

Response to Commentaries on Hypnosis in the Desensitization of Fears of Dying

Rapid Change and Clinical Empiricism

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ABSTRACT

The commentaries and criticisms of Karlin (2006) and Chaves (2006) are gratefully acknowledged. Both writers address the question of why clinicians adopt some techniques and eschew others. Clinicians who have experienced the ability of powerful psychotherapeutic techniques to produce rapid and substantial clinical change set that as their standard and measure their performance by it from session to session. Even in clinical domains with a relatively stable evidence base, responsible clinical practice will require therapists to be continually self-critical and self-correcting.

Key words: hypnosis; behavior therapy; evidence-based practice; anxiety disorders

I am grateful for the commentaries by Karlin (2006) and Chaves (2006) -- especially for Karlin's discussion of the potential dangers in using the videotape metaphor in hypnotic age regression, and for Chaves' correction of the historical record on the attitudes of early behavior therapists toward hypnosis. In particular, I wish to gratefully acknowledge Chaves' objection to my use of the term, "artifact," in discussing attributions of hypnotic phenomena to the social-behavioral-cognitive context of hypnotic situations. To the degree that hypnotic phenomena are produced by that context they are no less real than if they depended on an "altered" state of consciousness, and so they cannot be dismissed as artifacts. The social-cognitive theorists, such as Sarbin, were not dismissive of hypnotic phenomena, and I did not mean to imply that they were. (For the record, I will emphasize that my own working conception of clinical hypnosis sees it as the intersection of a normal, although highly concentrated state of consciousness, usually reserved for solitary, non-interpersonal situations, on the one hand, and the interpersonal context of social influence, on the other. What is unusual or "altered" about clinical hypnosis is this *combination* of mental state and interpersonal context.)

Both commentators, in different ways, address the question of how clinicians decide which therapeutic approaches to adopt or eschew. Karlin worries that a generation of clinicians is being trained who are in danger of limiting themselves to a rigid and uncritical adherence to

manualized, evidence-based treatment. Chaves observes that clinicians who had been trained in hypnosis and had positive attitudes toward it nevertheless did not use it in their clinical work.

Certainly, as an evidence-based practice, hypnosis in at least some of its applications has few peers -- see for example, Hawkins (2001) -- and so it is surprising that more scientifically-oriented psychotherapists have not made use of it. I hope that Chaves (2006) is correct, that "behaviorally oriented clinicians will not be theoretically constrained from adopting hypnotic techniques as evidence continues to mount of their efficacy in dealing with a wide range of significant clinical problems" (Chaves, 2006, this module). Then, maybe some of the clinicians Karlin worries about will begin to gravitate toward it. But I think it will take more than an accretion of evidence. It will take a change in attitude toward what constitutes evidence of success in the clinical situation.

A conviction shared by hypnotists, and behavior therapists, and also by non-behavioral therapists who were influenced by hypnosis, such as Haley (1973), is that powerful psychotherapeutic techniques can produce rapid psychological change. A recent published example are the cases described in this journal by Cigrang, Peterson, and Schobitz (2005) on the use of brief exposure treatment in the secondary prevention of PTSD. (A brief example from my own files: A man in his 40s with a lifelong fear of heights appeared for treatment after his young children began to tease him about it. After a quick assessment to rule out other psychopathology, I turned his chair to face the large window in my 13th-floor office and asked him if it would be okay if I opened the window just a crack. By the end of an hour and a half of *in vivo* exposure with modeling, the client was leaning out the window looking down at the street, anxiety free, and I was sitting out on the window ledge. Then the police arrived. The client remained free of his phobia four months later at a serendipitous follow-up.)

Clinicians who have experienced the ability to produce such rapid change often enough, at least in certain types of cases, come to expect it of themselves. That expectation brings with it the corollary idea that if a therapeutic intervention didn't produce rapid and substantial change, then it just plain didn't work; the case must be reformulated, and an alternative tactic must be invented. (It is hard to rationalize lack of change with the idea that change takes time once you have been convinced that it doesn't necessarily have to.) This is the standard I hold myself to, session by session, in my psychotherapeutic work, and it accounts for my frustration during the mid-game of my work with Betty (Hamburg, 2006). By that standard, I was failing; and the knowledge that the kind of cognitive-behavioral treatment I was attempting with her is evidence-based was cold comfort. Since most of my clients present with complex problems with no well-defined solutions, I am failing by my own standard much of the time. For me, managing the disappointment when an intervention does not rapidly yield a substantial result, and the anxiety of formulating an alternative intervention, is the precondition for doing effective psychotherapy -- or, at least, being honest with myself about trying to do effective psychotherapy.

I agree with Karlin (2006) that the evidence base for psychotherapy is far less solid than we would wish. I hope and expect that it will strengthen in the next few years. In the meantime, even in clinical domains where the evidence base is relatively firm, given the vagaries of current

syndromal diagnoses, and the infinite variety of our clients, we can never be sure that anything will work in an individual case; and responsible clinical work will require a continual process of skepticism, self-criticism, and self-correction.

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