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THE VALENCIA MODEL OF WAKING HYPNOSIS. NEW OR INNOVATIVE TECHNIQUES?

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The Valencia model of waking hypnosis presents some innovative features that allow an efficient and integrative use of hypnosis. The way hypnosis is presented to patients avoids trance explanations, or pathological-like terms. The hypnotized persons keep their eyes open while talking fluently. Moreover, hypnosis is contextualized as a general coping skill for self-control that uses the self-regulatory functions of the brain. This perspective is more permissive than the old conceptions of waking hypnosis, and involves the client more in the psychotherapy process. In addition, the model is integrative, as it has developed suggestion procedures to change the meaning of the patients' "symptoms", and their attitudes toward them. Thus, it is an approach that includes ideas from other psychotherapeutic perspectives. Experimental research shows that the Valencia model procedures are efficient and powerful to promote suggestions. Nevertheless, empirical evidence for its clinical applications is very scarce, and consequently, more research in needed.
Key words: *waking hypnosis, suggestion, psychological treatment, psychological intervention, cognitive-behavioral, psychotherapy.*

El Modelo de Valencia de Hipnosis Despierta presenta varias características innovadoras que permiten un uso eficiente e integrador de la hipnosis: la forma de presentarla al cliente evita un lenguaje tranceático o palabras "patologiformes", mostrándola como una estrategia general de afrontamiento y de auto-control, que usa las propiedades auto-regulatorias del cerebro. El paciente hipnotizado está con los ojos abiertos y conversando fluidamente. Esta perspectiva es más permisiva con el cliente y le responsabiliza más sobre su papel en el tratamiento que las perspectivas clásicas de hipnosis despierta. Además, trata de integrar distintas formas de intervención clínica, desarrollando procedimientos para el cambio del significado de los "síntomas", y de la actitud hacia ellos. La investigación experimental muestra la potencia y eficiencia de estos procedimientos para promover sugestiones, pero todavía carece de evidencia empírica en cuanto a su aplicación clínica.
Palabras clave: *hipnosis despierta, tratamiento psicológico, intervención psicológica, cognitivo-comportamental, sugestión, psicoterapia.*

Habitually, whenever we mention our interest in hypnosis, people bombard us with questions such as: Is hypnosis real? Could I remember things about my infancy under hypnosis? Could I have access to my subconscious under hypnosis? If, in addition, we say that it is not necessary for the hypnotized person to close his eyes and he can go on talking fluently, or walking, they are really surprised, and the amount of questions increases exponentially. What most laymen, and even professionals from psychology and medicine, intuit about hypnosis does not correspond to its experimental reality and its clinical application, due to the weight of the myths and erroneous beliefs about hypnosis. Perhaps that is why hypnosis is a technique that is not used very much in Spain by psychology professionals (Capafons & Mendoza, in press). These researchers indicate that, out of almost 800 psychology professionals interviewed, only 15.2% said they used hypnosis regularly, and only 7.6% knew about waking hypnosis (all those who responded referred to the Valencia model), and 9.2% knew about active-alert hypnosis. However, the psychologists who do use waking hypnosis consider it a useful technique, and easily and agreeably accepted by patients (Capafons & Mendoza, in press). Capafons and Mendoza also reviewed references of waking hypnosis in the current databases, finding very few clinical and experimental studies about it. This lack of information about and interest in waking hypnosis in Spain cannot be explained because it is recent—it is not—because Wells published a work on it back in 1924, and, before him, Carpenter (1852). It may more likely be due to the fact that it has been ignored in the research and clinical application in the Anglo-Saxon world. Probably, in the field of hypnosis, little attention has been paid to its "waking" variety

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because it was not in accordance with the general idea of hypnosis as a state of trance and sleep-walking (Sarbin & Coe, 1972). Therefore, we can answer the question posed in the title of this work about whether the Valencia model of waking hypnosis is a new technique. According to the Royal Academy of Language, *new*, among other things, means recently made or manufactured, what one sees or hears for the first time, repeated differently from what went before or from what one had learned, or that is added to what there was before, repeated or reiterated to renew it. Except for the last two definitions, the Valencia model of waking hypnosis, according to the rest of these definitions, is not a new technique. However, the word *innovative*, which, according to this Academy, means to change or modify something, introducing novelties, and, strangely enough, to return something to its former state, could define the model of waking hypnosis we are presenting. To sum up, our model is more innovative than new, like almost everything that is presented as "new" in psychology since the decade of the 80s. We defend that the Valencia model of waking hypnosis is innovative with regard to Wells' (1924) original use because it introduces novelties, such as, for example, that it is not so authoritarian, it revolves around self-hypnosis, and it promotes a different vocabulary to describe and use hypnosis than the one used by Wells, and also by authors who study active-alert hypnosis or some Ericksonian approaches. In this sense, it is also innovative and different from other more recent approaches to waking hypnosis (Iglesias & Iglesias, 2005), as our model of intervention and hypnosis is cognitive-behavioral.

WHAT IS WAKING HYPNOSIS?

The word "waking" refers to methods where the person does not need to be relaxed or to close his eyes in order to benefit from the suggestion. It is a way of differentiating these suggestion methods from the traditional methods, without meaning that the hypnotized person is not awake in the traditional methods by relaxation. We also use the word hypnosis to clearly designate that an induction ritual that is labelled *hypnotic*. Therefore, waking hypnosis can be considered as merely waking suggestion, which is used without this series of induction rituals. In contrast, it is important to clarify that when we talk about the Valencia model of waking hypnosis, we refer to a clinical procedure, and to a series of methods to change attitudes and use suggestions, with the following characteristics:

1. The person remains with eyes open.
2. Drowsiness or relaxation is not suggested, but instead activity and mental expansion.
3. The hypnotized person can talk fluently, walk, and perform daily tasks while experiencing the hypnotic suggestions.
4. It avoids suggesting trance, altered states of awareness, etc., paying attention to the vocabulary used to present hypnosis as a general coping strategy

These characteristics differentiate it from alert and active-alert hypnosis, because in waking hypnosis, it is suggested from the beginning that the person keeps his eyes open and that he talks naturally and fluently with the therapist, in addition to being presented as a self-control and coping strategy (Capafons, 2001a).

WHY WAKING HYPNOSIS?

We can consider two chief reasons: firstly, because it is a hypnotic technique, and, in this sense, it is highly probably to reveal the advantages of such techniques. When used as a single intervention, hypnosis does not seem effective to treat medical and/or psychological problems (Flammer & Bongartz, 2003). But when used as an adjunct, it seems to increase the efficacy of some psychological and medical interventions, especially in the case of pain, in which it is a well established treatment (Montgomery & Schnur, 2005). Hypnosis can also increase the efficiency of some treatments. In fact, Green and Lynn (2000) consider it an efficient technique to reduce the consumption of cigarettes, and Schoenberger (2000), an efficient adjunct in cognitive-behavioral treatments. Secondly, waking hypnosis has a series of added advantages over traditional hypnosis. Wells (1924) mentioned some of them: it avoids the appearance of being a mysterious procedure; it is faster and easier, both for the therapist and for the patient, and it can be used successfully in a higher number of subjects.

Thus, the Valencia model of waking hypnosis presents some advantages that justify its use:

- Like the waking hypnosis proposed by Wells (1924), as the person keeps his/her eyes open, there is less fear of losing control. Although control is not lost under any hypnotic condition, not closing one's eyes reinforces this idea. In this sense, it offers more possibilities as it is quicker, more accessible, and pleasant for a larger amount of subjects.
- Moreover, in contrast to Wells' model, which was very authoritarian and promoted the person's passivity

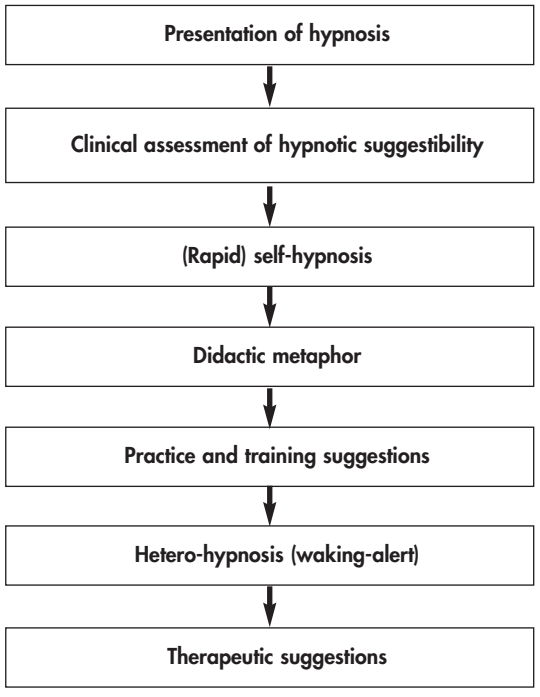
(John F. Chaves, personal communication to the second author, 12-1-2005), a strong characteristic of the Valencia model of waking hypnosis is that it favors the person's active participation while increasing the possibilities of therapy action (it is more versatile), because the hypnotized person can carry out any kind of habitual behavior, including in this behavioral repertory those behaviors required for therapy functioning: role-playing, in vivo exposure, etc. (Capafons, 1998b). Motivation for treatment and expectation of success are thus promoted (Capafons, 2001a).

- Lastly, the Valencia model presents waking hypnosis as a general skill strategy, for coping and self-control (Capafons, 1998b; 2001a), beyond a context of trance, in contrast to Wells' (1924) model.

ELEMENTS AND PROCEDURE OF THE VALENCIA MODEL OF WAKING HYPNOSIS

This model is based on the socio-cognitive or cognitive-behavioral paradigm of hypnosis. This is the first time that the topic of waking hypnosis is approached disregarding the concept of trance and defending the continuity between hypnotic and habitual behavior, resorting to variables such as expectations, motivation, attitudes, beliefs, etc. (Capafons, 1999; Lynn & Kirsch, 2005; Spanos & Coe, 1992). However, perhaps the most innovative aspect is the sequence we propose to manage the hypnotic suggestion, and which guides the practice of hypnosis, either waking or otherwise (Figure 1).

FIGURE 1
CLINICAL INTERVENTION SEQUENCE OF THE VALENCIA MODEL OF WAKING HYPNOSIS



Modified from Capafons, A. (2001a) Hipnosis [Hypnosis]. Madrid: Síntesis

Implicit in this sequence is our concern with generating efficient methods that are pleasant for the patient, quick, easy to learn and to apply (both for the patient and for therapist) and that reduce the percentage of dropouts as much as possible (Alarcón, Capafons, Bayot, & Cardeña, 1999). In this study, empirical evidence indicates that the efficiency of a therapeutic program to which is added hypnosis, may depend in particular on the induction method employed (Capafons, 2001b). Induction methods are efficient, depending on their own characteristics, the explanation of hypnosis offered to patients, and the expectations hypnosis generates in them (Capafons, 2001b; Lynn, Nash, Rhue, Frauman, & Sweeney, 1984). Hypnosis seems to help more when it promotes realistic expectations and positive attitudes (Schoenberger, 2000). Therefore, the Valencia model of waking hypnosis attempts to merge methods of changing attitudes towards hypnosis with induction methods and ways of dealing with the suggestions that enhance the pleasure and involvement of the person to be hypnotized in the intervention process.

Thus, the Valencia model of waking hypnosis includes three procedures to establish a good rapport, from a cognitive-behavioral viewpoint of hypnosis: the cognitive-behavioral presentation of hypnosis, clinical assessment of hypnotic suggestibility, and a didactic metaphor about hypnosis. Two methods of waking hypnosis are added to these procedures (Rapid Self-Hypnosis and (hetero) Waking-Alert Hypnosis), conforming the method we shall develop below. It is a structured but flexible sequence, whose central axis is Rapid Self-Hypnosis (RSH) (Capafons, 1998b). The ultimate idea is that the patients can inconspicuously activate the therapeutic suggestions in everyday situations where they need them (Capafons, 1999).

COGNITIVE-BEHAVIORAL PRESENTATION OF HYPNOSIS

When using hypnosis as adjunct of a treatment, it is advisable to appraise the patient's beliefs and attitudes

(Capafons et al., 2005), as inadequate expectancies modulate response to suggestion negatively (Kirsch, 1999). Therefore, some therapy time should be spent clarifying erroneous concepts so as not to generate false expectancies and to offer accurate information that corresponds to research. The goal of the cognitive-behavioral presentation is that patients experience for themselves certain reactions that help them to understand what can be expected from hypnosis. Therefore, the presentation includes a motor exercise with the Chevreul pendulum that illustrates the difference between "automatic" and "involuntary," reinforcing the concept of "interference," which is essential for the patient to begin to understand hypnosis as a self-control technique. Also, a comparison between going to the movies and being hypnotized is established, so that a piece of fiction can determine automatic and intense, but voluntary, responses (Capafons 2001a).

This presentation is an attempt to transmit the following ideas: a) responses to suggestions are actions of the user, the therapist only helps; b) these actions are automatic, but voluntary, although they are experienced as happenings; c) whatever occurs during hypnosis depends on the client using similar resources to other everyday actions (for example, letting himself be carried away by a piece of fiction, like in the movies); d) hypnosis involves everyday reactions that are activated or deactivated voluntarily; e) therefore, hypnosis is a way of self-control; f) being hypnotized does not mean being in a trance or the like, but having one's mind prepared to use the resources that, also in daily life, cause responses we perceive as automatic.

The presentation reveals hypnosis as a voluntary process of the client, avoiding words such as "trance," "dissociation," or "altered awareness," that may be associated with the idea of loss of control, generating fear or even direct rejection in some patients (thus losing efficiency). The experimental results indicate that when making this, or a neutral, presentation, there are significantly less dropouts among people who openly reject hypnosis if they are offered hetero-hypnosis than if hypnosis is labeled as a state of trance (Capafons et al., submitted for publication). However, if offered self-hypnosis, dropouts disappear and there are no differences between the three types of presentations (neutral, trance, cognitive-behavioral) when changing negative attitudes towards hypnosis (Capafons et al., 2005). The explanation could be that self-hypnosis may reinforce the belief that they will not lose control, thus increasing the client's sense of security and confidence. Therefore, the cognitive-behavioral presentation is far from mysterious or "pathologiform" conceptions of hypnosis, and this will be used during the rest of the intervention to motivate the client to experience the suggestions.

COGNITIVE-BEHAVIORAL ASSESSMENT OF HYPNOTIC SUGGESTABILITY

In this model, the attitude towards hypnosis and towards the therapist, and whether the person collaborates within a context of trust are assessed. For this purpose, classic hypnosis exercises are used, granting them a different meaning. As there is a high correlation between giving the same suggestions under hypnosis and out of hypnosis (Hilgard, 1965), the initial assessment is performed out of the hypnotic context (Capafons, 2001a). Thus, we facilitate the client's becoming more familiar with waking hypnosis. For example, in the first exercise of postural swaying, it is suggested that, while the person remains with closed eyes, feet together, and body relaxed, his body starts to sway. If upon listening to this suggestion, the patient sways slightly, this means he is not interfering, because this movement is expectable without the intervention of any suggestion. If the patient sways ostensibly, we assume he is collaborating and experiencing the effect of the suggestion and, therefore, his attitude is positive and his expectation is adequate. In the second exercise (falling backwards), the first step is to show the patient that he has complete control to prevent the therapist from letting him fall backwards without catching him. For example, the person is asked to throw himself backwards to verify that the therapist can catch him. Subsequently, the therapist talks to the client (who has his eyes closed) from various places so the client can make sure from the therapist's voice that he knows at all times that the therapist is at the right distance and place to be able to catch him. Then, and in the same position as the swaying exercise, it is suggested to the patient that he will notice a lack of balance and will fall backwards. If the patient falls backwards, we conclude that he clearly trusts the therapist. If he also felt the lack of balance, we assume that he experienced the suggestion. But if, despite noticing the lack of balance, the patient interferes with the fall, we can conclude he has a negative attitude, especially if he really fell backwards when asked to do so to verify that the therapist could catch him. He may have

a negative attitude towards hypnosis and not towards the therapist, because otherwise, he would have refused to fall backwards in this test. Finally, we proceed to apply a few more exercises, more or less along the same lines, and that we will not comment upon to save space.

As can be seen, the way we use and interpret these classic exercises is different from the habitual way, innovating when assessing attitudes and expectations qualitatively, and hey are very useful to determine the patient's predisposition to collaborate and become involved in therapy. In fact, the way these exercises are used is an attempt to generate expectations of success in the client, so he will accept the high probability of responding to the therapeutic suggestions. Lastly, all the exercises are valuable also because they provide information about the steps that are a part of the different self-hypnosis methods that are used in the intervention.

THE METHOD OF RAPID SELF-HYPNOSIS (RSH)

This is the main axis of the Valencia model (Capafons, 1998a, b). Other elements of the model (presentation of hypnosis, assessment, and didactic metaphor) are useful for any kind of hypnosis, especially if used from a cognitive-behavioral and self-control perspective. For this purpose and depending on the circumstances, clients, problem, etc., the adequacy of each element should be assessed. However, RSH is essential to apply the Valencia model of waking hypnosis coherently. As indicated by Lynn, Kirsch, and Rhue (1996), defining the hypnotic experience as self-hypnosis decreases clients' reticence and involves them actively in the therapeutic process. There is also experimental evidence showing that to start with self-hypnosis facilitates subsequent response to the suggestions and to hetero-hypnosis (Jonson, Dawson, Clark, & Sikorsky, 1983). Specifically, RSH has the following characteristics (Capafons, 2004): a) speed, essential so it can be used efficiently in situations where the patient needs it; b) inadvertence and structuring of the steps to be performed; c) easy to learn, facilitated by its connection with the exercises to assess suggestibility, which also facilitates the expectations that these steps will be effective; d) the self-suggestions are given with open eyes (Capafons & Mendoza, in press).

There are three steps (pressing hands, falling backwards, and arm immobility) in RSH, designed to instigate sensations of relaxation, heaviness, and body immobility (this is explained to the client), although some people may experience sensations of weightlessness and levitation. In this case, the procedure is adapted to match the patients' needs. The rationale offered to the client is that these exercises are designed to activate the brain so it can function rapidly and efficiently. The therapist models the steps over the entire learning process, including the process of fading the clear and visible movements in the long version of RSH (Capafons, 2001a; 2004). Compliance with a challenging suggestion (difficulty to raise one's arm) is the sign that the person is under self-hypnosis. At first, the client may go through the learning process with open eyes if he so prefers. Once he has learned, he is instructed so he can activate the whole process without the need of the first two steps, and with open eyes. He will only have to reproduce the sensation of his hand being stuck to his leg or something similar (dissociation from his arm) to "activate" his brain. For this purpose, the therapist should explain the concept of sensory/emotional recall (Kroger & Fezler, 1976). By using arm dissociation as a method of induction-confirmation of being self-hypnotized (short version), we are already using waking hypnosis. The person feels activated, with open eyes, maintaining a "natural" body position and fluent conversation, with all the advantages this has for generalization to daily life of the advances achieved in therapy (Capafons, 2001a). The experimental results in RSH reveal its efficacy to promote responses to suggestions, and show it to be more efficient (pleasant and preferred) than Spiegel and Spiegel's (1978) eye-roll method. In contrast, the short version of RSH is more powerful, pleasant and preferred than the long version (Martínez-Tendero, Capafons, Weber, & Cardeña, 2001; Reig, Capafons, Bayot, & Bustillo, 2001).

THE DIDACTIC METAPHOR. CONSOLIDATION IN CHANGING ATTITUDES

Once the client has experienced self-hypnosis, he is presented with a metaphor whose purpose is to consolidate the following ideas: hypnosis is not dangerous, effort and perseverance are required to achieve behavioral change, and it is an important instrument, but it is an adjunct. The metaphor is used as a didactic resource that helps the client to consolidate and remember the information about hypnosis (Porush, 1987). Once self-hypnotized, the client is asked to imagine himself facing a series of fictitious difficulties (surviving in a jungle) that he solves successfully, thanks to his effort and the correct use of a machete that represents hypnosis (Capafons, 2001a). Research shows that, after

listening to the metaphor, most of the participants change their opinion about hypnosis, accepting it as an adjuvant technique for self-control (Capafons, Alarcón, & Hemmings, 1999).

Hetero-Waking-Alert Hypnosis (WAH) (alert hand)

(Hetero)-Waking-Alert Hypnosis (WAH) is used in this model as a complement and support to RSH, especially with patients who present more difficulties with self-hypnosis because they prefer to be hypnotized by the therapist (Capafons, 1998a; 2001a). The therapist may hypnotize the patient in order to reinforce the efficacy of the self-suggestions administered using self-hypnosis (Capafons, 2001a; 2004). Normally, it is suggested that RSH is more efficient to activate the client's resources, and it will be successful in modulating, regulating, and producing therapeutic change (Capafons & Mendoza, in press). In contrast, with this technique, the patient is encouraged to keep his eyes open, to adopt the appearance of an active person, and even to be able to carry on a conversation with the therapist (similar to RSH). WAH requires a slight physical exercise (moving the dominant hand rhythmically until the movement becomes automatic) that helps evoke a general activation, so the client can walk while he remains hypnotized. This induction method includes suggestions of an expanded mind, increased heart-beat, breathing, and speed of brain functioning. Research indicates that WAH has certain advantages over other techniques such as active-alert hypnosis (Bányai, Zseni, & Túry, 1993) because: a) it is more pleasant (Cardeña, Alarcón, Capafons, & Bayot, 1998) and it promotes a higher level of suggestion (Alarcón, Capafons, Bayot, & Cárdena, 1999); b) it includes prior exercises to prevent patients from confusing being activated with being anxious, which could otherwise occur (Ludwig & Lyle, 1964); c) it is less bothersome than the Bányai method, as it does not require an ergonomic bicycle or a very large room; d) the WAH-hypnotized person keeps his eyes open, which does not always occur with the active-alert Bányai method; e) it produces a lower number of dropouts than the active-alert method.

THE CLINICAL PROCEDURE OF THE VALENCIA MODEL OF WAKING HYPNOSIS

The essential idea is to convince the client, by using hypnotic suggestions, that he has more possibilities of overcoming his problem than he thinks. This is to increase the expectations of personal efficacy and of results (Kirsch, 1985; 1986), promoting the client's motivation to engage in the intervention. This is common to the use of traditional hypnosis (Barber, 1985). In our case, it goes one step further, to the extent that the suggestions are given with open eyes. This allows us to set up a game with the patient, who begins to verify that a series of stimuli (pencils, watches, or any object, even imaginary ones) can provoke reactions that they would not naturally produce. For example, it can be suggested to the patient that to see or touch a clock can provoke heaviness. After some time, the opposite reaction can be suggested, so that the patient experience a sense of weightlessness when seeing or touching a clock. These exercises allow us to ask the client three key questions:

1. "How can some objects evoke different reactions, when there is no reason for them to provoke any of them naturally?" The answer is obvious: the way of thinking and talking about them (giving oneself suggestions), and allowing the brain to put its self-regulatory mechanisms into practice (a correct passive attitude, in terms of Frankl's [1985] logotherapy).
2. The next question is also obvious: "Can the magnitude, form, characteristics, etc., of your problem (for which the patient comes to therapy) depend on your not using your language and thinking correctly, thus hindering your brain's self-regulatory functions?" The answer is also simple: it seems affirmative, because the person has experienced different emotions depending on the self-suggestions.
3. Finally, the third key question is asked: "If, with the help of hypnosis, you managed to notice weightlessness, and a little later, heaviness, and later immobility, to finish with extreme activity, don't you think you could experience other things that would help you to overcome your problem?" The answer is also in this case, affirmative.

People usually answer these three questions appropriately, and the meaning of their "symptoms" changes: they are no longer something immobile that occurs out of their control, but instead, it is their attitude and understanding of the problem which modulates and even determines part of it, or at least its maintenance. In this sense, our model merges the behavioral tradition, the humanist-experiential traditions of Logotherapy, and even Ego Psychoanalysis (Korchin, 1976), in which the meaning

and attitude towards one's "symptoms" are elements that promote the symptoms and prevent their diminution. Therefore, with our model, we try to modify the interpretation of the meaning, but using a basically behavioral terminology and procedure, derived rigorously from experimental research. In this sense also, the Valencia model of waking hypnosis is innovative, but not "new." We believe that the strategic tradition, even ego psychoanalysis or logotherapy (Hutzell & Lantz, 1994) would find points in common with our model. If we point out to these authors that we use metaphors, we promote a correct passive attitude when necessary (to stop fighting the symptom uselessly), we use the person's own strategies, etc., this might make them think that we are discovering the Mediterranean. Perhaps the most innovative aspect of the Valencia model is that the suggestive exercises performed are fun (efficiency), the language and behavioral intervention strategies employed, and that it systematically adheres to the principles and results obtained in experimental research on hypnosis.

CLINICAL RESEARCH

A large part of the efforts of the research team of Valencia were aimed at the experimental validation of their model of waking hypnosis. However, there are very few studies about its clinical efficacy (Capafons & Mendoza, in press). There is currently only one study published (Mendoza, 2000), that uses an $N = 1$ design, which suggests the efficacy of the model in smoking cessation. Moreover, a preliminary investigation (Martínez-Valero et al, in preparation) shows that a cognitive-behavioral treatment plus hypnosis and medication is more effective than the same treatment without hypnosis, and than only medication, in the treatment of fybromyalgia.

In general, clinicians' experience with waking hypnosis is positive, observing a great potential as an adjunct (Capafons & Mendoza, in press). For example, we relate the case of a patient, a lyrical singer, whose aim was to increase his self-confidence and assurance when facing his public, as he had physical difficulties performing to his full potential. Among other aspects, negative thoughts about anticipatory anxiety were addressed, and he was instructed in RSH. The patient, pleasantly surprised, said that this was a great help to him right when acting. He was capable of practicing the technique in very few seconds and of administering the chosen self-suggestions when facing his public. Moreover, he commented that knowing that he could use RSH at any time made him feel very secure. At follow-up, this patient used the technique to get on with his mother, with whom he used to have arguments, to sleep calmly the night before a gala performance, or to rehearse his songs more efficiently and without getting nervous. To sum up, this patient had learned a useful way of self-control. This experience is in accordance with that of other clinicians: RSH promotes the generalization of responses, which reveals its value as a general coping strategy.

CONCLUSIONS

In general, it is very difficult to create something absolutely new. Surely, "to discover or rediscover" is different from "inventing something." Perhaps this is one of the novel contributions of the Valencia model of waking hypnosis: to rediscover waking hypnosis 70 years after its birth, but providing it with a new perspective, starting out from behavioral-socio-cognitive assumptions of hypnosis (Sarbin & Coe, 1972; Kirsch & Lynn, 1998) and under the support of empirical research. The model suggests some directions to follow, but allowing one to adapt flexibly to the characteristics of each case. This approach to waking hypnosis is very careful in its use of language. No reference is made to trance or altered states of awareness, to prevent scaring or discouraging clients. Moreover, it emphasizes self-control and perseverance. Finally, it is an attempt to integrate different perspectives of clinical psychological intervention, using hypnosis as a central argument, but also as an adjunctive technique. Therefore, this model considers waking hypnosis a possible alternative and complement to the traditional use of hypnosis, using techniques and suggestive, pleasant, useful, easy to learn and to teach, and, ultimately, efficient practices. Only future research will indicate whether the Valencia model is also an efficient clinical way to use hypnosis as an adjunct. For the time being, the professionals' experience, always heuristic, is affirmative.

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