypnosis.

For 40 of my 45 years of practice, I operated very much like most of my colleagues. During the last 5 years, I didn't change what I was doing; I just realized that I didn't understand what I was doing. If patients easily

and rapidly responded to my suggestions with certain prescribed behaviors when I was hypnotizing them, I considered them high or virtuoso hypnotizables. I assumed that it was they who would benefit the most from the clinical use of hypnosis. I also assumed that the corollary would be equally true: low hypnotizables were unlikely to benefit from treatments which presumably included hypnotic inductions.

The four patients retrospectively reported below are representative of many others I have seen over the past 45 years. They clearly demonstrate that the above two assumptions are not valid: 1) patients who demonstrate high levels of hypnotizability do not necessarily profit from hypnosis; and 2) patients who demonstrate even very low levels of hypnotizability can still profit from hypnosis.

The first patient presented here supports the current belief which expects clinical successes to come most regularly and effectively when dealing with "high hypnotizables." The second patient seriously questions that belief. The third patient clearly refutes the idea that clinical success can best or only be achieved with "high hypnotizables." The fourth patient demonstrated opposing clinical results on two occasions.

Case Reports

Case 1

When I was co-teaching a course on hypnosis, a female student showed up in a state of panic. Before I met Diana, she had had an operation for an orthodontic purpose called a split palate. Because she had been deficient in clotting factor 8, postoperative bleeding was a severe problem. Her head and face turned purple because of bleeding into the oral tissues. Now she needed to have

a tooth extracted for orthodontic purposes and she was terrified.

Diana proved to be a virtuoso hypnotic subject, easily exhibiting every hypnotic behavior I could think of suggesting. I suggested that she continue to relax in order to address her pre-surgical anxiety. Brought out of her trance after just a few minutes of induction, I asked her if she still felt panicky. She responded, "No. I am appropriately concerned about facing any surgery, even a minor procedure like a tooth extraction, but I feel no panic."

She requested that I accompany her for the extraction. The oral surgeon was not experienced with hypnosis, but was understanding and cooperative. I asked Diana if she thought she could have the extraction done using only hypnosis as the anesthetic. She was enthusiastic about the idea. With less than 5 minutes of induction followed by the suggestion that she had been given an injection of lidocaine, the tooth was extracted. I had only suggested a mock injection of an imaginary analgesic for pain control.

That day Diana and I had our 15 minutes of fame and stardom. We were both heroes to every student present at the extraction. One student, in a tone of amazement asked, "Didn't that hurt?" Diana responded, "No, I was across the room watching the extraction." I had suggested only analgesia. On her own, she had decided to have an out of body approach to pain and anxiety control.

Blood wouldn't stop oozing out of the extraction site in response to the usual pressure of a gauze pad. I suggested that she re-enter her trance and stop the bleeding. She tried but could not stop the bleeding on her own. I tried hetero-hypnosis. In a commanding voice, I asked an assistant for some of the suture material that was made out of factor 8 (imaginary) and announced that I was going

to place a pursestring suture (also imaginary) over the extraction site. I mentioned that a pursestring suture is in a figure 8. The bleeding stopped. We got another 15 minutes of fame. Diana went dancing that night.

Was it hypnosis or just elapsed time that stopped the bleeding - or both? No one knows. Because of the bias I held at that time, I expected all the favorable results we got were because the patient presented with high hypnotizability. No specific suggestions were given for her anxiety about the extraction except for her overall relaxation and pain control during the extraction. However, I did use specific suggestions to control her post-extraction bleeding because she was unable to do this on her own.

Case 2

The Chicago Society of Clinical Hypnosis is the local branch of the American Society of Clinical Hypnosis. At monthly meetings in the 1980's, we would bring our most interesting or most difficult patients to show off our successes or to ask for help from each other.

One Friday, a physician presented a pretty, blond, blue-eyed girl of about 12 years of age. After a bout of flu, Tammy had developed a strange and persistent symptom. For about six months, every 15 seconds (like clockwork) she would exhale an explosive burst of air that sounded like a combination of a cough and sneeze (C/S). Only during sleep did the C/S's cease.

Tammy had been seen by a variety of medical specialists over the previous 6 month period to no avail. A psychiatrist who was present thought that treatment with hypnosis could not be helpful because she presented with a symptom that was presumed to be neurologic (i.e., physical, not emotional) in nature.

Everyone tried to induce a trance through

HYPNOSIS, HYPNOTIZABILITY AND TREATMENT

relaxation techniques - all failed. No clinician present would have considered Tammy to have been hypnotizable.

My turn came. I wondered how she could relax in the face of a C/S every 15 seconds. I had read about inducing a trance through tension but had never tried it. I tried it. I suggested that Tammy extend and stiffen her arms and legs as much as possible. Every time she relaxed at all, I encouraged her to stiffen her arms and legs more. This went on for about 15 minutes. She did not close her eyes; the rigidity of her arms and legs seemed completely voluntary; no trance-like behavior was exhibited. I did not mention the C/S.

The psychiatrist, who clandestinely had been timing the frequency of the C/S's announced, "every 20 seconds now." Although my technique with this apparently un hypnotizable subject seemed to reduce the frequency of her symptom, it did not eliminate it. The meeting ended and everyone went home.

The next Monday, Tammy's father phoned me at my dental office to tell me that through Friday evening and the next day the C/S's progressively reduced in frequency and by Sunday afternoon were gone completely. Tammy returned to school that Monday.

At the next two monthly meetings, Tammy's physician reported that she had been completely C/S free. There seemed to be no need for further follow up and the Society went on to other concerns. Obviously, this un hypnotizable subject was able to profit through a trance tension technique. Why? It is unclear; but what is clear is that her lack of traditional hypnotizability did not predict her successful response to treatment.

Case 3

Late one Saturday afternoon, a lady in her early 40's presented at my dental office

for hypnosis to help her quit cigarette smoking. Lilith had been a heavy smoker since she was 14 years old. She was one of the most resistant persons I have ever met in my 45 years of experience with hypnosis. Instead of responding to my suggestions, she spent the time suspiciously watching me to see what I was going to do. She remained alert and never closed her eyes. At the end of the hour, I asked her if she thought she had been hypnotized. When she responded "No", I could only agree that I did not think that she had been hypnotized either. I added that just because we had not succeeded that day it did not mean that she was un hypnotizable. Attempts on another day or with a different hypnotist might well succeed.

Lilith got out of the chair, immediately lit a cigarette, and began smoking. Although I usually did not allow smoking in my office, I did not make it an issue that time. She smoked the cigarette half-way and put it out. I asked if that was the way she usually smoked. She responded, "No, I usually smoke cigarettes down to the nub. Strange, I wonder why I did that."

Lilith left. I never expected to hear from her again, but she phoned me the next Monday and said, "Dr. Sutchter, I don't know what you did, and I'm pretty sure that you don't either" (Right, I did not). "When I left your office, I got into my car and took out a cigarette, looked at it for a while and then threw it out the window. I have not smoked since I saw you, and what is more amazing, I have not wanted to."

I responded that it had only been two days since our session and that she should call me again in 3 months. She called. "Dr. Sutchter, I have not smoked; I have not wanted to smoke; I have not had withdrawal or weight gain, and I am going to take courses in becoming a hypnotist." By chance, her son was a lifeguard at the pool in my building, so I was

able to keep track of her for almost 2 years. During that time, Lilith did not smoke. Once again we have a case where the patient proved to be un hypnotizable in a traditional sense. Few or no therapeutic suggestions had been administered. Nevertheless, the patient remained completely abstinent from smoking immediately following my attempt to hypnotize and treat her. What happened? I do not know but I am happy that whatever I did seemed to work.

Case 4

A fourth patient, by herself, demonstrated how completely unrelated classical hypnotizability can be to clinical outcome. A 22 year-old female asked me for help in quitting smoking. I recognized intuitively that, if anything, Aphrodite was even more "hypnotizable" than Diana (Case 1). For those of you who fantasize that tests of hypnotizability are of any value, Aphrodite was evaluated on the Hypnotic Induction Profile (HIP) by an independent, experienced psychologist/hypnotist who was and is committed to measures and tests of hypnotizability. Aphrodite's eye roll on the HIP was a 3/4, with an Induction score of 9/10 (Spiegel & Spiegel, 1978).

Before treatment, I asked her my standard questions: Do you want to quit smoking, or are you quitting because you think you should. If the response is the latter, I generally avoid getting involved. Her response was an emphatic "I want to quit smoking."

Aphrodite was a very finicky eater. If anything tasted or looked "nasty" to her she would not try it or go near it.

I believe that she entered a trance almost before I began the induction. I suggested that cigarettes would henceforth taste so "nasty" that she would avoid them completely.

Interestingly, Aphrodite felt that she had not entered a trance. I believe that was her perception because, for her, no novel sensation had occurred. I had previously observed her dissociate frequently and, unguided, seemed to drift in and out of trancelike states several times daily. Her mother and sisters were aware that she "zoned out" frequently.

Although Aphrodite claimed that she had not entered a trance, she nevertheless felt stuck and could not get out of her chair. I then redid what did not work the first time, and gave her suggestions that she could get out of the chair when we were through. She got up.

Aphrodite immediately bummed a cigarette from my doorman and began smoking. However, she exclaimed, "There is no taste—I don't taste anything! Maybe it's because it's not my brand. When I get home, I'll try my usual brand." Later, she still experienced no taste when smoking cigarettes.

It took Aphrodite 4 days of intrepid smoking to get her taste for cigarettes back. Aphrodite currently smokes about as much as she did before we tried hypnosis. I believe that Aphrodite consciously overpowered everything I thought we had achieved with hypnosis. She now says, "I thought I was being honest when you asked me if I wanted to quit smoking or just thought I should. I suppose I really did not want to stop."

Thus, although an extremely high hypnotizable subject, Aphrodite got no benefit from hypnosis for smoking. However, about 6 months after the failed attempt at smoking cessation, Aphrodite, in severe pain, phoned me to say that she had broken two natural and artificial fingernails by decking a rival for a man. The raw skin under the nails was exposed, and several shards of nail were imbedded in the nail bed. The pain prevented Aphrodite from bending the two involved fingers at all. I

HYPNOSIS, HYPNOTIZABILITY AND TREATMENT

quietly and reassuringly said, "Aphrodite, go back to that place where you were when we were trying to get you to stop smoking. Let the pain drain out of your fingers and fall onto the floor."

The pain reduced greatly in severity immediately. Aphrodite was then able to bend her fingers and remove the shards relatively comfortably by herself. Same person—opposite treatment results for different problems.

Conclusion

How to relate the clinical results in my four cases? I do not know, but it obviously cannot be done by relying on traditional or current evaluations of hypnotizability. Aphrodite's case could be suggesting one way of predicting clinical outcome: forget "hypnotizability." Just ascertain the immediacy of the need as perceived by the patient.

Clinicians want client/patient evaluations that will help them to predict outcomes of

therapy when using hypnosis. To do that we are asking the wrong questions when we limit our investigations to traditional or current concepts of hypnotizability. We may merely be measuring phenomena of importance only to stage hypnotists or researchers who do not need our help in evaluating the elements of hypnotizability that they need.

In response to what we call hypnosis, do these four patients all share some characteristics as yet unidentified? Are their clinical successes the result of unknown personal properties? Are they just responding differently to something unknown? Is some sort of mental processing going on that we know nothing about? Are superior clinical results with "high hypnotizables," and the lack of clinical results with low or non-hypnotizables merely self fulfilling prophecies? Are they the result of which ceremonies we have chosen as inductions? Questions abound. Answers are needed.

REFERENCES

- Appel, P.R. & Bleiberg, J. (2005). Pain reduction is related to hypnotizability but not to relaxation or to reduction in suffering. *American Journal of Clinical Hypnosis*, 48, 153-161.
- Araoz, D. (2005). Defining Hypnosis. *American Journal of Clinical Hypnosis*, 48, 123-126.
- Barber, T.X. (1965). Measuring "hypnotic-like" suggestibility with and without "hypnotic induction": Psychometric properties, norms, and variables influencing response to the Barber Suggestibility Scale (BSS). *Psychological Reports*, 16, 809-844.
- Barber, T.X. & Calverly, D.S. (1963). Toward a theory of hypnotic behavior: Effects on suggestibility of task motivating instructions and attitudes toward hypnosis. *Journal of Abnormal and Social Psychology*, 67, 557-565.
- Braffman, W. & Kirsch, I. (1999). Imaginative suggestibility and hypnotizability: An empirical analysis. *Journal of Personality and Social Psychology*, 77, 578-587.
- Christensen, C. (2005). Preferences for descriptors of hypnosis. *Journal of Clinical and Experimental Hypnosis*, 53(3), 281-289.
- Daniel, S.A. (2005). The perspective of a teacher and clinician: The 2003 APA Division 30 Definition of Hypnosis. *American Journal of Clinical Hypnosis*, 48, 141-143.
- Ellenberger, H. (1970). *The discovery of the unconscious*. New York: Basic Books.

- Erickson, M. (1980). Deep hypnosis and its induction. In Rossi (Ed.). *The collected papers of Milton H. Erickson on hypnosis: Vol 1 The nature of hypnosis and suggestion.* (pp. 331-339). New York: Irvington.
- Frischholz, E.J. (1985). The relationship among dissociation, hypnosis, and child abuse in the development of multiple personality disorder. In R.P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp 99-126). Washington, DC: American Psychiatric Press, Inc.
- Frischholz, E.J. (2005a). Remembering André Weitzenhoffer, Ph.D. *American Journal of Clinical Hypnosis*, 48, 5-27.
- Frischholz, E.J. (2005b). Some remarks about the Appel and Bleiberg (2005) Study. *American Journal of Clinical Hypnosis*, 48, 163-164.
- Frischholz, E.J. (2007). The Future of professional hypnosis: Comment on Kirsch, Mazzoni and Montgomery. *American Journal of Clinical Hypnosis*, 49, 185-194.
- Frischholz, E.J., Braun, B.G., Lipman, L.S., & Sachs, R.G. (1992). Psychopathology, hypnotizability, and dissociation. *American Journal of Psychiatry*, 149: 1521-1525.
- Frischholz, E.J., Tyron, W.W., Fisher, S., Maruffi, B.L., Vellios, A.T., & Spiegel, H. (1980). The relationship between the Hypnotic Induction Profile and the Stanford Susceptibility Scale, Form C: A replication. *American Journal of Clinical Hypnosis*, 22, 185-196.
- Gauld, A. (1992). *A history of hypnotism.* Cambridge, Great Britain: Cambridge University Press.
- Green, J.P., Barabasz, A.F., Barrett, D., & Montgomery, G. (2005). The 2003 APA Division 30 Definition of Hypnosis. *American Journal of Clinical Hypnosis*, 48, 89.
- Hammond, D.C. (2005). An integrative, multi-factor conceptualization of hypnosis. *American Journal of Clinical Hypnosis*, 48, 131-135.
- Heap, M. (2005). Defining hypnosis: The UK experience. *American Journal of Clinical Hypnosis*, 48, 117-122.
- Hilgard, E.R. (1965). *Hypnotics susceptibility.* New York: Hartcort, Brace and World.
- Hilgard, E.R. & Hilgard, J.R. (1975). *Hypnosis in the relief of pain.* Chicago: Kaufman.
- Hull, C.L. (1933). *Hypnosis and suggestibility: An experimental approach.* New York: Appleton-Century.
- Katz, R., Kao, C.Y., Spiegel, H., & Katz, G.J. (1974). Pain, acupuncture and hypnosis. In J.J. Bonica, *Advances in neurology.* New York: Raven Press.
- Killeen, P. & Nash, M.R. (2003). The four causes of hypnosis. *International Journal of Clinical and Experimental Hypnosis*, 51, 195-231.
- Kirsch, I. (2003). Professional opinions about hypnosis: Results of the APA Division 30 survey. *Psychological Hypnosis*, 2, 4-5.
- Kirsch, I., Mazzoni, G., & Montgomery, G.H. (2007). Remembrance of hypnosis past. *American Journal of Clinical Hypnosis*, 49(3), 171-178.
- Lynn, S.J. & Rhue J.W. (Eds) (1991). *Theories of hypnosis: Current models and perspectives.* New York: Guilford.
- McConkey, K.M. (2005). On finding the balanced path of hypnosis. *American Journal of Clinical Hypnosis*, 48, 137-139.

HYPNOSIS, HYPNOTIZABILITY AND TREATMENT

- Mesmer, F.A. (1948). *Mesmerism by Dr. Mesmer* (G. Franklaur VR Meyers, Trans.) London: Mac Donald.
- Nash, M.R. (2005). The importance of being earnest when crafting definitions: Science and scientism are not the same thing. *International Journal of Clinical and Experimental Hypnosis*, 53(3), 265-280.
- Ohigashi, H., Huffman, M., Izutsu, D., Koshimizu, K., Kawanaka, M., Sugiyama, H., Kirby, G., Warhurst, D., Allen, D., Wright, C., Phillipson, J., Timon-David, P., Delmas, F., Elias, R., Balansard, G.. (1994). Toward the chemical ecology of medical plant use in chimpanzees: The case of *Vernonia amygdalina*, a plant used by wild chimpanzees possibly for parasite-related diseases. *Journal of Chemical Ecology*, 20(3), 542-553.
- Page, J.E., et al. (1997). Chemical basis for *Aspilia* leaf-swallowing by chimpanzees: A reanalysis. *Journal of Chemical Ecology*, 23(9), 2211-2226.
- Perry, C. (2004). Can anecdotes add to an understanding of hypnosis? *International Journal of Clinical and Experimental Hypnosis*, 52, 218-231.
- Peter, B. (2005). Gassner's exorcism-not Mesmer's magnetism: Is the real predecessor of modern hypnosis. *International Journal of Clinical and Experimental Hypnosis*, 53(1): 1-14.
- Rossi, E.L. (2005). Let's be honest with ourselves and transparent with the public. *American Journal of Clinical Hypnosis*, 48, 127-129.
- Ruch, J.C., Morgan, A.H., & Hilgard, E.R. (1974). Measuring hypnotic responsiveness: A comparison of the Barber Susceptibility Scale and the Stanford Hypnotic Susceptibility Scale, Form A. *International Journal of Clinical and Experimental Hypnosis*, 22, 363-376.
- Spiegel, H. & Greenleaf, M. (2005). Commentary: Defining hypnosis. *American Journal of Clinical Hypnosis*, 48, 111-116.
- Spiegel, D., Detrick, E., & Frischholz, E.J. (1982). Hypnotizability and psychopathology. *American Journal of Psychiatry*, 139, 431-439.
- Spiegel, H. & Spiegel, D. (1978). *Trance and treatment: Clinical uses of hypnosis*. New York: Basic Books, Inc.
- Spiegel, H. & Spiegel, D. (2004). *Trance and treatment: Clinical uses of hypnosis*. 2nd ed. Washington, D.C.: American Psychiatric Press.
- Spiegel, H., Aronson, M., Fleiss, J.L., & Haber, J. (1976). Psychometric analysis of the Hypnotic Induction Profile. *International Journal of Clinical and Experimental Hypnosis*, 24, 300-315.
- Tart, C.T. (1979). Quick and convenient assessment of hypnotic depth: Self report scales. *American Journal of Clinical Hypnosis*, 21, 186-207.
- Weitzenhoffer, A.M. (1953). *Hypnotism: An objective study in suggestibility*. New York: John Wiley and Sons, Inc.
- Weitzenhoffer, A.M. & Hilgard, E.R. (1959). *Stanford Hypnotic Susceptibility Scales, Forms A and B*. Palo Alto, CA: Consulting Psychologists Press.
- Weitzenhoffer, A.M. & Hilgard, E.R. (1962). *Stanford Hypnotic Susceptibility Scale, Form C*. Palo Alto, CA: Consulting Psychologists Press.
- Woody, E. & Saddler, P. (2005). Some polite applause for the 2003 APA Division 30 definition of hypnosis. *American Journal of Clinical Hypnosis*, 48, 99-106.
- Yapko, M. D. (2005). Some comments regarding the Division 30 definition of hypnosis. *American Journal of Clinical Hypnosis*, 48, 107-110.