Maintaining Standards in Hypnosis Training - the Need for Patient Protection: the Australian Experience

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Increasingly around the world as clinicians and researchers alike become more sophisticated in their understanding of the hypnotic process, there is developing a conviction that the hypnotic state or process itself poses no inherent dangers for patients, but that its inexpert use may. The development of acute anxiety, deterioration in depression, or psychotic-like reactions are possible, not as a consequence of the use of hypnosis but as the result of inappropriate suggestions, metaphors or images the clinician may promote. The idea of a protective mechanism in the patient that will prevent harm is unproven; flies in the face of self-destructive mechanisms observed with many patients and maybe an excuse for clinicans abdicating reponsiblity for patient care. Disturbed psychological processes, already the cause of the patients difficulties, may be activated by hypnotically based therapies just as they may by any psychotherapy approach. This danger applies to both the directive and nondirective techniques.

The solution to potential patient harm is to ensure that all clinicians of whatever discipline have adequate and appropriate clinical training prior to being allowed to practice. In the Australian context the appropriate disciplines already licensed to practice their profession complete an appropriate academic training in the nature and nuances of hypnosis (30 hours); practical experience of direct and indirect approaches; supervised case management (50 hours); and a three part examination of competence (cases; written examination and oral examination), prior to acceptance as full members of the Australian Society of Hypnosis. Only by completing this training and peer reviewed assessment are clinicians able to receive the backing of the Society and recommendation to patients of their competence as clinicians using hypnosis.

One of the rationales for the existence of most hypnosis societies around the world is to offer training in hypnotically assisted therapies to the appropriate health professionals and to develop their hypnotically enhanced clinical skills. Most societies offer this training in the expectation that they will maximise the benefits that patients gain from the use of hypnosis and to minimise potential adverse effects. Apart from the protection of patients it is also in our best interests as clinicians that the status of hypnosis is maintained at the highest possible level. Four of the important questions to be considered when evaluating training are:

- Does training enhance skills and maximise patient benefit?
- In what ways are adverse effects prevented by training?
- What is the appropriate level of training that is required?
- What form of accreditation is appopriate?

Does training enhance skills?

There is little doubt that training in hypnosis is necessary if clinicians are to benefit their patient from its use. Most of the problems that arise from the use of hypnosis appear to arise where the practitioner has inadequate or minimal training, or with practitioners without appropriate clinical skills. As Fromm (1980, 1995) noted, clinicians inadequately trained in psychology and psychotherapy may result in their patients experiencing a disproportionate number of adverse or negative effects associated with the clinical use of hypnosis. Studies indicate that while appropriately trained therapists still report on the existence of adverse effects their therapeutic skills allow them to minimise deleterious consequences for their patients. What adverse effects does training prevent?

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Adverse effects of the experience of hypnosis

Does the hypnotic experience or state, or hypnotically assisted therapy, by whatever means it is encouraged or induced, pose any dangers to the patient's physical, psychological or social well-being?

The early concerns about the possible adverse effects of hypnosis were related to the issue of volitional control and the potential for the hypnotised subject to act in ways in which they would not otherwise behave or accept. In particular early concerns focussed on the influence of hypnosis in the commission of criminal offences and the alteration of volitional control reported in the many cases of sexual abuse and seduction, that had come to the attention of the authorities. These concerns were some of those expressed as early as 1784 by the Commission to Investigate Mesmerism set up by the French Government.

The issue of volitional control and hypnosis is beyond the scope of this paper. Suffice to say the answer to the question of whether subjects be caused, as a result of hypnosis to act in ways that they would find unacceptable or potentially harmful to themselves or others remains equivocal. The answer has to be "Maybe yes, maybe no" depending on the context of the hypnosis, subject characteristics including pathological processes, the techniques used and the psychological processes which may be outside the participant's awareness. As Orne (1972) noted, however, the pathological and destructive processes within an individual may be stimulated or activated by any number of therapy processes, including hypnosis.

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Does the state of altered cognitive and affective processes resulting from hypnosis itself pose a danger?

It is unlikely that a "state" that is available within most peoples' repertoire of psychological functioning would in itself be harmful. Seldom does nature provide the majority of a species with a characteristic, in this case hypnotic capacity, that is by its very nature harmful to a member of the species. Abnormal or atypical characteristics may be different but the evidence shows that the majority have hypnotic capacity and so we are not talking of an atypical or abnormal characteristc. Of course with many of the patients we treat there are atypical characteristics not usually found as the norm in a member of the human species. These pathological processes are often the targets of our treatment strategies.

Does hypnosis in therapy pose a risk to anyone's psychological health and well-being?

Since the beginnings of the professional therapeutic use of hypnosis (in fact since the work of the Marquis de Puysegar in 1784) there has been concern expressed about the possible adverse effects of the clinical hypnosis (Estabrooks, 1943; Wolberg, 1948; Williams, 1953; Weitzenhoffer, 1957; Rosen, 1960; Meares, 1960,1961; Orne, 1965; Conn, 1981; Lynn, Martin, & Frauman, 1996) and, in particular, the use of hypnosis by lay practitioners or as a form of entertainment (Wolberg, 1948; Weitzenhoffer, 1957).

The purported adverse effects have included deepening depressive reactions, the precipitation of panic and of psychotic disorders. But clinicians and researchers are not of one mind on this issue. Some suggest the use of hypnosis is without any dangers (Janet, 1925; Le Cron 1961). Others maintain hypnosis may only pose risks if incorrectly applied (Yapko, 1992). And others suggest hypnosis is, in itself, potentially dangerous with some patients.

What is the evidence that such adverse effects exist?

Numerous studies and opinions concerning potential adverse effects have appeared in the hypnosis literature over the past hundred years. Three types of evidence are available; clinical anecdotes or case reports; surveys of practitioners; and interviews with participants in clinical, research and entertainment settings.

Clinical accounts

The Marquis de Puységur in 1784 expressed concerns about the potential adverse effects of hypnosis when he accidentally created "artificial somnambulism" (Conn, 1981). By the middle of the 19th century frequent concerns were being raised about the use of hypnosis, although in the first instance these related to the manipulation of patients to act against their will or to their seduction (Reiter, 1958; Conn, 1981).

In the first half of this century numerous reports appeared concerning the sequelae of hypnosis. Hilgard, Hilgard and Newman (1961) reviewed this literature that claimed headaches, tremor, neurotic and psychotic symptoms could arise from the clinical application of hypnosis. They noted 15 cases of hypnosis related to the development of psychotic symptoms in the previous 50 years, and argued, that in most cases these adverse effects occurred in subjects who had a long history of pre-existing disturbance.

Clinical accounts of the complications arising from hypnosis appeared sporadically and by the time of his landmark text on fact and fiction in hypnosis, Marcuse (1959) highlighted 11 major areas of concern. These related to the psychological well-being of the subject involved, suggested physiological sequelae; acute distress reaching hysterical proportions; hypnotically suggested mutism, blindness or disturbances of memory. Mostly these were the result of the inexperience of the clinician involved and complications in the suggestions or metaphors used, rather than the hypnosis itself.

A variety of clinical complications were subsequently reported and reviewed by Hilgard, Hilgard and Newman (1961). They cited 15 cases in the literature between 1948 and 1960 in which severe sequelae, including psychotic reactions, have followed the use of hypnosis. For example, Meldman (1960) reported a case of "personality decompensation" following hypnotically based treatment for a flying phobia. Rosen (1960) expressed concerns about the ineffective management of abreactions and unspecified psychological sequelae. Meares (1961) expressed concerns about the application of hypnosis with the overly dependent personality type; the pre-psychotic schizophrenic patient; the schizoid personality type; and the depressed patient. He highlighted problems that might arise in dealing with acute panic reactions, abreactions, the incomplete removal of non-therapeutic suggestions, difficulties in terminating "trance" and symptom substitution.

Concerns about the potential for the use of hypnosis to encourage the acting out of suicidal ideas in the depressed patient have been the focus of many clinicians and researchers. Cheek and Le Cron (1968) warn against the use of hypnosis with the depressed patient. Similarly Spiegel and Spiegel (1978), Miller (1979), Burrows (1980), Crasilneck and Hall (1985) and Watkins (1987) express the same concerns about the potential for hypnotically based treatments encouraging patients to act on suicidal ideation. Such views are not universally accepted particularly by those who use indirect techniques (Gilligan, 1987; Yapko, 1992) but even here there is the caution about the care needed in selecting appropriate techniques. Haberman (1987) reported a deterioration in psychological functioning when a non-professional practitioner used hypnosis with a patient with pre-existing psychotic difficulties. In a dental setting Kleinhauz and Eli (1987) reported on four cases of anxiety, depression, post-hypnotic confusion and cognitive impairment after the clinical use of hypnosis.

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In his reviews MacHovec (1986; 1988) reported 86 case examples of adverse effects of hypnosis, 50% of cases occurring in a clinical setting, 25% in research settings and 25% as a result of stage performances. He generally concluded the risks of moderate to severe after-effects of hypnosis are 7% in research and clinical samples and 15% in relation to stage performances. His review of the complications of hypnosis begins by noting under-reporting of adverse effects of hypnosis in the clinical setting. This may occur from the fact that most clinicians when faced with adverse effects deal with them utilising their therapeutic skills and hence the complications are short-lived. In his second review of the complications MacHovec (1988) listed 48 adverse symptom reactions reported by participants who had no such previous problems.

Surveys of practitioners

Averback (1962) surveyed 828 psychiatrists and achieved a response rate of 50%. 210 adverse reactions coincident with the use of hypnosis were reported by 120 of these practitioners. The frequent reporting of psychotic decompensation (N=119) was notably higher than in other studies, but may have resulted from the fact that these difficulties would have been referred to a psychiatrist for treatment whereas other difficulties may not.

Levitt & Hershman (1962) obtained responses from 866 of the 2500 questionnaires mailed to members of the two principal American Societies of Hypnosis. Of the replies 301 reported "unusual reactions" to hypnotic interventions, with anxiety, panic, depression (9.63%); headache, vomiting, dizziness, fainting (4.98%); crying and hysteria (2.99%); and overt psychoses (1.66%) being the most common. This study had many methodological problems and as a consequence the results are difficult to interpret.

Judd, Burrows and Dennerstein (1986) in a survey of 1086 members of the Australian Society of Hypnosis reported 88 adverse effects from the 202 responses received. Again the most common of the complications were panic and anxiety (60%); as well as "over-dependency" (28%); difficulties in terminating trance (28%) and worsened or precipitated psychoses (15%). MacHovec (1986) estimated the risk factors as 25% in the clinical setting, 31% in the experimental setting and 33% as a result of stage performances.

If we consider hypnosis as an altered state of consciousness and a form of persuasive communication (Yapko 1992), then it is not the hypnosis itself that may cause any such harm, but the communication that is associated with the hypnotic process, the context in which the hypnosis takes place and the adequacy of the management of the suggestions given (i.e. the appropriateness of suggestions used; individual unwanted associations to the suggestions or state and failure to adequately complete suggestion removal). As Yapko (1992) noted it is the unintentionally directed associations to other

experiences that may be anti-therapeutic.

The risks of adverse effects may be attributed to subjective characteristics such as psychopathology, previous unresolved emotional trauma and hypnotisability. Adverse effects have also been attributed to practitioner characteristics such as lack of screening for at risk subjects, misdiagnosis of disorders, ambiguous suggestions, inappropriate interventions, ineffective trance termination and inadequate debriefing.

The therapy context within which the hypnosis is induced may present some special problems. If, as Yapko (1992) suggests, hypnosis is best thought of as a form of persuasive communications, then what prevents harmful communications from having a deleterious effect. The alteration of cognitive processes in a therapy context may also heighten the potential for harm since trust and expectations of expertise are a central part of the therapeutic context. The expertise and ethics of the practitioner would one hopes prevent the communications of harmful persuasive communications. How do we ensure the expertise of the clinican in not presenting deliberately or more significantly unwittingly harmful persuasive communications. I would suggest that it is only by appropriate training and peer reviewed accreditation that we can take pro-active measures to prevent patient harm through therapist ineffectiveness. We can only attempt to prevent harm through inexperience or a lack of knowledge. The courts may best handle the few who deliberatly cause harm or abuse their positions of trust.

Therapeutic influences in hypnosis may arise from direct, indirect or metaphorical persuasive communications as well as the development of self-induced hypnotic symptom relief. Similarly it is feasible that the use of specific metaphors, indirect or direct suggestions may interfere with the usual ability of a person to protect themselves. In particular there is a myth frequently perpertrated by clinicians that the human psyche has an inherent mechanism of self protection against unsafe influences. This mechanism then serves to protect the patient from suggestions that could be potentially harmful. If this were so then patients would not engage in cognitive or behavioural processes that were maladaptive and a characteristic of the abnormalities of the psychological states we treat.

I note however that this presentation of hypnosis as largely just a persuasive communication does not help us in understanding what it is that makes hypnosis a particularly potent persuasive communication compared to other persuasive communications.

Conclusions

My review of the clinical and research literature brings me to the following conclusions.

1. There are adverse effects that can arise through the use of hypnosis in clinical and other settings.
2. While most adverse effects are transitory and mildly distressing there is the potential for serious deleterious effects, including psychotic decompensation, depressive and panic reactions, and suicidal acting out.

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3. There is no evidence that hypnosis per se is the cause of these deleterious effects. Adverse reactions may arise from pre-existing patient vulnerabilities; therapist inexperience in dealing with psychotherapeutic problems; the use of inappropriate suggestions and metaphors; failure to remove unwanted non-therapeutic suggestions; failure to fully re-orientate the patient and failure to de-brief the patient adequately.
4. These problems are more likely to arise if the context does not allow them to be adequately addressed (e.g. in stage performances) or if the training and experience of the practitioner is not sufficient for them to deal with the problems as they arise (e.g. inadequate training in the areas of hypnosis or psychological functioning).
5. Lay practitioners lacking in the appropriate level of psychological and clinical training are, therefore, more likely to encounter and cause adverse reactions. They are less likely to be able to respond to them therapeutically and ensure the patient's recovery.
6. The practice of hypnosis requires the demonstration of a level of knowledge, skills and supervised training in therapy approaches relevant to the problem being addressed. Most professions require their members to offer treatment only in those fields in which they have appropriate training. The protection of the patient requires this limitation be maintained.
7. Adequate training and accreditation procedures need to be in place to ensure the patient is not subject to treatment approaches of which the practitioner does not have adequate understanding.
8. The use of hypnosis in contexts that pose greatest dangers ought to be controlled or disallowed for the public protection. Despite the claims to the contrary, there are a significant number of reports of serious sequelae following the use of hypnosis on stage.

Patient pathological processes versus the "protective" mechanisms to prevent harm

The harmful effects attributed to the application of hypnosis seem to me come about through three different influences. Firstly the patients may as a result of their pathology possess essentially self-destructive processes based on a belief in their own deserving of punishment. Masochistic processes are frequently a part of pathology and the resistance to therapeutic change. The basis of this is related to low self-esteem, poor self-worth, guilt and self blame. Secondly suggestions or methaphoric processes used in the change of state by either direct or indirect means may not appropriate as a result of unwanted or unknown associations. Thirdly the process of change thought processes may itself create great threat as in the case of panic at the perceived alteration of the cognitive state.

Ensuring the training of practitioners

Why do we need controls over who practices hypnosis? In order to protect the public, to protect our own clinical use of hypnosis and to ensure that the clinical practice of

hypnosis does not fall into disrepute as it has been in the past we need to ensure the adequate training of all practitioners.

We need to recognise there are serious and minor adverse effects from hypnosis inappropriately or inexpertly applied. These include: The aggravation of depression; the precipitation of panic attacks; the precipitation of psychotic processes; the encouragement of dissociative states that may interfere with patients functioning; the masking of serious medical difficulties; the creation of iatrogenic (therapist created) disorders; causing false memory to be accepted as reality (false memory syndrome); and anxiety or pain reduction enabling or encouraging potentially dangerous behaviour

Peer assessment and certification - the Australian model

The *Australian Society of Hypnosis (ASH)* was established in 1971 as a training and accreditation organisation. It is a Federal grouping with training programmes run by branches in each of the six states of Australia.

Currently it has between 1200 and 1400 members of whom 300 are in training. ASH is accepted by the International Society of Hypnosis (made up of 32 national constituent societies world wide) as the only recognised training programme in Australia.

ASH represents the several disciplines who may according to Australian state law practice hypnosis clinically. It is not exclusive or protectionistic except for the protection of the public. All members:

1. are tertiary qualified health professionals;
2. have adequate psychological teaching as part of their professional training;
3. adhere to a code of ethics which includes the undertaking to stay within their area of professional expertise;
4. have a state registration board with appropriate legal sanctions.

Currently this comprises general practitioners; medical specialists (including psychiatrists, anaesthetists, dermatologists; etc.); psychologists and dentists in accordance with the legal restraints.

The training course includes a minimum of 30 hours didactic teaching concerning the nature of hypnosis and its practice; a minimum of 50 hours practical supervision in an individual or group context. They must work with a minimum of 10 patients or clients during the time of their training. At the end of the supervised training the Associate Members of the Society may sit the examination for Full Membership based on their successfully completing a formal examination for accreditation with independent and duplicate marking.

To proceed to Full Membership which gives not only the status of competence in hypnotically based clinical practice, but also the right to receive from the Society referrals. In this peer reviewed accreditation they must present for examination 2 supervised case histories; complete a 3 hour written examination in three parts; and 1/2 hour oral examination or interview.

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The proposed post-graduate diploma of clinical hypnosis

Currently the Australian Society of Hypnosis is in negotiations for the training programme in hypnosis to become a part-time post-graduate qualification of the University of Melbourne. The proposed programme which would run within the Department of Psychiatry (where the current teaching programe runs) would be available to the appropriately licensed health professionals who can legally practice hypnosis. The programme will include 60 hours of teaching (40 x 1 1/2 hour sessions) on hypnosis and its applications clinically and a minimum of thirty hours supervision in the first year. This is likely to be arranged into ten one day sessions. At the end of this year participants will complete a formal assessment in the form of an examination or essay.

In the second year of their training the programme will involve on-going supervision (30 hours) and additional workshops focussed on developing the therapeutic skills appropriate to each discipline. To complete the assessment candidates are likely to need to submit two or three detailed supervised clinical cases and undergo a final oral or viva examination by interview that assesses their clinical skills. While this process is still being negotiated the benefits for the quality and breadth of training and the status of hypnosis as a therapeutic medium is likely to be enhanced.

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A River runs through it: The Relational Self in Psychotherapy

Stephen Gilligan

■ *The symptom is like a stone drawing a person deeper into the depths of beingness. If a person resists the movement or becomes identified with it, bad things tend to happen. If they continue to happen, the person may consult a therapist at some point. The slogans we examine here can help a therapist recognize the inevitability and blessedness of each symptom, while remaining sober about the danger of improperly relating with it. Self-relations encourages therapists to join and harmonize with the currents running through the client, so that in relatedess a human way of being with experience can be renewed.*

"And we did what we did, made love attentively, then
Dove into the river, and our bodies joined as calmly
As the swimmer's shoulders glisten at dawn,
As the pine tree stands in the rain at the edge of the village.
The affection rose on a slope century after century.
And one day my faithfulness to you was born."

From *The Good Silence* by Robert Bly

Self-relations psychotherapy is an approach developed by the author (Gilligan, 1994, 1996) over the past decade. Based in part on the legacies of Milton Erickson and Gregory Bateson (see Gilligan, 1987), it is also influenced by the gifts of Morehei Ueshiba (the founder of aikido), Ghandi, Groucho Marx, Jerry Garcia, T.S. Eliot, Martin Luther King, Jr., and my daughter Zoe. It seeks to repoeticize experience while encouraging a deeper sobriety of being present in life without sentimentality, self-pity, or grandiosity. It endorses a marriage between the power of love and the love of power, and thus seeks the primacy of being as well as the art of becoming. It offers an explicit way of thinking about how life becomes (and remains) a problem for people, and suggests specific principles and methods by which individuals may find their way out of recurrent suffering.

This paper presents some ideas of Self-relations and then describes what the