

Hazards of ‘Final’ Definition

Commentary: On the Centrality of the Concept of an Altered State to Definitions of Hypnosis.

John A. O’Neil, MD, FRCPC*

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These comments are coming from a general hospital psychiatrist who uses hypnosis, especially in the treatment of disorders with an autohypnotic component. I strongly endorse the central idea that ‘hypnosis’ should reference an altered state of consciousness.

SEMANTICS

I would maintain the primary meaning of hypnosis as an altered state of consciousness, and then test hypotheses around that definition to discover the ‘boundaries’ of that altered state. Wagstaff (this issue) does this to some extent in his paper, but seeking a ‘final’ or ‘exact’ definition is a hazardous undertaking, both semantic and empirical.

The semantic hazard appears when Wagstaff quotes the Oxford English Dictionary’s definition of ‘definition’ as “a statement of the exact meaning of a word, especially in a dictionary.” This implies a fatal element of self-reference, which could invite the addendum: “. . . this definition of ‘definition’ is its most exact meaning because it is printed here, in this best of all extant dictionaries!” We are ‘threatened’ by such implicit self-reference all the time, but while it trips up artificial intelligence every time, we routinely evade the danger by intuiting what we mean by a word, regardless of its ‘exact definition’.

The empirical hazard arises to the extent that every definition conceals a latent hypothesis, and no hypothesis about ‘reality’ can claim to be either ‘final’ or ‘exact’. If the hypothesis later proves to be false (e.g. if later thinking abandons ‘altered state of consciousness’ as a cogent concept), then we

would be faced with two alternatives: that the word refers to something which doesn’t exist (e.g., ‘Santa Claus’ or ‘unicorn’), or else update its ‘final’ definition—so much for ‘final’. Lavoisier named oxygen ‘oxygen’ to connote ‘acid-producing’, but when acids were subsequently found not to require oxygen, chemists didn’t then scramble to find a new word for the gas they were already familiar with.

In any case, I find Wagstaff’s struggle with definition to be surprisingly illuminating, compelling, entertaining, etc., but especially sobering. Much is clarified along the way.

I am genuinely ambivalent about Wagstaff’s final definition of hypnosis either as “1) an alleged altered state of consciousness” or as “2) acceptance of the suggestion . . .” (p. 102) On the one hand, I find both arms of the definition lame (‘alleged’ and ‘acceptance of the suggestion’) and on the other I am gratified that this rigorous attempt to formulate a final definition (of anything purporting to be real) has failed.

We intend our words to designate real entities or phenomena, apart from how accurately they do so. In facing a patient, I intend my listing of their signs and symptoms to accurately designate objective and subjective aspects of their lived experience; I intend that the disorder named (the diagnosis) designate a real pathological entity, apart from how successful it is at doing so.

Consequently, I intend that ‘hypnosis’ designate a real state of consciousness which is different from the average expectable alert waking state, and which might be ‘trumped’

* McGill University,
3830 Lacombe,
Montréal, Québec
H3T 1M5 Canada
e-mail: john.oneil@
mcgill.ca

by certain other states such as those conventionally labelled as delirious, demented, obtunded, asleep, comatose, etc., but which could cut across certain other waking states, such as sleepy, hypervigilant, frightened, angry, depressed, rueful, etc.

And so I intend that ‘hypnosis’ name a particular kind of altered state of consciousness, but not an alleged altered state of consciousness. An alleged seizure or a subject’s absolute conviction about having had one would not suffice to distinguish a real seizure from a pseudoseizure. Objective indicators of altered states of consciousness are, of course, more subtle than, say, epileptic patterns on the EEG, but physiological indicators and advances in brain imaging may well become as clear for hypnotic states as the EEG is for a seizure. And just as there are a variety of EEGs for a variety of seizures, there may well be a variety of indicators for various altered states of consciousness which would map out what a hypnotic state and a meditative state have in common, and how they differ.

CLINICAL PRACTICE

In clinical practice, the reality of a hypnotic state is generally judged by the whole practical context of the encounter: the quality of the working alliance, what is required to induce a hypnotic state (rapidity, pacing, repetition), what can be accomplished in the hypnotic state, what is required to re-alert from the hypnotic state (again, rapidity, repetition, pacing), and the quality of recall of the hypnotic state upon re-alerting. What can be accomplished in the hypnotic state varies according to the presenting problems and psychic structure of the subject, as this can vary especially in the case of Dissociative Identity Disorder, one the most severe autohypnotic (dissociative) diagnoses.

Other diagnoses, such as PTSD, Somatoform Disorder, other Dissociative Disorders, or Borderline Personality Disorder, likewise typically have significant autohypnotic components. The great utility of such cases is that they are ‘hard’—they test the limits of any definition when

reinterpreted as a hypothesis. My assumption is that, as for anything else in medicine, pathology informs normality, and any generalization about normality is mistaken if it fails to embrace pathological cases.

What do such patients teach us? The patient may be referred because other people have observed them in states which they consider globally different, and for which the patient may claim amnesia. On arrival in the office, such a patient may begin ‘normally’ but then appear to enter an altered state of consciousness, which resolves only upon employing techniques generally considered as hypnotic re-alerting. So the first point to be made is that the question of re-alerting procedures is as important as the question of induction procedures.

When equal attention is paid to re-alerting to the present, then a number of issues can be further parsed in the question of definitions of hypnosis. Hypnotizability can intend two independent variables: ease and speed of entering an altered state, and the depth achieved—even if the two often covary. A patient may require a long and onerous induction to enter a hypnotic state, but then appear to be in very deep hypnotic trance, not only because of what is accomplished in that state, but also in the long and onerous re-alerting required to bring the patient back to the here and now. Again, objective measures may one day clarify differences between ‘easy shallow’ hypnotizability and ‘arduous deep’ hypnotizability.

SUGGESTION

The paper points out that suggestion has four interrelated but remarkably distinct applications: 1. Suggestibility independent of hypnosis; 2. Suggestions made in the course of any hypnotic induction; 3. the specific suggestion that the hypnotic induction is hypnotic; 4. Suggestibility once the subject is in the hypnotic state. I found the research on suggestion #3 especially interesting, and deal with this below under ‘Placebo effect’.

I am struck by the ubiquity of ‘suggestion’ throughout the paper, as if hypnosis can’t be addressed except in the context of

suggestion, and as if the discussion were limited to ‘normal’ subjects. I wondered if the author’s concerns reflect the research world of hypnosis quite distinct from the clinical world of hypnosis.

I certainly recognize that I routinely use suggestion #3—the suggestion that the induction I use will be a hypnotic induction, but I also endorse the well-known clinical adage that “all hypnosis is self-hypnosis”. In the cases I treat, many of the milder cases require formal hypnotic inductions with their usual suggestions (or invitations) for relaxation, cataplexy, visualization, etc., whereas more severe cases may merely call for my ‘permission’ to enter an altered state at a given point in the session. And I specifically promote competence in self-hypnosis in all cases that need it; I judge it preferable for someone in emotional turmoil, between sessions, to calm themselves autonomously rather than to rely on popping a pill. So any patient who has been in treatment with me for any length of time will dispense with the formal induction (and its suggestions), and enter the altered state when the appropriate moment arrives.

Once in the hypnotic state, suggestion is generally a decreasing part of the therapeutic work. At the outset, invitations to visualize

are common (e.g., a special or safe place; a workroom), and patients may be almost magically suggestible with regard to various peripheral details of hypnotic imagination but at the same time utterly impervious to any suggestion which tries to bypass or negate the core of the pathology. If they were globally ‘suggestible’ in the conventional sense, then they could be easily suggested back to mental health. Not at all the case! Suggestion is subordinated to the general therapeutic ethos, and this leaves it by the wayside, as regards the core of hypnosis.

PLACEBO EFFECT

I interpret the increased response of subjects who are told that the induction they are about to undergo is a hypnotic one as a placebo effect—the effect of what the word ‘hypnosis’ connotes to the subject. Similarly, it would be interesting to see whether a subset of subjects have a nocebo effect to the suggestion—a specific inhibition to entering an altered state when told that this is the intent. These are interesting and testable questions.

In conclusion, I thank Wagstaff for his clarity and exhaustive survey of the literature, and look forward to further debate about these fundamental issues.

REFERENCE

- Wagstaff, G. F. (2014). On the Centrality of the Concept of an Altered State to Definitions of Hypnosis. *Journal of Mind–Body Regulation*, 2(2), 90–108.