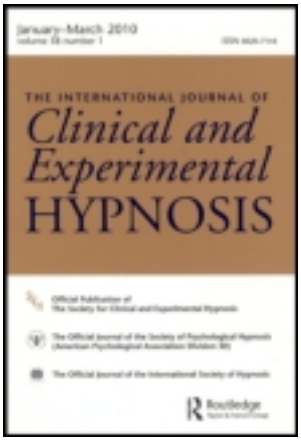

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Motor and Sensory Dissociative Phenomena Associated with Induced Catalepsy: A Brief Communication

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MOTOR AND SENSORY DISSOCIATIVE PHENOMENA ASSOCIATED WITH INDUCED CATALEPSY: *A Brief Communication*

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Abstract: The purpose of this study was to investigate dissociative symptoms that may occur as an epiphenomenon of tactile-induced catalepsy. In 15 participants, catalepsy was induced in the right arm, and dissociative symptoms were evaluated using a self-report questionnaire. In comparison with the left, noncataleptic arm, the right cataleptic arm was perceived differently. In addition to increased rigidity, the cataleptic arm was characterized by the presence of paresthesias, a decreased perception of sense and a decreased awareness of the arm. Moreover, the self-reported changes in perception were significantly correlated to the hypnotically induced arm-immobilization part of the Stanford Hypnotic Susceptibility Scale. In conclusion, catalepsy induction elicits a variety of dissociative symptoms and provides a useful research paradigm for the study of motor-perceptual dissociative phenomena.

Catalepsy refers to a state of waxy-flexibility and tonic immobility in one or more body parts. It has been observed to occur as a defensive reaction toward stress both in animals and humans (Gallup & Maser, 1977) and is sometimes referred to as freezing (Kulikova, Kozlachkova, Maslova, & Popova, 1993) or somatoform dissociation (Nijenhuis,

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Spinhoven, Vanderlinden, Van Dyck, & Van der Hart, 1998). Apart from the stress context, the phenomenon of catalepsy can be elicited in a hypnotic context (Diehl, Meyer, Ulrich, & Meinig, 1989; Grond, Pawlik, Walter, Lesch, & Heiss, 1995; Sacerdote, 1970a, 1970b), which might provide a useful research paradigm for the study of motor and sensory dissociative experiences. However, in most studies in which hypnotic techniques are applied to elicit catalepsy, it remains unclear how catalepsy was induced. This makes it hard to replicate the results and interpret the findings. Also, although catalepsy induction is meant to provoke stiffness and waxy-flexibility, other co-occurring dissociative symptoms have hardly been studied. The present study is set up to list dissociative symptoms that occur as an epiphenomenon after induced catalepsy. Once catalepsy induction is standardized and co-occurring dissociative symptoms are studied, catalepsy could become a useful research paradigm in provoking motor-perceptual dissociative phenomena.

Sacerdote (1970a, 1970b) was the first to apply the induction of catalepsy for therapeutic purposes. He described the technique as (conducted) inversed-hand levitation. To achieve catalepsy, he placed the elbow of the person on the armrest of the chair the person was sitting in. He then took the wrist and lifted the arm in a vertical position. By alternately supporting and releasing the forearm, he induced catalepsy. Sacerdote (1970a, 1970b) discovered catalepsy could not only be used as a hypnotic induction technique but the altered perception of the cataleptic hand could also diminish pain sensations.

In Kihlstrom's information processing theory, dissociation is described as a disruption of the normal integrative functions of consciousness and sensory and motor processes (Kihlstrom, 1992). When applying Kihlstrom's dissociation theory to catalepsy, one could assume this disruption concerns sensorimotor functions, resulting in a change in the perception of (parts of) the cataleptic body. For example, in arm catalepsy, there is no longer an explicit awareness that the arm can be moved. Although objectively nothing is wrong with the arm, the person perceives the arm as stiff and is not able to bend it. Some evidence is also found for the idea that sensory information processing changes during catalepsy (Diehl et al., 1989). For example, a PET study found a state of total body catalepsy to be related to a deactivation of primary visual and (less significantly) primary auditory areas. This may reflect a shift in selective attention away from external stimuli and toward internal sensations (Grond et al., 1995).

Although Sacerdote (1970a) noticed diminished pain perception after catalepsy induction and some evidence for a change of sensorimotor processing has been found in neuroimaging studies, co-occuring dissociative phenomena have never been closely studied. In the present study we investigated changes in self-reported motor and sensory experiences. First, we hypothesized that phenomena other than stiffness will co-occur in the cataleptic body part. This means the

cataleptic arm will be perceived as stiff and difficult to move, but there will also be symptoms like paresthesias, with the arm feeling gone, strange, unreal, or not belonging to the person. We constructed a questionnaire to measure these co-occurring phenomena. Second, we expected participants with high hypnotic susceptibility to show more dissociative symptoms in the cataleptic arm than participants with low hypnotic susceptibility. Finally, we expected dissociative symptoms after tactile catalepsy induction to be related to hypnotic suggestions of catalepsy and arm immobilization.

METHOD

Participants

A total of 15 right-handed female undergraduate university students, of whom most (12) were previously tested for hypnotic susceptibility in a Dutch normative study of the Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C; Näring, Roelofs, & Hoogduin, 2001), participated in the present study. They were randomly selected and participated voluntarily. The mean age of the participants was 22 years and 1 month (*SD*, 2 years and 2 months). The mean score on the SHSS:C was 6.67 (*SD*, 2.02, range 4–10; $N = 12$), indicating that the hypnotic susceptibility was high following the norms for Dutch students (Näring, Roelofs, & Hoogduin).

Measures

Dissociative phenomena during catalepsy were measured by the *Catalepsy Questionnaire* (CQ; Roelofs & Hoogduin, 1999), a 22-item questionnaire that was constructed by two of the authors because no suitable measure was available yet (see Appendix A for the complete questionnaire). The CQ assesses changes in perception of both the right and the left arm. Ten items addressed the right arm, ten identical items addressed the left arm, and two items addressed both arms. Each item could be rated on a 5-point Likert scale (1 = *not at all* to 5 = *yes, totally*). The scores of Items 1, 5, 9, 10, 13, 15, and 22 had to be reversed, so scores on all items indicated more presence of that particular symptom. Examples of items are "It felt as if it was hard to bend the right arm" and "It felt as if the left arm was heavy." The 22 items were clustered in three categories: "Both right and left arm" consisted of Items 7 and 22, "Catalepsy" consisted of Items 1, 3, 8, and 15, and "Dissociative symptoms" consisted of the remaining 16 items.

The Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C; Weitzenhoffer & Hilgard, 1962) is designed to measure hypnotic susceptibility, classified into four categories: ideomotor actions, response inhibitions, cognitive distortions, and posthypnotic suggestions. After a standard hypnotic induction, 12 items of progressively greater difficulty are given. The scale showed good reliability (Hilgard, 1965).

Procedure

The participants sat in a comfortable chair with steady armrests. They had to put both arms on an armrest. The experimenter took a place at the right side of the participant and took her right arm, after having asked permission to touch that arm. Then, he induced catalepsy in that arm following the catalepsy protocol (see Appendix B for the complete protocol), based on the reversed hand levitation described by Sacerdote (1970a). It took only a few minutes for each participant to reach a right-arm cataleptic state. After a short mental rotation task (not part of the present study, for details about that study, see Roelofs, Hoogduin, & Keijsers, 2002), the participant was told to shake her arms and hands so the catalepsy would disappear. All participants reported the arm being perceived as usual after they had shaken their arms. Then, the participants had to fill out the CQ, which was presented by a different experimenter (see Table 1 for mean scores per item). All experimental sessions were recorded on videotape, and a random check was done afterward for whether any suggestions were made during the catalepsy induction that could interfere with the research question. This was not the case. The SHSS:C was assessed at least 4 weeks earlier, being part of a different, independent study. As a result, the assessment of the SHSS:C, the induction of the catalepsy, and the presentation of the CQ were all done by different persons.

RESULTS

First, paired t tests were conducted to check whether the participants perceived the arm as cataleptic (see Table 2). A significant difference in reported sensations of catalepsy was found between the left and the right arm, t (14) = –8.42, $p < .001$. A significant difference in perception of the right versus the left arm was found, t (14) = –12.79, $p < .001$, demonstrating that in addition to stiffness and a feeling of rigidity, dissociative symptoms occurred more in the cataleptic arm than in the noncataleptic arm. The total score on the two items that represent perceived difference between both arms (M = 3.46, SD = 1.39, range 2–10) indicates that the right arm was indeed perceived as different than the left arm.

To check whether hypnotic susceptibility was related to changes in perception of both the left and the right arm, correlations between the total SHSS:C score and the total score on the CQ were calculated. Interestingly, there was no significant correlation between the total SHSS:C score and the CQ score for both the normal left, r = .17, p = .61, and cataleptic right arm, r = .40, p = .20.

Finally, the third hypothesis was addressed: the relationship between tactile catalepsy induction and hypnotic induction of catalepsy (Item 5

Table 1
*Means (*SDs*) on Each Item of Catalepsy Questionnaire (*N = *15)*

Item	Right arm	Left arm
Easy to bend	1.93 (1.10)	4.40 (1.18)
A tingling feeling	4.00 (1.36)	1.07 (0.26)
Hard to bend	3.93 (1.10)	1.40 (0.63)
As if the arm was light	3.00 (1.56)	2.33 (1.18)
As if the entire arm belonged to you	2.67 (1.18)	3.53 (1.51)
As if the arm felt strange	4.13 (0.83)	1.13 (0.35)
A normal feeling in the arm	1.80 (1.21)	4.80 (0.41)
As if (a part of) the arm was gone or unreal	3.60 (0.99)	1.00 (0.00)
A numb feeling	4.00 (0.93)	1.07 (0.26)
As if the arm was heavy	3.00 (1.41)	1.53 (0.74)
As if both arms felt different from normal	1.73 (1.03)	
No differences experienced between the left and the right arm	1.69 (1.18)	

Note. The range of each item is 1 = *not at all* to 5 = *completely*.

Table 2
*Means (*SDs*) of Cataleptic and Dissociative Symptoms in Both Arms (*N = *15)*

	Left arm	Right arm
Catalepsy*	3.00 (1.46)	8.00 (1.46)
Dissociative symptoms**	11.80 (2.11)	29.27 (4.96)

*Catalepsy range 0–10. **Dissociative symptoms range 8–40.

of the SHSS:C) and arm immobilization (Item 8 of the SHSS:C). Analysis of the relation between CQ scores (right arm) and the two motor items of the SHSS:C (arm immobilization and catalepsy), separately, demonstrated a significant correlation between CQ score and SHSS:C arm immobilization, $r = .63$, $p < .05$, but not between CQ score and SHSS:C catalepsy, $r = -.16$, $p = .62$. No correlation was found for the CQ scores of the left arm, $r = -.13$, $p = .69$, and $r = .35$, $p = .27$, for arm immobilization and catalepsy, respectively.

DISCUSSION

The present study showed tactile induced catalepsy could be induced effectively, as was shown by the fact that participants reported difficulty in bending their cataleptic arm and perceiving it as being stiff. Although not mentioned in the catalepsy induction, other dissociative symptoms

besides stiffness—like the cataleptic arm being perceived as "strange" and "as if the arm was not there or unreal"—were present as well. This change in perception was not present in the noncataleptic left arm. Second, a high but nonsignificant correlation was found between the SHSS:C and the CQ but only for the cataleptic arm. Finally, a significant correlation was found between the CQ and the arm immobilization item of the SHSS:C, again only for the right arm. Strangely, this correlation was not present between the CQ and the catalepsy item of the SHSS:C. This may be explained by the fact that the CQ measures not only catalepsy but also motor and sensory dissociative epiphenomena. As a result the score on the CQ could be related to immobilization much more strongly than to waxy-flexibility only. Besides that, both questionnaires are scored on different scales (a binary scale and a five-point Likert scale for the SHSS:C and the CQ respectively), which may have affected the results.

Only 15 persons participated in the study. Nevertheless, the differences between the cataleptic and the noncataleptic arm were very high, $d = 3.42$, making it likely that the findings are strong and are likely to be generalizable.

Another limitation of the present study concerns the fact that, because catalepsy was induced in only the right arm, this arm gets more attention that the left arm. The participants are focused only on their right arm, which is where they expect any changes to occur and which is being held by the experimenter. So, one could argue it still is not proven that the changes are completely due to the induction of catalepsy and not to the attention paid to that particular arm. Regarding the research question in the present study, this is of minor importance, because the study investigates the effects of induced catalepsy and not the mechanisms that put the arm in a cataleptic state. In a way, attention could very well be a valuable ingredient to change the perception of a particular body part. However, in future research, it would be interesting to use a control group that just holds their arms upright.

We tried to control for demand characteristics by only suggesting stiffness and confusion of the muscles and not mentioning either the purpose of the study or any other possible effects of a catalepsy induction (see also Appendix B for the exact wording of the catalepsy induction). Also, to keep the catalepsy induction and the measurement of symptoms independent of each other, the questionnaire was not presented to the participant by the person who had induced catalepsy. Further, the assessment of the SHSS:C took place at least 4 weeks earlier by yet another person and in the perspective of another, independent study, which makes it unlikely that this assessment revealed anything about the topic of the present study.

A dissociative state is assumed to be "an altered state of consciousness in which ordinary perceptual, cognitive or motor functioning is impaired" (Brewin & Andrews, 1998, pp. 951). In this

paper, evidence was found for the presence of dissociative phenomena after catalepsy induction. Ordinary perceptual and motor functioning was indeed impaired as a result of a catalepsy induction. In an earlier study, evidence was found that an alteration in mental motor representations had taken place after a catalepsy induction (Roelofs et al., 2002). Compared to healthy arms, subjects were slowed in mental rotations of the cataleptic arms, especially for larger arm rotations.

In this stage, research needs a paradigm in which motor-perceptual dissociative phenomena are provoked. The present study showed that induced catalepsy provoked changes in self-reported motor and sensory experiences, stiffness as well as other dissociative phenomena. Also, the total dissociative symptoms reported after the tactile induced catalepsy seems to be strongly related to responses to hypnotic suggestions for arm immobilization. To conclude—at least on self-report measures—catalepsy leads to an altered perception of the cataleptic body part. This interesting field of study needs further exploration though, taking into account physiological markers of catalepsy.

REFERENCES

Brewin, Ch. R., & Andrews, B. (1998). Recovered memories of trauma: Phenomenology and cognitive mechanisms. *Clinical Psychology Review*, *18*, 949–970.

Diehl, B. J. M., Meyer, H. K., Ulrich, P., & Meinig, G. (1989). Mean hemispheric blood perfusion during autogenic training and hypnosis. *Psychiatry Research*, *29*, 317–318.

Gallup, G. G., & Maser, J. D. (1977). Tonic immobility: Evolutionary underpinnings of human catalepsy and catatonia. In J. D. Maser & M. E. P. Seligman (Eds.), *Psychopathology: Experimental models* (pp. 334–357). San Francisco: W. H. Freeman.

Grond, M., Pawlik, G., Walter, H., Lesch, O. M., & Heiss, W.-D. (1995). Hypnotic catalepsy-induced changes of regional cerebral glucose metabolism. *Psychiatry Research: Neuroimaging*, *61*, 173–179.

Hilgard, E. R. (1965). *Hypnotic susceptibility* (pp. 230–247). New York: Harcourt, Brace & World.

Kihlstrom, J. F. (1992). Dissociative and conversion disorders. In D. J. Strein & J. E. Young (Eds.), *Cognitive science and clinical disorders* (pp. 247–270). San Diego, CA: Academic Press.

Kulikova, A. V., Kozlachkova, E. Y., Maslova, G. B., & Popova, N. K. (1993). Inheritance of predisposion to catalepsy in mice. *Behavior Genetics*, *23*, 379–384.

Näring, G. W. B., Roelofs, K., & Hoogduin, C. A. L. (2001). The Stanford Hypnotic Susceptibility Scale, Form C: Normative data of a Dutch student sample. *International Journal of Clinical and Experimental Hypnosis*, *49*, 139–145.

Nijenhuis, E. R. S., Spinhoven, Ph., Vanderlinden, J., Van Dyck, R., & Van der Hart, O. (1998). Somatoform dissociative symptoms as related to animal defensive reactions to predatory imminence and injury. *Journal of Abnormal Psychology*, *107*, 63–73.

Roelofs, K., & Hoogduin, C. A. L. (1999). *A 22-item questionnaire for catalepsy*. Unpublished manuscript, Radboud University Nijmegen at Nijmegen, The Netherlands.

Roelofs, K., Hoogduin, C. A. L., & Keijsers, G. P. J. (2002). Motor imagery during hypnotic arm paralysis in high and low hypnotizable subjects. *International Journal of Clinical and Experimental Hypnosis*, *50*, 51–66.

Sacerdote, P. (1970a). An analysis of induction procedures in hypnosis. *American Journal of Clinical Hypnosis*, *12*, 236–253.

Sacerdote, P. (1970b). Theory and practice of pain control in malignancy and other protracted or recurring painful illnesses. *International Journal of Clinical and Experimental Hypnosis*, *18*, 160–180.

Weitzenhoffer, A. M., & Hilgard, E. R. (1962). *Stanford Hypnotic Susceptibility Scale, Form C*. Palo Alto, CA: Consulting Psychologists Press.

APPENDIX A

CATALEPSY QUESTIONNAIRE

Indicate to what extent you experienced the feelings mentioned in the questionnaire *during catalepsy*:

	Not at all				Completely
1. as if the right arm was easy to bend	1	2	3	4	5
2. a tingling sensation in the right arm	1	2	3	4	5
3. as if the left arm was hard to bend	1	2	3	4	5
4. as if the right arm was light	1	2	3	4	5
5. as if the entire left arm belonged to you	1	2	3	4	5
6. as if the left arm felt strange	1	2	3	4	5
7. as if both your arms felt different than usual	1	2	3	4	5
8. as if the right arm was hard to bend	1	2	3	4	5
9. a normal feeling in the right arm	1	2	3	4	5
10. a normal feeling in the left arm	1	2	3	4	5
11. as if (a part of) the right arm was gone or unreal	1	2	3	4	5
12. numb feeling in the right arm	1	2	3	4	5
13. as if the entire right arm belonged to you	1	2	3	4	5
14. as if the right arm felt strange	1	2	3	4	5
15. as if the left arm was easy to bend	1	2	3	4	5
16. as if the left arm was light	1	2	3	4	5
17. as if the right arm was heavy	1	2	3	4	5
18. a numb feeling in the left arm	1	2	3	4	5
19. as if the left arm was heavy	1	2	3	4	5
20. a tingling sensation in the left arm	1	2	3	4	5
21. as if (a part of) the left arm was gone or unreal	1	2	3	4	5
22. no differences experienced between the left and the right arm	1	2	3	4	5

APPENDIX B

PROTOCOL FOR CATALEPSY

1. Information

Before the procedure starts, general information is given to the participant, and the participant is reassured and told that it concerns a simple experiment without any negative consequences. The participant is also told that there is nothing to worry about, it is perfectly safe and no risks are involved.

The explanation is as follows:

"What I am going to do in a minute is bring your arm in a catatonic state. It is called catalepsy. You may know it from snakes. They are often seen to be standing stock still for a long time. There are also these "living statues," people who pretend to be a statue and are able not to move for a long time. They can do that because they bring themselves to a total body catalepsy, the same kind of stiff state that I am about to bring your arm into. The mechanism is as follows:

> Normally, there is gravity and your muscles constantly react to that. Your arm normally is pulled down by gravity. So your muscles have a basic tension to compensate for gravity. They are adjusted to the gravity condition that is always there. What I am going to do is confuse the muscles of your arm. I am going to make the muscles feel as if gravity is no longer there. That is, I am going to provide information that is not consistent with gravity. As a result, the muscles in your arm will get a different tonus. This is something that happens automatically; you don't have to do anything yourself. As a result of that changed muscle tonus, you will feel a stiffness in that particular arm. It will also be easy to keep that arm in the same position. In order to achieve this state, I will move your forearm up and down, and at the same time I will block that movement. It is nothing special, really. The stiffness will disappear after you have shaken your hands a bit.

2. Procedure

The person who induces the catalepsy (E) takes the wrist of the participant (P) in his hands. The elbow of P rests against the arm of a chair. E takes the forearm from its horizontal position and lifts it a bit higher. Then, E pushes the forearm of P slightly and slowly up and down, alternatively supporting and releasing the forearm. E pushes the upper muscles down as the arm goes up and pushes the under muscles up as the arm goes down, just opposite of the natural movement of the muscle contractions. In other words, E pushes the forearm a little bit up and a little bit down and blocks this movement at the same time. E pushes the forearm continuously until a point where E

feels some sort of resistance in it. No suggestions about dissociation are given at all. Only suggestions of stiffness of the arm are given. P does not have to do anything. Because people tend to find it hard to do nothing and ignore what E is doing, one could distract P by small talk for example. After 1 to 5 minutes of pushing the forearm up and down in decreasing amplitude, the arm will be in catalepsy. E checks if catalepsy is indeed present by softly pushing the arm down. Catalepsy is present if the arm returns to its elevated position, as is seen in tonic immobility.

If P is trying to help, by moving the forearm actively, no catalepsy will be attained. In that case, E has to emphasize that P does not have to do anything, because the effect will occur naturally.

3. *Debriefing*

E asks P what he or she has felt. E suggests that catalepsy is more easily reached as P has done it more often. It's as if the arm has learned what it has to do. E also normalizes the procedure and states that nothing out of the ordinary has happened.

Motorische und sensorische dissoziative Phänomene bei induzierter Katalepsie: ein Kurzbeitrag

Muriel A. Hagenaars, Karin Roelofs, Kees Hoogduin und Agnes van Minnen

Zusammenfassung: Ziel der vorliegenden Studie war es, dissoziative Symptome, die als Epiphänomen taktil induzierter Katalepsie auftreten können, zu untersuchen. Katalepsie des rechten Arms wurde bei 15 Teilnehmern induziert und die dissoziativen Symptome wurden mittels eines Selbsberichts evaluiert. Der rechte Arm wurde Im Vergleich zum linken, nicht-kataleptischen Arm, verändert erlebt. Zusätzlich zur größeren Rigidität zeichnete sich der kataleptische Arm durch das Vorhandensein von Parästhesien, einer herabgesetzen Empfindungswahrnehmung und einer verminderten Bewußtheit des Arms aus. Darüber hinaus korrelierten die berichteten Veränderungen der Wahrnehmung signifikant mit dem Teil der hypnoseinduzierten Arm-Unbeweglichkeit aus der Stanford-Skala. Aus dem Ergebnis wird gefolgert, dass die Induktion von Katalepsie verschiedene dissoziative Symptome hervorruft und ein nützliches Paradigma für die Erforschung motorisch-perzeptiver dissoziativer Phänomene darstellt.

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Phénomène de dissociation moteur et sensorielle associé à une catalepsie induite: communication brève

Muriel A. Hagenaars, Karin Roelofs, Kees Hoogduin, et Agnes van Minnen

Résumé: le but de cette étude était la recherche de symptômes dissociatifs qui peuvent apparaître lors de l'épiphénomène de la catalepsie induite de

manière tactile. Pour 15 participants, la catalepsie était induite dans le bras droit et les symptomes dissociatifs étaient évalués par une questionnaire auto-induit. En comparaison avec le gauche, le bras non-cataleptique, le bras droit cataleptique était perçu différemment. En plus d'une rigidité accrue, le bras cataleptique se caractérise par la présence d'une paresthésie: diminution de la perception, et d'une conscience accrue de ce bras. De plus, les changement auto-rapportés de la perception corrélaient de façon significative avec l'immobilisation du bras induite par hypnose selon l'échelle de susceptibilité hypnotique de Stanford. En conclusion, l'induction cataleptique met en place une variété de symptomes dissociatifs et fourni un paradigme de recherche utile pour l'étude des phénomènes dissociatifs de perception moteur.

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Fenómenos sensoriales y motrices disociativos asociados con la catalepsia nducida: Una comunicación breve

Muriel A. Hagenaars, Karin Roelofs, Kees Hoogduin, y Agnes van Minnen

Resumen: El propósito de este estudio fue investigar los síntomas disociativos que pueden ocurrir como un epifenómeno de la catalepsia tactil inducida. Inducimos catalepsia en el brazo derecho de 15 participantes y evaluamos los síntomas disociativos mediante un cuestionario. En comparación con el brazo izquierda, no cataléptico, se percibió al derecho de manera diferente. Además de un aumento en la rigidez, el brazo cataléptico se caracterizó por la presencia de parestesias, y decrementos en la sensación y consciencia del brazo. Además, los cambios mencionados en la percepción se correlacionaron significativamente con la inmovilización inducida en la Escala de Susceptibilidad Hipnótica de Stanford.. En conclusión, la inducción de catalepsia provoca una variedad de síntomas disociativos y provee un paradigma útil para investigar fenómenos disociativos motriz-perceptuales.

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