FREE GUIDE

Choosing the right hypnotherapy training for you

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The UK College of Hypnosis & Hypnotherapy

Contents

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INTRODUCTION

There are few things more confusing than the many different types of training, qualifications and organisations in the world of hypnotherapy training.

It's not hard to teach basic hypnosis, at the same time many people seem to lose all critical thinking when it comes to learning hypnosis. Combine this with a lack of agreed training standards and no government regulation, and you end up with a market that allows for some very poor training indeed. We constantly hear stories about poor training materials, incoherent information and a meagre amount of real clinical skill development.

The famous hypnotherapist Gil Boyne, who passed away recently, set up many of the training programmes around the world. He was rightly shocked at the quality and hype surrounding many hypnotherapy training schools and would start each course inviting participants to "name and shame" other training schools! We aren't going to do that here. However, we do encourage you to keep your critical thinking engaged as you do your research. The questions below have been put together based on 10 years of teaching and talking to students.

You might find it helpful to keep a spreadsheet with the names of the training schools, their websites and the answers you get to these questions. We hope you find them helpful and invite your feedback.

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15 Questions to ask yourself (or the training provider) when choosing a hypnotherapy training

1. **What sort of hypnotherapy do you want to train in and practice? (the four main types of hypnotherapy)**
2. **Do you want to learn a more scientific approach or a more alternative approach?**
3. **What sort of course format suits you?**
4. **What award is given? Is it externally awarded? It is accredited and recognised by a range of independent professional organisations? What assessment is required of students to obtain the qualification or are all attendees awarded?**
5. **How much does the course cost and how many training days and hours do you get for your money? How much will it cost overall in terms of travel, accommodation, etc?**
6. **Is the course giving a solid coherent foundation upon which to build, or does it cover a wide range of differing models/ ideologies?**
7. **Will you be learning how to think and plan treatments like a therapist, designing customised approaches for each client? Or will it be entirely script-based?**
8. **Will you learn a range of techniques or just one main technique?**
9. **How much practical experience does the course offer vs theoretical content?**
10. **Will the training allow you to study other mainstream psychotherapy approaches (like Cognitive Behavioural Therapy) or does it keep hypnotherapy as something separate? Will you be able to engage with the rest of psychology or be limited to hypnosis/trance/NLP discussions?**
11. **What are the textbooks for the course?**
12. **Will I be learning a "Purple Hat Therapy"?**
13. **What training materials are provided? Can an excerpt from a course manual be provided before booking?**
14. **Who is the main trainer? What is their background? Are they also a therapist?**
15. **What guidance and information is provided into setting up and running your own practice/business? What post-course support is provided?**

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Question 1: What sort of hypnotherapy do you want to train in and practice?

Hypnosis has evolved over the last 150 years. Thanks to a great deal of research, there is a growing realisation that many of the practices being taught are questionable and lacking in evidence.

The main types of hypnotherapy that are taught and practiced are:

1/ Traditional Hypnotherapy

2/ Hypno-Analysis (Regression Hypnotherapy)

3/ Ericksonian Hypnotherapy (and/or NLP)

4/ Cognitive Behavioural Hypnotherapy

What follows is a brief explanation of each approach and the pros and cons of each approach. The most important questions to consider are a) Is there any evidence for the approach? and b) What sort of therapy do I want to practice?
This is the longest answer but probably the most important in terms of understanding the pros and cons of each approach.

1/ Traditional Hypnotherapy

The core of the approach is direct suggestion for improvement of symptoms. For example, "Every day you will begin to feel calmer and more confident… that old discomfort and worry are fading, fading, fading and you step forward each day with greater ease and comfort, strength and confidence… "

Hypnotherapy's current reputation is mostly based on the traditional approach. It is quite mechanistic in terms of how this traditional approach understands what happens in hypnosis, with the suggestions of the therapist somehow putting the client (mechanically) into a "trance", where their mind is receptive to the words of the therapist as outside influences that can't be resisted (rather than the client being engaged and having some "agency"). There is good evidence for this approach being used for pain control, inducing relaxation, treating irritable bowel syndrome and some simple forms of anxiety.

Pros:
- Simple and straightforward
- Can be effective for many simple or specific conditions

Cons:
- Some clients don't seem to respond.
- The idea of a "hypnotic trance state" puts off some clients and isn't really needed. Moreover, it is disconnected from most of mainstream psychology and leaves hypnosis as a strange outlier in abnormal psychology.
- Simplistic, mechanical model of how hypnosis works
- Fails to understand underlying patterns of thought, feelings and behaviour that could be causing the symptoms. This means that the symptoms are not being properly addressed.

2/ Hypno-analysis (Regression Hypnosis)

Basically a neo-Freudian approach popularised by Dave Elman, which sees psychological problems as originating in some trauma or unresolved event in the client's past. Clients are regressed back to the cause or event, the emotion is released and that event is experienced differently. It's a model that

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sees clients as being trapped by their past, victims of their sub-conscious. However, it does hold a form of romantic appeal for some. There is little evidence for its effectiveness and today psychologists would be concerned about the possibility of creating false memories or triggering unnecessary emotional reactions during regression. This type of hypnotherapy was very popular in the 1950s and 60s, but lots of training schools still teach this.

The claim is that unless the root cause is found and resolved then the suggestions given in hypnosis won't "stick". Modern approaches focus more on "maintaining factors" or "vicious circle" of thoughts, feelings and behavior – and how to break that vicious circle.

It also robs of the client of their own power, putting the therapist in a more powerful role, which goes against a lot of recent research that indicates therapy is more successful when the locus of control is with the client.

Also, clients can often experience very intense emotions that may re-traumatise them. Memories under hypnosis are more vivid and can feel more true, but research shows that memory is an active reconstruction and so can be influenced by the present context.

The American Psychological Association considers regression hypnosis to be so risky that they require their members to give clients a letter informing them of the risks for them to sign.

Pros:
- Often a very attractive, somewhat "magical" model that appeals to the idea that we are trapped by our past.

Cons:
- Little evidence of effectiveness.
- Little evidence that the client's presenting problems originate in an initial sensitising or traumatic event.
- Memories recalled under hypnosis are not necessarily accurate but can be experienced as more real than original memories – leading to issues of false memories being created.

3/ Ericksonian Hypnotherapy (and NLP)

Based on the approach of Milton Erickson, who believed the client's conscious mind was often the problem, that the unconscious could find creative solutions and that hypnotic trance occurred naturally, even spontaneously. There is particular focus on the conscious mind of the client being resistant, with the solution already present in the client's unconscious. In Ericksonian hypnotherapy, the therapist might communicate in a way that, without the client knowing or being able to resist, they enter hypnosis and the therapist then implants messages in their communications that are accepted by the client's unconscious. The hypnotherapy is often quite indirect, sometimes covert and the therapeutic ideas can be embedded in stories, confused messages and metaphors.

Pros:
- Claims to be particularly effective with clients who are "resistant" or very controlling.
- Has a romantic perhaps magical appeal.
- Appeals to those who like to view the hypnotherapist as a sort of master or guru (which is certainly the way many people related to Milton Erickson).

Cons:
- Little evidence for Ericksonian hypnotherapy and no evidence that indirect, covert suggestions work better than direct (traditional hypnosis) suggestions.
- Some research indicates that clients receiving indirect suggestions become more anxious and less trusting of the therapist.
- Perhaps it is better to call this "indirect suggestion therapy", as it appears to operate in a different

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way than normal hypnosis.
- On the one hand, it's difficult to learn this style of communication, and on the other hand it appears to release the therapist from responsibility as everything depends on the client's unconscious being ready to make changes!

What about NLP?

Very often Ericksonian Hypnotherapy is taught side-by-side with Neurolinguistic Programming (NLP). A sort of "grab bag" of different therapy techniques gathered from studying several "expert" therapists, NLP makes many quite grand claims that have so far not been substantiated by research. The handful of observations that make up its evidence base have mostly been proven false in more substantive, rigorous research. However, it has been sold strongly into personal growth and training environments.

Pros:
- Claims to teach simple, powerful techniques and that you can become a "Master Practitioner" in just seven days.
- Claims to work fast and cures phobias in just one hour (with the Fast Phobia Cure).

Cons:
- Researchers in the psychological sciences no longer conduct any research into NLP.
- Very little evidence to back up the strong claims it makes. Today clinical psychologists regard it as pseudoscientific and a relic of the 1980s.
- Studies of the Fast Phobia Cure fared badly against established CBT treatment programmes.

4/ Cognitive Behavioural Hypnotherapy

This is both a return to Traditional Hypnosis and an important evolution. Firstly, it doesn't consider hypnosis to require "trance" (whatever that really means) and, based on extensive research, it understands hypnosis as being *focused attention, combined with a positive motivation and strong expectation, upon a dominant idea* – and that profound changes in our experience can occur when we focus our attention on ideas in this way. It therefore doesn't see hypnosis as a magical trance or altered state of consciousness – but more as something that the client is actively doing (hypnosis is an act that client does, not a "thing" done to the client).

In this approach, hypnosis is comprised of normal psychological factors used in a special way (rather than as a branch of abnormal psychology) and because of this it can be integrated into mainstream psychology. Cognitive behavioural hypnotherapy (CBH) focuses on changing the symptoms (as in traditional hypnosis) *as well as* addressing the underlying thinking and behaviour that maintains those symptoms.

Where hypno-analysis (regression hypnotherapy) focuses on "originating cause" as the powerful factor, CBH sees the "maintaining causes" as where we can make change. Rather than asking what caused it in the first place, the question CBH asks is, how is it being maintained and how can it be changed?"

Pros:
- Sees hypnosis as something that the client does, and a skill that can be taught (all hypnosis is self-hypnosis in this model).
- Integrates hypnosis with cognitive behavioural therapies.
- Scientific, empirically driven model (rather than speculative).
.- Evidence-based approach (both evidence for the effectiveness of CBT approaches and also that add-

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ing hypnosis to CBT improves outcomes above CBT alone) .
- A focus on client empowerment and teaching coping skills (a goal in CBT is that the client becomes their own therapist).

Cons:
- It is focused on science rather than a more speculative/magical approach - this may not be appealing to some.

At the UK College we teach Cognitive Behavioural Hypnotherapy – which means learning traditional hypnotherapy too – as well as examining hypno-analysis and Ericksonian hypnotherapy, Incorporating what is useful from those approaches. However, you won't find us teaching NLP, regression hypnotherapy or covert hypnosis methods. These approaches, while attractive to some, make unsubstantiated claims with little evidence to back them up.

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Question 2: Do you want to learn a more scientific approach or a more alternative approach?

Historically, there are two main approaches to hypnosis: one grounded in scientific language and enquiry; another more centred on speculative, "magical" notions, using the language of "trance", "altered states of consciousness" and the "wonder of the unconscious".

Two schools of thought about hypnosis

Magical	**Scientific**
Mechanical (hypnotists words act on the client)	Social Interaction (client engages with the hypnotist in a way that allows ideas to create responses)
Trance	Focused attention and absorption
Altered State of Consciousness	Absorption and deep relaxation
Credulous	Skeptical
Locus of power in the hypnotist	Locus of power in the client
The "subconscious mind" (as if this is a "thing" or "entity" with it's own agenda)	Habits and automatic responses
Change happens through the depth of trance state and the power of the hypnotist's world affecting the unconscious or subconscious of the client	Change happens through the powerful experiences arising from positive motivation, increased expectation, and focused attention on the ideas and images that the therapist presents to the client – often combined with sufficient repetition – which creates new responses to situations.

Ask yourself which approach suits you and which would you like to use with clients? Perhaps more importantly, consider what type of hypnotherapist you would choose if you needed help with an important issue – the magical or the scientific?

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Question 3: What sort of course format suits you?

Some courses run one Saturday a month for two years, others are 10 weekends a year. Our courses run in three intensive 7-day blocks. We find students like the focus that this format brings.

Which course format works for you?
- Consider travel time, costs, time off work and time away from family.
- Do you want to take a weekend every month for a year? Or study in a more concentrated way?
- Which format best suits how you learn, focus, stay motivated, etc.

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Question 4: What award is given? Is it externally awarded? It is accredited and recognised by a range of independent professional organisations?

Find out exactly what award or qualifications you will receive at the end of the course, and if you can then start to practice. This isn't so much about the letters you can put after your name, but rather to enquire exactly what qualification you will receive.

Many courses have different elements – for example:
Foundation Training + Certificate Training + Practitioner Training + Diploma Training + Post-Graduate Diploma Training.

At The UK College, once you have been awarded your Diploma in Cognitive Behavioural Hypnotherapy (after three weeks of training and completing a written assessment) and have your insurance you can start practicing. We strongly recommend you join a professional organisation like the National Council of Hypnotherapy or The General Hypnotherapy Register.

What assessment is required of students to obtain the qualification or are all attendees awarded?

Some training courses simply require you to attend the classroom training and then you are awarded the qualification. However this is rarely sufficient in terms of providing evidence and verifying that the student has sufficiently learned and is able to apply the skills of being a hypnotherapist.
For example our qualification, in addition to 21 days (132 hours) of classroom training, requires a written assessment comprising of short essay answers to 28 questions – which provide evidence that the student meets the national occupational skills for hypnotherapy. An experienced psychotherapist reviews and marks the answers, providing feedback where the student needs to resubmit in order to make level required for the qualification.

Is it externally awarded?

Some training schools simply print off their own qualifications. Other training schools have created a separate, but related organisation that approves their qualification. This is not best practice, because they are essentially "rubber-stamping" their own examinations and standards. It's generally better that any training qualification be recognised by several of the main organisations, and ideally be verified by an external, government-regulated examining body.

Is the award accredited and recognised by a range of independent professional organisations?

You should make sure that your qualification is recognised by at least two of the following bodies:

- The National Council of Hypnotherapy (NCH)

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- The General Hypnotherapy Register (GHR)
- The Register for Evidence-Based Hypnotherapy and Psychotherapy (if studying a cognitive behavioural hypnotherapy diploma) (REBHP)

At the UK College, our Diploma is awarded and verified by NCFE, a national OfQual-regulated awarding and examining body that is regulated by the same government department that oversees GSCEs and A-Levels. Our Diploma is also recognised by the NCH, GHR and REBHP.

Once you have your Diploma and you will also be eligible to register with the CNHC (usually via NCH or GHR membership). This is increasingly important - CNHC is a voluntary regulator and register for complementary therapists (the category that hypnotherapy falls under). CNHC was originally funded with government money and is now self-funding with continued support from the Department of Health. For example, the Dept of Health recommends to the NHS and GP practices that they only use CNHC-registered therapists.

As an Accredited Voluntary Register (AVR), the CNHC has been audited by The Professional Standards Authority (the government body that monitors professional standards in health and social care, including doctors, nurses, social workers, etc.) and has met the high standards required for AVR status, which we expect to become increasingly important over the coming years.

Question 5: How much does the course cost, and how many hours do you get for your money? How much will it cost overall in terms of travel, accommodation, etc?

We recommend you break down the costs involved, and take time to be clear on the actual classroom hours that you'll receive. While cost should not be the deciding factor, it will certainly be an important component. In addition, you need to take travel and accommodation costs, and registration fees into account.

There is a generally agreed minimum standard of 120 classroom hours, supplemented by home study - the NCH, GHR and most other registers have agreed to this minimum.

Some training schools require more than this, others less (therefore violating the standard), while some don't make clear how many actual training days or hours are involved. Make sure you get at least the minimum 120 hours of classroom training.

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Question 6: Is the course giving a solid foundation upon which to build, or does it cover a lot of different ideologies?

There are a number of training schools that appear to cover the entire range of hypnotherapy approaches AND most of psychotherapy - in only 12 weekends. Here's a typical schedule (taken from the prospectus of an existing training school):

- Module One: hypnosis (Weekend 1)
- Module Two: Regression and Hypno-analysis (Weekend 2)
- Module Three: NLP (Weekend 3, etc.)
- Module Four: Ericksonian Hypnotherapy
- Module Five: Freud and Jung
- Module Six: Emotional Freedom Technique
- Module Seven: Cognitive Behaviour Therapy
- Module Eight: Advanced NLP Techniques
- Module Nine: Advanced Hypno-Analysis etc
- Module Ten: Treating Phobias, Public Speaking anxiety, fear of flying, Social Anxiety, General Anxiety, Weight Loss and Panic Attacks
- Module Eleven: Pain control, Post-Traumatic Stress Disorders, OCD and Depression
- Module Twelve: Smoking Cessation, Addictions, Habit Control, Insomnia, Psychosexual disorders and Sports Performance

This might appear comprehensive, but there is no way to do justice to - or even scratch the surface of - these different approaches in that timescale!

Our Approach:

We believe that students need to be trained in one approach as in-depth as possible. They can (and should) have an appreciation of other approaches and perhaps even draw on techniques from them, but all within a core framework driving the therapist's understanding of what is happening with the client (the working model or case conceptualisation). Not all therapies are equally effective, and having a fully rounded, working understanding of an evidence-based approach provides a genuine therapeutic foundation for real-world practice.

We have a technically eclectic but theoretically integrative outlook, drawing on a wide range of techniques pulled from different approaches that are used and understood within a single theoretical approach.

Question 7: Will you be learning how to think and plan treatments like a therapist, designing customised approaches for each client? Or will it be entirely script-based?

Many training programmes offer modules that cover every conceivable presenting issue. However, the application tends to be very prescriptive ("when presented with 'x' problem, do 'y' treatment") and very dependent on existing script. While you can experience some success with this approach it is fairly superficial and doesn't bring many clinical skills to bear. Basically, "paint by numbers" therapy. Alternatively, it can also result in what we call "shotgun" therapy, with the therapist trying one powerful technique after another but with no real rationale behind using them.

The heart of therapy is the working *alliance* with the client. Developing a working relationship together, the client and therapist agree the goals, settle on a working model of the problem, and together pinpoint the therapy tasks (interventions/techniques) to be used. A therapist with good clinical skills can assess what is happening with the client, clarify the goals, develop a working model of

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the problem (what is making this issue occur?) and use that model to develop their treatment plan – all in a collaboration ("shoulder-to-shoulder") with the client. The working model or "conceptualisation" of the client's presenting problem becomes the rationale for the therapy tasks and techniques one decides to use. Rather than flipping from one powerful technique to another, the skilled therapist uses the information ("this didn't work") to inform the working model and come up with new treatment approaches. They are like a scientist formulating hypotheses about why the problem is still there and what needs to change to bring about resolution. Everything that happens in therapy should become more data for the therapist and client to figure out what to do next. That is how a good therapist thinks, plans and conducts therapy.

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Question 8: Will you learn a range of evidence-based techniques or just one main one?

As well as training schools that teach the entire world of psychotherapy in just 10 weekends, there are those that teach just one main technique (often hypno-analysis with some suggestion therapy). This type of therapist reads a script unless the issue is "deeper", and then they will do hypno-analysis to get to the "core" of the problem. However, there isn't really any evidence that this approach works. It's better to learn a wide range of techniques that have proven efficacy. Solution Focused Hypnotherapy, for example, is one technique that is popular however it lacks a strong evidence-base, moreover a solution-focused, strengths-focused approach really sits within a larger framework of techniques. A monkey-wrench is a great and flexible tool – but really one wants more in the toolbox, and to apply those tools in a methodical way rather than just applying one "powertool" after another.

The CBH approach allows for a wide range of evidence-based techniques to be used - called the CBH "tool box" comprising 35 different techniques. Which techniques you use (the treatment plan) is based upon the working model of the problem – some clients may benefit from assertiveness training or acceptance-based approaches, while others need to learn self-hypnosis or how to relax all their muscles. These techniques are just a few "cognitive-behavioural" techniques, have good evidence of efficacy, and can be combined with hypnosis.

Question 9: How much practical experience does the course offer vs theoretical content?

On some courses there is more lecture than practice. On others, there is no student discussion. Ideally courses are an effective mix of theory, practical exercises and discussion. A good course will typically involve about 50 per cent practical exercises, 25 per cent lecture, 25 per cent discussion.

We aim to offer a minimum of 40 per cent of course time on practical therapist-client exercises. The first day is dedicated to learning self-hypnosis, then on the second day you will be "hypnotising your client" (aka a fellow student) – and gaining immediate hands-on experience. Each practical exercise includes time for detailed feedback and discussion with your "client", then some further discussion within the group, ensuring that we squeeze as much learning out of each practical as possible!

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Question 10: Will the training allow you to study other mainstream psychotherapy approaches (like Cognitive Behavioural Therapy) or does it keep hypnotherapy as something separate?

Many hypnotherapy training programmes seem to have a slight disdain for mainstream psychology and psychotherapy, often presenting hypnotherapy as something separate, more powerful. However, there is a vast body of research on psychotherapy - particularly CBT – We believe that respect for existing knowledge and study in psychology is fundamental for anyone embarking upon hypnotherapy (or psychotherapy) as a career.

Question 11: What are the textbooks for the course?

Good courses are based on good textbooks. Ask training schools for the title of the course textbooks and an additional recommended reading list. This will tell you a lot about the source of the techniques taught and the overall approach.

It's important to note that there is a considerable difference between popular books on hypnotherapy compared to clinical textbooks. On the one hand, there are books by well-known media figures such as Paul McKenna, where you'll find very few citations and references; they don't draw upon the body of extensive research into hypnosis and psychotherapy. Good clinical textbooks, on the other hand, reference a large range of existing knowledge (academic and scientific journals, or other core textbooks).

Many courses do not have recommended textbooks and are based entirely on the approach and experience of the trainer. Other courses use textbooks that are from 50 years ago. The field has evolved since then.

How to tell a good textbook?
Look at the references, citations and bibliography. The textbook should ideally be summarising research papers published in peer reviewed academic journals. The index will also give you a good idea of the range of topics discussed.

How does UKCHH do it?
We have an extensive list of recommended reading for the course. Here are our three main textbooks:

- The Practice of Cognitive-Behavioural Hypnotherapy, by Donald Robertson
- Hartland's Medical and Dental Hypnosis, by Michael Heap and Kottiyattil Aravind, 4th Edition
- Essentials of Clinical Hypnosis: An Evidence-based Approach, by Jay Lynn and Irving Kirsch

You can view our full reading list here.

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Question 12: Will I be learning a "Purple Hat Therapy"?

A serious question that could save you a lot of time, money and personal embarrassment!
So-called "Purple Hat Therapies" are when someone takes a therapeutic technique that works, then adds a new (but non-effective) element to it (e.g. wearing a purple hat). The new therapy is then marketed and sold to therapists who want to learn "the new best thing". Very often what is new isn't effective and what is effective isn't new.

We are passionate about students learning what works in therapy, the history of evidence-based psychotherapy and developing a healthy skepticism towards "the new best thing". It is frustrating to see the extent of marketing hype in the therapy training world. We advise you to be diligent. Do your research. To quote Donald Meichenbaum, Professor Emeritus, University of Waterloo, Canada, and one of the originators of CBT: *"The toughest part of being a therapist is how NOT to get caught up with all of the questionable psychotherapeutic 'bullshit' that pervades the field."*

Here's a good article on Psychotherapy and Pseudoscience: Five Indicators of Dubious Treatments
https://www.mentalhelp.net/articles/psychotherapy-and-pseudoscience-five-indicators-of-dubious-treatments/

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Question 13: What training materials are provided? Can an excerpt from a course manual be provided before booking?

Students should receive a course manual that both covers the key issues and provides a range of practical exercises, scripts, assessment tools and forms.

You can tell a great deal about a course from taking a look at an excerpt from a course manual. Ask the training school for an excerpt (10-12 pages) to should give you an idea of the course content, how well it is written and how rigorous the approach.

How Does UKCHH do it?
Each of the three stages of our training is accompanied by a 250/300-page manual, providing concise articles on the key issues, practical considerations, scripts and practical exercises – as well as extensive forms and assessment tools. All of which are well referenced.
The Appendix contains an article from one of our course manuals - The Medical and Scientific Acceptance of Hypnosis. Here is a link to download another excerpt from our course manuals – some pages from our module on Pain Control.
http://www.ukhypnosis.com/wp-content/uploads/2015/08/Pain-Control-Excerpt.pdf

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Question 14: Who is the main trainer? What is their background? Are they also a therapist?

Most training courses will have one main trainer (sometimes the training is split evenly between two trainers, although that is rare). Some training courses will have a different trainer for each module (consider if this will work for you, or will it muddy your understanding?).

Is it important the trainer has some basic qualifications in psychology or psychotherapy? There are pros and cons to either training with someone who switched career to became a hypnotherapist and open a training school, with a long-term professional who has dedicated their life to psychotherapy and personal development. You have to decide which will suit you better.

Many trainers turned to training because they didn't enjoy doing therapy. We believe something important is gained when the trainer has also been (and ideally continues to be) a successful therapist. Their day-to-day therapy work influences their teaching with daily pragmatic experience, and when

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they teach “best practice” they are continually reminded of the basic “good stuff” in therapy that all too often gets forgotten.

Our main trainer is Mark Davis. He has a degree in Psychology and Philosophy, spent five years training rigorously in a semi-monastic environment in India, and a further 10 years in the United States practicing and teaching meditation, yoga and Eastern Philosophy. He originally trained at the UK College in 2006 and built a very successful practice using only the CBH approach. Between courses he runs an active practice that greatly enhances the student experience as discussions often revolve around practical, real-life examples and solutions.

Question 15: What guidance and information is provided into setting up and running your own practice/business?

Many training schools deliver a training course with no view to supporting newly training therapists into successful practice. Your training in the clinical skills of hypnotherapy is only one part of a comprehensive action to build a successful business – in this case the business of being a successful hypnotherapist.

Just as learning to cook delicious food and serve it in attractive ways is just one part of setting up and running a restaurant, in the same way you will need to address various operational, administrative and most of all marketing efforts to succeed as a hypnotherapist.
To succeed you need to know:
a) what steps to take,
b) you need to actually take the steps (yes!)
c) and you need to be able to spot and the deal with the different psychological obstacles (lack of confidence, feeling hopeless, stress, worry, feeling stuck) that arise for anyone setting up in business on their own.
Having business support in terms of peers and mentors is usually essential.
Ask the training provider what support they provide. How do they help you get into practice?

Also be prepared to invest some reasonable sum of money in professional support for business coaching, design and marketing, personal therapy to overcome obstacles.

All of the “obstacles” that arise in setting up a practice are problems that need to be solved. Be prepared and plan properly for success. Others have done and you can too!

Our Support
At the UK College we provide advice and support on the many steps needed to get your business started. Particularly how to develop the right mindset and approach to be able stick with your commitment to succeed – as well as how to apply what you’ve learned on the course to overcome your own psychological hurdles (hypnotise yourself to be a great hypnotherapist, for example – see our Hypnotherapy for Hypnotherapists script!).

We’re particularly experienced with web marketing and what is required in order to rank well in Google, get clients to your site and get them to take action. We are usually ranking number 1 or 2 for all the main keywords related to hypnotherapy training. That’s been a skill that we’ve developed over the last 10 years with a huge investment in professional advice. All of which is made available to our Diploma students.

From 2017 forwards two hours of personal business coaching is provided to each student on our Diploma courses – as well as access to some special resources on how to build a successful website.

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Other Frequently asked questions

1/ What do I need to do be a hypnotherapist? What training is required? Don't I need more than just a training course?

In terms of therapeutic ability, you do need to have good people skills and be able to communicate and listen well. These things can be learned and developed. Most of the development occur during therapy. We don't believe that long training in counselling skills is required or particularly helpful. In our experience, some people come out of long counselling or psychotherapy training programmes more confused, less natural and less spontaneous than when they began. We've also observed that many students use the idea of "I just need another training course" to avoid starting therapy.

You can learn the theory (ideas) and do some practical training (classroom work in pairs) but then you actually need to get your feet wet and start doing therapy. That is the best way to learn. This needs to be supported by ongoing supervision, which is essential, and continued study and/or continuing professional development (CPD). As a therapist you're always learning and developing – you are never complete.

You'll also need reasonable administration skills - you will be running a business - and good-to-excellent marketing skills. Hypnotherapists are in private practice - if you can't market to bring clients in then it won't matter how good you are as a therapist.

Our intensive training (theory and practice) in evidence-based hypnotherapy has a strong focus on learning the core tasks of psychotherapy (i.e. what expert therapists do in any field). Then we get you into practice. We have ongoing CPD workshops, a website community and supervision to help you develop as a working therapist.

2/ Is hypnotherapy effective compared to other types of therapy?

Hypnotherapy has a good evidence base. However, many of the earlier studies lack the good research design (randomised control trials, for example) that are required today.

A search in PubMed (online search for academic articles on health) shows more than 12,000 results for hypnotherapy - more than for psychotherapy, and much, much more than NLP. We've developed a graphic showing how different authoritative organisations have reviewed hypnotherapy and hypnosis (see Fig. 1, below). The British Psychological Society published a report into The Nature of Hypnosis in 2001. It's expert panel concluded:

"Enough studies have now accumulated to suggest that the inclusion of hypnotic procedures may be beneficial in the management and treatment of a wide range of conditions and problems encountered in the practice of medicine, psychiatry and psychotherapy……

There is convincing evidence that hypnotic procedures are effective in the management and relief of both acute and chronic pain and in assisting in the alleviation of pain, discomfort and distress due to medical and dental procedures and childbirth.

Hypnosis and the practice of self-hypnosis may significantly reduce general anxiety, tension and stress in a manner similar to other relaxation and self-regulation procedures. Likewise, hypnotic treatment may assist in insomnia in the same way as other relaxation methods.

There is encouraging evidence demonstrating the beneficial effects of hypnotherapeutic procedures in alleviating the symptoms of a range of complaints that fall under the heading 'psychosomatic illness.' These include tension headaches and migraine; asthma; gastro-intestinal complaints such as irritable bowel syndrome; warts; and possibly other skin complaints such as eczema, psoriasis and urticaria [hives].

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[...] There is evidence from several studies that its [hypnosis'] inclusion in a weight reduction programme may significantly enhance outcome."

- The Nature of Hypnosis, British Psychological Society 2001.

Fig. 1

Systematic Reviews and Reports on Hypnosis

	The British Psychological Society	BMJ	BMA	NHS National Institute for Health and Clinical Excellence	NIH National Institutes of Health
	British Psychological Society	**British Medical Journal**	**British Medical Association**	**National Institute Of Clinical Excellence**	**National Institutes of Health (US)**
Conditions	*The Nature of Hypnosis, 2001 (Heap, Aden, Brown, Naish, Oakley, Wagstaff & Walker)*	*Clinical Review: Hypnosis & Relaxation Therapies, 1999 (Vickers & Zollman)*	*Subcomittee Report: The Medical Use of Hypnotism, 1955 (Prof. T. Ferguson Rodger)*	*Guidelines for Treatment of IBS (2008)*	*Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia (2005)*
Psychosomatic Disorders	**Yes**	**Yes***	**Yes**		**Yes**
Tension headaches	Yes				Yes
Warts	Yes				
Skin Disorders: Psoriasis, eczema, urticaria	Yes				
IBS	Yes	Yes		Yes	Yes
Asthma	Yes	Yes			
Anxiety	**Yes w CBT**	**Yes w CBT**	**Yes**		
Stress & Tension reduction	Yes				
Panic Attacks		Yes			
Phobias	Yes w CBT	Yes w CBT			
Pain Relief	**Yes**	**Yes**	**Yes**		**Yes**
Acute Pain Relief	Yes	Yes	Yes		
Chronic Pain Relief	Yes	Yes			Yes
Anaesthesia	Yes		Yes		
Pain relief for Childbirth	Yes		Yes		
Cancer support: pain, stress, nausea	Yes	Yes			Yes
Behavioural Change					
Obesity / Weight reduction	Yes**	Yes w CBT			
"Morbid patterns of thought & behaviour"			Yes		
*	By implication				
**	when included as part of an overall plan for weight control or when combined with CBT				

3/ Should I study NLP as well? Is that important?

Despite very exciting claims, NLP has failed to deliver research results, with no significant evidence for its effectiveness 35 years after being introduced. It is sold and marketed heavily, and promises to make you a Master Practitioner in just seven days. Undoubtedly there are some good ideas and techniques – but most are taken from somewhere else.

4/ How much can I earn as a hypnotherapist?

If you are committed to becoming a full-time hypnotherapist and investing proper time, money, study and energy then you can probably earn somewhere between £25,000 to £55,000 per annum (before tax and national insurance). We have a dedicated session on the final phase of the course dedicated to potential revenue streams and how to effectively budget and forecast.

5/ What do all the different titles and organisations mean?

See our list of acronyms in the Appendix.

6/ Should I learn regression?

There is little evidence for the effectiveness of regression-based approaches. It usually isn't a single event that causes the problems but an ongoing catalog of events - the original cause isn't the maintaining cause. Also there is no area of hypnotherapy that carries so much risk. Hypnotherapy is basically incredibly safe – except when it comes to regression hypnotherapy where people can suddenly change their beliefs about what happened in their childhood, etc. The largest legal case against a therapist ($2 million) was due to the therapist conducting regression hypnosis to find a forgotten episode of child abuse (which had never actually happened).

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7/ What about stopping smoking hypnotherapy?

We consider Smoking Cessation Hypnotherapy as an advanced application requiring mastery of a range of skills and interventions, as well as huge degree of confidence communicated by the therapist - all delivered in potentially a two-hour intensive session. There are very few psychotherapists or psychologists that will attempt smoking cessation because outcomes rates are generally very low, and placebo rates are extremely low. Research shows that hypnosis on its own is not effective (despite all the claims made), therefore we teach this as a CPD workshop (MasterClass) that teaches a "multi-component" approach and we do not include it in our standard diploma training. Many of our specialist CPD workshops build upon the basic skills covered in the Diploma training.

8/ Other schools offer Cognitive Behavioural Hypnotherapy training – what makes yours different?

We've been teaching this approach longer than any other training school in the UK – and, to the best of our knowledge, in the world. Most of the other training schools teach CBT plus traditional hypnosis, which means they teach cognitive behavioural therapy then hypnosis in the traditional sense (inducing trance, accessing the subconscious mind, etc). Our approach is far more integrative – we have trademarked the term "Hypno-CBT" to identify this approach as different. Our Hypno-CBT® approach is integrative in three ways:

1. Our approach to hypnosis is based upon a cognitive-behavioural model, with hypnosis defined in terms of focused attention, motivation, expectation, imagination and visualisation. There is no trance or altered state in our model (these are viewed as "surplus concepts" which add nothing to the explanation of hypnosis).

2. We conceptualise client problems as often comprising negative self-hypnosis (clients responding hypnotically to their own negative thoughts). This allows us to integrate hypnotherapy very tightly into CBT.

3. "De-hypnotising" from the stream of automatic negative thoughts becomes a key focus in our approach. This "dehypnosis" is commonly known as "mindfulness of thoughts" or "cognitive distancing" or "cognitive defusion". Many different techniques are used to achieve dehypnosis.

4. We train clients to become more integrated in terms of thoughts, emotion and behaviour, so that thought, feeling and action can become ONE, leading to authenticity and FLOW rather than thinking and feeling one thing while doing something else. Our therapeutic interventions bring together the domains of emotion, behaviour and cognition (e.g. our ABC Triple Exposure hypnotherapy).

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1/ “How Much Can I Earn as a Hypnotherapist?” by Mark Davis

3/ Common Acronyms in the Hypnotherapy Profession

3/ MANUAL EXCERPT: The Medical and Scientific Acceptance of Hypnosis

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1/ How much can you earn as a hypnotherapist?

If you are committed to becoming a full-time hypnotherapist and investing properly in terms of time, money, study and energy, then you can probably earn somewhere *between £25,000 to £55,000* income (before tax and national insurance). However, many hypnotherapists end up doing hypnotherapy part-time and never really developing a successful full-time practice.

It's hard to earn more than £55,000 per year simply because of several limiting factors:

a) The costs of admin, marketing, room rent, professional registration, supervision, CPD and insurance will usually be somewhere between 20-40 per cent of your income.

b) Realistically, most therapists would find it too much to see clients more than 25 hours a week for 48 weeks a year (assuming four weeks holiday per year).

c) If you earn more than £83,000 then you have to register for VAT and add it onto your prices (or pay the VAT out of your current prices).

So, generally £83,000 is the maximum gross revenue a therapist will earn as very few therapists can increase prices or revenue enough to make it worthwhile registering for VAT.

[NB: If you are deemed a "health professional" then you probably won't have to register for VAT, but please talk to your accountant or take advice from a tax advisor.]

The biggest cost for most therapists is room rent – which can be anywhere from £6/hour to £40/hour, depending on location, type of room and the contract agreement. Some therapists choose to work out of their own home or build a therapy room in the garden or convert the garage to a therapy room. These can be very good ideas to consider in terms of cutting costs, however, there are also a range of issues in working from home (professionalism, security, privacy, etc.) that need to be carefully considered.

Typically, in London you can rent a therapy room in a four-hour block for £60 (£15/hr). You have to commit to the time period each week and pay each month. The tricky thing becomes using all four hours each week, which is unlikely. Also, you have to pay for the room while you are on holiday (yuck!). So, in terms of planning and costs, you have to estimate having a "fill-rate" of typically 60 per cent to 75 per cent. This quickly increases the average cost-per-therapy-hour for renting the room, e.g. at a 60 per cent fill rate, £15/hr becomes £25 per therapy hour delivered.

In term of overall costs therapists can expect room rent to usually be 20 per cent to 30 per cent of their gross revenues. If you are charging £65/hour then the real cost of the therapy room might be £13 to £20 per hour. Or you might be able to take a room on an "ad-hoc" basis (when you need it), but you will often be charged a lot more – perhaps £25 to £40 per hour in central London.

Both novice and experienced therapists need to keep a close eye on their room rent costs, being careful not to commit too much at the beginning. For example early on as a therapist I took a room on Wimpole Street thinking I'd be immediately successful at a cost of £300/month for a four-hour slot per week in a very nice therapy clinic… after 4 months and only one client I dropped it then invested in marketing and finding an ad-hoc arrangement that worked for me instead.

Marketing Costs

Always remember that advertising is one of the fastest ways to burn through money. It's easy to get carried away and think that by placing some large full-page adverts in local or national newspapers or on a website that suddenly everyone will want to knock down your door. What you will need is a good website and well-designed materials (business cards, brochures, letterhead etc). In addition you might want to advertise with Google or sign up to paid directo-

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ries. This is large and important topic – being a good therapist is not sufficient, you need also to be good to excellent at marketing! Or recognise the need to hire or develop that expertise.

Therapists might spend anywhere from 2 per cent to 20 per cent of their revenues on marketing. However they will, at the beginning, spend anywhere from 40% to 70% of their time on the marketing of their practice. If you want a full time practice it is full time work to build one, the same as any other business.

Notes

Many therapists will pay a lot more in room rent; some will pay much less. Getting a low room rent and a good fill rate is essential - I average about 85 per cent occupancy at one location, which is fantastic. Getting above 60 per cent occupancy on a room is good. Obviously, if you can get a room on an ad-hoc or flexible basis that can be much better.

If you work from home it's a huge cost saving. BUT do not try to save money on room rent and miss out on business opportunities. Many therapists may hire a room in a city-centre location (e.g. a health centre) and charge a higher rate there, but also see clients locally (perhaps at home) for a lower rate.

Most therapists don't properly plan, budget and spend on a marketing budget. They don't spend enough on the right things and fail to measure the results of what they spend. But if you invest in you website you will do better; finding good people to help with marketing your website is one of the hardest challenges.

You should expect to spend more on marketing in your first two years. Either you will learn how to do the marketing yourself (writing articles, website maintenance, internet marketing, website design, email newsletters, etc) or you will pay someone to do that for you (more expensive but it could be quicker).

We recommend that most students get someone to do it for them to begin with while they learn how to do it themselves. Learning how to market your business, in particularly mastering some of the simple technical aspects of updating a website, using Facebook, setting up Google Adwords, designing a flyer, making a recording, writing an email newsletter and sending it – these skills make up a good part of being a successful private therapist.

VAT: VAT registration is currently at £79,000, which is quite easy to hit in London (46 weeks x 16 hours x £120 per hour = £88,320). Suddenly you have to pay 20 per cent the VATman – can you raise your prices by 20 per cent to cover this? Unlikely without a drop in bookings.

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List of Common Acronyms

Acronym	Full Name	Notes
ACT	Acceptance and Commitment Therapy	
BABCP	British Association of Behavioural and Cognitive Psychotherapists	Main register for accredited CBT therapists
BACP	British Association of Counselling and Psychotherapy	
BPS	British Psychological Society	
CBT	Cognitive Behavioural Therapy	
CNHC	Complementary and National Healthcare Council	Umbrella organisation for complementary therapists (including hypnotherapists)
GAD	General Anxiety Disorder	
GHR	General Hypnotherapy Register	
HPC	Health Professions Council	
ISMA	International Stress Management Association	
NCFE	Northern College of Further Education	- external verifier. NCFE is a government regulated awarding (examination) body – that is monitored by the Office for Qualifications and Examinations (OfQual) – the same government department that oversees GCSE and A-Level results.
NCH	National Council of Hypnotherapy	
NOS	National Occupational Skills	
OCD	Obsessive Compulsive Disorder	
PMR	Progressive Muscle Relaxation	
PSA	Professional Standards Authority	Government organisation overseeing health and social care professionals
PTSD	Post Traumatic Stress Disorder	
REBHP	Register for Evidence-Based Hypnotherapy & Psychotherapy	
UKCP	UK Council of Psychotherapy	

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APPENDIX 3: The Medical & Scientific Approval of Hypnotherapy (Manual Excerpt_

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The therapeutic use of "trance", in its generic sense, is found in virtually every culture across the world and most likely stretches back into ancient prehistory. The hypnotic state as we know it today has its precursor in the convulsive 'emotional crises' and 'somnambulistic trances' of 18th century mesmerism. However, the modern scientific understanding of hypnosis really originated with the pioneering work of a Scottish physician named James Braid (1795-1860). Braid, who coined the term 'hypnotism', categorically rejected any supernatural explanations of "trance" and grounded the study of hypnosis on a firm neuropsychological basis, publishing his findings in Neurypnology (1843), arguably the first book on 'hypnotherapy' per se.

The medical practice of hypnotherapy, as the documents cited below prove, has subsequently been approved by the British Medical Association (BMA), a recognition which was first stated in 1892, reinforced in 1955, and followed by the American Medical Association (AMA) in 1958. The information which follows is taken from analysis of key documents in the history of the hypnotherapy profession which were identified by a historical research project conducted by The UK College of Hypnosis and Hypnotherapy.

British Medical Establishment

James Braid's influence was greater abroad, especially in France, than in the UK. However, by the late 19th century British interest in hypnosis began to revive. The Society for Psychical Research (SPR) was formed in 1893 to study phenomena of parapsychology and hypnotism. Several important textbooks on hypnotism were published at this time by the authors C. Lloyd Tuckey, J. Milne Bramwell, and Francis Cruise. In 1906, Tuckey, Bramwell and others formed a Medical Society for the Study of Suggestive Therapeutics –taking its name from an influential book by Bernheim (1884).

In 1892 the BMA had responded to the growing interest in hypnotherapy by commissioning a special committee of eleven doctors 'to investigate the nature of the phenomenon of hypnotism, its value as a therapeutic agent, and the propriety of using it.' In addition to studying the work of James Braid, the Committee sent representatives to Paris and Nancy to personally observe the experiments of Jean Martin Charcot and Hippolyte Bernheim -two of the most important figures in the history of hypnosis. Their report was received by the BMA and published in the British Medical Journal, it opens with a clear recognition of the phenomenon of hypnosis:

> The Committee, having completed such investigation of hypnotism as time permitted, have to report that they have satisfied themselves of the ***genuineness*** of the hypnotic state. (BMA, 1892, *my italics*)

The Committee, however, reject the theory of 'animal magnetism', in other words they recognise Braid's 'psycho-physiological' account of hypnosis as scientific, but not Mesmer's supernatural theory of invisible fluids and forces. The Committee also agree with Braid's later view that his own expression 'hypnotism' -from upnoV the Greek word for sleep- was essentially a misnomer,

> The Committee take this opportunity of pointing out that the term hypnotism is somewhat misleading, inasmuch as sleep, as ordinarily understood, is not necessarily present. (Ibid.)

It is worth noting, however, that Braid introduced 'hypnotism' as an abbreviation of the slightly less misleading term 'neuro-hypnotism', meaning 'sleep of the nervous system' not sleep as ordinarily understood. Braid's attempt to substitute the name 'monoideism' (fixation upon a single idea) never really caught on, neither was he fully satisfied with that terminology himself.

Following these opening comments, the Committee proceed to outline a reasonably accurate account of the physical and mental characteristics of the hypnotic state,

> Among the ***mental phenomena*** are altered consciousness, temporary limitation of will-power, increased receptivity of suggestion from without, sometimes to the extent of producing passing delusions, illusions, and hallucinations, an exalted condition of the attention, and post-hypnotic suggestions.
>
> Among the ***physical phenomena*** are vascular changes (such as flushing of the face and al-

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> tered pulse rate), deepening of the respirations, decreased frequency of deglutition [i.e., swallowing], slight muscular tremors, inability to control suggested movements, altered muscular sense, anaesthesia, modified power of muscular contraction, catalepsy, and rigidity, often intense. (Ibid., *my italics*)

The Committee rightly stress that the experience of hypnotic "trance" varies widely, and that although these responses are typical they are seldom all found together in a single case. They conclude with a statement of the main therapeutic benefits of hypnosis,

> The Committee are of opinion that as a therapeutic agent hypnotism is frequently effective in ***relieving pain***, ***procuring sleep***, and alleviating many ***functional ailments*** [i.e., psycho-neuroses]. (Ibid., *our italics*)

The report is brief - we have quoted most of the text here- but generally supportive of hypnotherapy. However, certain concerns are expressed as follows,

> ***Dangers*** in the use of hypnotism may arise from want of knowledge, carelessness, or intentional abuse, or from the too continuous repetition of suggestion in unsuitable cases. The Committee are of the opinion that when used for therapeutic purposes its employment should be ***confined to qualified medical men***, and that under no circumstances should ***female patients*** be hypnotised except in the presence of a relative or person of their own sex. In conclusion, the Committee desire to express their strong disapprobation of ***public exhibitions*** of hypnotic phenomena, and hope that some legal restriction will be placed upon them. (Ibid., *my italics*)

At this point the report departs from genuine scientific observation and lapses into hypothesis and speculation. These so-called 'dangers' refer mainly to concerns over the potential misuse of hypnosis, either through incompetence or wilful abuse. Nevertheless, the report could be taken to imply that hypnosis itself is somehow dangerous. Many eminent professionals have disputed such notions, to take just one example, Gil Boyne (president and founder of the American Council of Hypnotist Examiners) has campaigned for many years against similar accusations. As a result of Boyne's work, a total of 32 bills aiming to restrict the practice of hypnotism in various US states have been defeated, mainly because no satisfactory evidence has been established to support claims that hypnosis itself is dangerous.

1955 BMA Report on Hypnosis

However, almost sixty years later, following the concluding recommendations made in the 1892 BMA report, the 1952 Hypnotism Act was passed for inclusion in the Book of Statutes. The Hypnotism Act regulates all public presentations of hypnosis in the UK, moreover, it includes the following legal definition of hypnotism:

> "***Hypnotism***" includes hypnotism, mesmerism and any similar act or process which produces or is intended to produce in any person any form of induced sleep or trance in which the susceptibility of the mind of that person to suggestion or direction is increased or intended to be increased but does not include hypnotism, mesmerism or any similar act or process which is self-induced. (*The Hypnotism Act*, 1952)

Subsequently a voluntary organisation called the Federation of Ethical Stage Hypnotists was formed and some non-statutory Home Office guidelines on the practice of stage hypnosis were published. The next year, however, in response to this legislation, the Psychological Medicine Group of the BMA commissioned a Subcommittee, led by Prof. T. Ferguson Rodger, to deliver a second, and more comprehensive, report on hypnosis. The Subcommittee consulted several experts on hypnosis from various fields, including the eminent neurologist Prof. W. Russell Brain, and the psychoanalyst Wilfred Bion. After two years of study and research, its final report was published in the British Medical Journal (BMJ), under the title 'Medical use of Hypnotism'. The terms of reference were:

> To consider the uses of hypnotism, its relation to medical practice in the present day, the advisability of giving encouragement to research into its nature and application, and the lines upon which such research might be organised. (BMA, 1955)

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The Subcommittee rightly notes that the definition established in the Hypnotism Act is inaccurate and unsatisfactory. In its place, they propose the following medical definition of 'the hypnotic state':

> A temporary condition of ***altered attention*** in the subject which may be induced by another person and in which a variety of phenomena may appear spontaneously or in response to verbal or other stimuli. These phenomena include ***alterations in consciousness*** and ***memory***, ***increased susceptibility to suggestion***, and the production in the subject of responses and ideas unfamiliar to him in his usual state of mind. Further, phenomena such as ***anaesthesia***, ***paralysis*** and ***rigidity of muscles***, and ***vasomotor changes*** can be produced and removed in the hypnotic state. (Ibid., *my italics*)

It is especially noteworthy that the Subcommittee substitute 'altered attention' for the Book of Statutes' expression 'induced sleep'.

The Subcommittee made a point of endorsing the earlier 1892 report, commenting that its conclusions 'showed remarkable foresight and are mainly applicable today.' They also provide a more extensive statement on the medical uses of hypnosis and conclude that it is an effective technique in the treatment of neuroses, psycho-somatic conditions and physical pain:

> The Subcommittee is satisfied after consideration of the available evidence that ***hypnotism is of value*** and may be ***the treatment of choice*** in some cases of so-called ***psycho-somatic disorder*** and ***psychoneurosis***. It may also be of value for revealing ***unrecognised motives*** and ***conflicts*** in such conditions. As a treatment, in the opinion of the Subcommittee it has ***proved its ability*** to remove symptoms and to alter morbid habits of thought and behaviour. […]
>
> In addition to the treatment of ***psychiatric disabilities***, there is a place for hypnotism in the production of ***anaesthesia*** or ***analgesia*** for surgical and dental operations, and in suitable subjects it is an effective method of ***relieving pain in childbirth*** without altering the normal course of labour. (Ibid., *my italics*)

The Subcommittee strongly recommend that further research take place and that medical undergraduates be introduced to hypnosis as part of their standard psychiatric training, and that 'instruction in the clinical use of hypnotism should be given to all medical postgraduates training as specialists in psychological medicine.'

Regarding the supposed 'dangers' of hypnotherapy, the Subcommittee provide a statement slightly more relevant to modern society than that in the 1892 report, but equally controversial,

> The ***dangers*** of hypnotism have been ***exaggerated*** in some quarters. The Subcommittee is convinced, however, that they do exist, especially when it is used without proper consideration on persons predisposed, constitutionally or by the effects of disease, to severe psychoneurotic reactions or antisocial behaviour. The commission of crimes involving even danger to life is not entirely to be ruled out. (Ibid., *my italics*)

They also go on to note the risks involved in the intense relationship and powerful emotions which are thought to be quickly created in certain therapeutic relationships. This seems to be a reference to the possible mismanagement of 'abreaction' and the 'transference relationship', although those terms are not used by the authors of the report. Again, these remarks are speculative and the comment should be added that most professional hypnotherapists would dispute the implication that hypnosis is inherently dangerous. However, some professional therapists might agree that that in certain cases, such as in the treatment of client's exhibiting psychotic symptoms, the use of certain techniques may be contra-indicated. The further idea that hypnosis could be used to suggest the commission of dangerous or criminal acts is, however, contradicted by most research on the subject.

It is also worth noting that the 1955 report significantly modifies the earlier suggestion that the use of hypnotherapy should be 'confined to qualified medical men', by recommending that,

> […] the use of hypnotism in the treatment of physical and psychological disorders should be confined to ***persons subscribing to the recognised ethical code*** which governs the relation of doctor and patient. This would not preclude its use by ***a suitably trained psychologist or medical auxiliary*** of whose competence the medical practitioner was personally satisfied, and who would carry out, under medical direc-

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> tion, the treatment of patients selected by the physician. (Ibid., *my italics*)

Professional hypnotherapy organisations now have their own specific code of ethics and practice which would effectively supersede the medical 'ethical code' recommended here. Also, most hypnotherapists study the psychology and psychotherapy relevant to their subject and would tend refer to themselves as 'therapists' rather than 'psychologists', as this would imply that their primary training is in academic psychology rather than clinical hypnotherapy. The recommendation that medical supervision is required is obviously only relevant to certain cases where the client is receiving treatment for certain types of physical illness.

According to a statement of proceedings published elsewhere in the same edition of the BMJ, the report was officially 'approved at last week's Council meeting of the British Medical Association.' (BMA Council Proceedings, BMJ, April 23rd, 1955:1019, my italics). This statement goes on to say that,

> For the past hundred years there has been an ***abundance of evidence*** that psychological and physiological changes could be produced by hypnotism which were worth study on their own account, and also that such changes might be of ***great service in the treatment of patients***. (Ibid., *my italics*)

Following this approval of the report by the BMA, the British Society of Dental Hypnosis (BSDH) –an organisation formed following the Hypnotism Act in 1952- was expanded to incorporate a medical section and renamed the Dental & Medical Society for the Study of Hypnosis. In 1968 the society was renamed again as the British Society of Medical & Dental Hypnosis (BSMDH). From 1969 to 1975, the BSMDH published the British Journal of Clinical Hypnosis, which was later superseded by the Proceedings of the BSMDH. The BSMDH were subsequently recognised by the General Medical and Dental Councils, the Medical Protection Society and the Medical Defence Union, although the BSMDH have informed me that they are still not officially recognised by the BMA.

In 1978 the Royal Society of Medicine (RSM) formed a section for 'Hypnosis and Psychosomatic Medicine' whose aims are 'to promote the knowledge and understanding of hypnosis and psychosomatic medicine.' In 1983 the Royal Society of Medicine approved a diploma level training course in hypnotherapy designed by the BSMDH. BSMDH training is only open to doctors, dentists and approved paramedical professionals, it consists of courses, workshops and meetings amounting to 14 days or more and spanning a period of 3 years. At present (2001), the BSMDH and its associated regional organisations have a combined membership of approximately 600 doctors and dentists who employ hypnotherapy within a medical context.

In 1977 the British Society of Experimental & Clinical Hypnosis (BSECH) was formed. Membership mainly consists of medical doctors and other health professionals. The Society publishes a journal, which is now called Contemporary Hypnosis. In 1980, the British Society for the Practice of Hypnosis in Speech and Language Therapy was formed, which is mainly open to speech therapists.

The Board of Science of the BMA published an official policy report on Alternative Therapy in 1986. This is clearly a very inferior document to the 1955 report. However, it does make a number of statements with regard to hypnotherapy. They open by emphasising that hypnotherapy is 'available as part of orthodox medical treatment.' It cites at length and with approval a report commissioned by the Royal Society of Medicine in 1984, entitled 'Symposium on Psychological Influences and Illness: Hypnosis and Medicine.' Dr. David Waxman, President of the BSMDH gave oral evidence to the BMA Working Party and quoted as stating that those conditions most amenable to hypnosis are 'primarily the neuroses: anxiety, phobic problems, obsessional illnesses, or hysterical conversion symptoms.' The BMA report concludes by formally stating policy as follows,

> **Hypnotherapy**. Although the hypnotic state is not fully understood, this should not lead to neglect of hypnosis as a technique as it can benefit certain patients. There is a case for increased research to provide better understanding of hypnotherapy. However, hypnotherapy should only be used as part of the planned management of a condition, and such planned management should always begin with a proper diagnosis. In view of this, the Working Party believes that the use of hypnotherapy should be restricted to medical practitioners, dentists, and trained and qualified clinical psychologists.

In its submission of evidence to the House of Lords Select Committee on Science and Technology (2001) the BMA officially stated that 'Hypnotherapy and counselling may be considered as orthodox treatments', i.e., as opposed to 'complementary' or 'alternative' treatments. However, the Select Committee report classes hypnotherapy as a branch of complementary and alternative medicine

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(CAM). Hypnotherapy is categorised as a member of the 'second group' of CAM therapies which, according to the Select Committee report, are used to complement conventional medicine but do not purport to embrace diagnostic skills.

With regard to research, in 1999 the British Medical Journal (BMJ) published a 'Clinical Review' of hypnosis and relaxation therapies in which a carefully conducted overview of the best medical evidence on hypnosis confirms its effectiveness in alleviating pain and treating various medical conditions. Cognitive-behavioural therapy (CBT) is ultimately derived from hypnotherapy, incidentally, and the CBT techniques used in these kind of studies are often identical to standard hypnotherapy interventions such as goal visualisation. In any case, the study proves that hypnosis is effective in the following cases,

> There is good evidence from randomised controlled trials that both hypnosis and relaxation techniques can reduce anxiety, particularly that related to stressful situations such as receiving chemotherapy. They are also effective for panic disorders and insomnia, particularly when integrated into a package of cognitive therapy (including, for example, sleep hygiene). A systematic review has found that hypnosis enhances the effects of cognitive behavioural therapy for conditions such as phobia, obesity, and anxiety.
>
> Randomised controlled trials support the use of various relaxation techniques for treating both acute and chronic pain, […]. Randomised trials have shown hypnosis to be of value in asthma and in irritable bowel syndrome […].
>
> Relaxation and hypnosis are often used in cancer patients. There is strong evidence from randomised trials of the effectiveness of hypnosis and relaxation for cancer related anxiety, pain, nausea, and vomiting, particularly in children. (BMJ, 1999)

In essence the Clinical Review suggests that hypnotherapy has proven its effectiveness mainly in the treatment of pain, insomnia, and anxiety. It is interesting to compare this research overview to the one provided by the British Psychological Society (BPS) below. Together they demonstrate that hypnotherapy has become an established, evidence-based treatment for a number of common conditions.

The American Medical Association

Three years after the BMA report the American Medical Association (AMA) followed suit by officially approving a two-year study on the 'Medical use of Hypnosis' by their Council on Mental Health, led by Dr. M. Ralph Kaufman. In this report, the AMA, like the BMA, recognised hypnotherapy as an orthodox medical treatment. In the preface to the report it is stated that 'in substance, the Council's report indicates that there are definite and proper uses of hypnosis in medical and dental practice,' (AMA, 1958). The AMA proceedings provide the following summary of conclusions and statement of approval,

The Board submitted an informal report on hypnosis, which was developed by its Council on Mental Health acting as a Committee of the Whole [AMA] to study the medical use of hypnosis. The report stated

> (1) that the use of hypnosis has ***a recognised place in the medical armamentarium*** and is a ***useful technique in the treatment of certain illnesses*** when employed by qualified medical and dental personnel;
> (2) that teaching related to hypnosis should be under responsible medical or dental direction;
> (3) that as certain aspects of hypnosis still remain unknown and controversial, active participation in high level research by members of the medical and dental professions is to be encouraged; and
> (4) that the use of hypnosis for entertainment purposes is vigorously condemned. […]
>
> The Reference Committee on Hygiene, Public Health, and Industrial Health ***approved the report*** and commended the Council on Mental Health for its work. The House of Delegates adopted the Reference Committee report […]. (AMA Proceedings, JAMA, Sep. 1958: 57, *my italics*)

The AMA 'Hypnosis Committee' also stated their 'essential agreement' with the 'excellent report' published by the BMA, and proceeded to state their general agreement with the BMA definition of hypnosis. They repeatedly stress that hypnosis should be studied against a 'background of psychodynamic psychology and psychiatry.' Compared with the BMA, they are much more inconclusive about the possible 'hazards of hypnosis' and simply agree that no firm evidence could be established and that 'this is an area for further research', a fact which seems to conflict with their 'vigorous' condemnation of stage

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hypnosis. Overall this report is shorter, more ambiguous and less conclusive than the British one, but it does officially acknowledge the effectiveness of hypnotherapy and its useful role in psychiatry and medicine.

The American Psychiatric Association (APA)

In 1961, the American Psychiatric Association published a policy document entitled 'Regarding Hypnosis: Position Statement' (APA Document Reference 610001). The statement was prepared by the Committee on Therapy and officially approved as their policy by the Council of the APA on February 15th 1961. It begins,

> Hypnosis is a specialised psychiatric procedure and as such is an aspect of the doctor-patient relationship. Hypnosis provides an adjunct to research, to diagnosis and to treatment in psychiatric practice. It is also of some value in other areas of medical practice and research.

This report bemoans the limited number of controlled studies available at the time. It continues by raising concerns over the safe use of hypnosis, and referring to some of its key applications,

> Hypnosis is appropriately and properly used in the course of therapy only when its employment serves therapeutic goals without posing undue risks to the patient. With selected patients, it can be used for sedative, analgesic and anaesthetic purposes; for the relief of apprehension and anxiety; and for symptom suppression. It can also be used, but on a still more highly selective basis, as an adjunct in the treatment of patients with neurotic or psychotic illness.
>
> Hypnosis or hypnotic treatment, as in any other psychiatric procedure, calls for all examinations necessary to a proper diagnosis and to the formulation of the immediate therapeutic needs of the patient. The technique of induction of the trance state is by far the least important of the many facets of the hypnotic procedure and under no circumstance should it be taught independently.

They do conclude that hypnosis has 'definite application' in various fields of medicine. However, they complain that many courses in hypnosis are too brief and focus primarily upon the induction, without paying due attention to other aspects of treatment. They call for improved training in hypnosis to be made available to any physicians requesting it.

The (US) National Institute of Health (NIH)

The National Institutes of Health (NIH) is part of the US Department of Health & Human Services; it is one of the foremost medical research organisations in the world and responsible for the US Government's medical research at a national level. In 1995, the NIH established a Technology Assessment Conference that compiled an official statement entitled 'Integration of Behavioural & Relaxation Approaches into the Treatment of Chronic Pain & Insomnia.' This is an extensive report that includes a statement on the existing research in relation to hypnotherapy for chronic pain. It concludes that:

> The evidence supporting the effectiveness of hypnosis in alleviating chronic pain associated with cancer seems strong. In addition, the panel was presented with other data suggesting the effectiveness of hypnosis in other chronic pain conditions, which include irritable bowel syndrome, oral mucositis [pain and swelling of the mucus membrane], temporomandibular disorders [jaw pain], and tension headaches. (NIH, 1995)

This report is conservative in its conclusions but at least recognises some of the existing medical research on the effectiveness of hypnotherapy.

The British Psychological Society (BPS)

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In 2001, the Professional Affairs Board of the British Psychological Society (BPS) commissioned a working party of expert psychologists to publish a report entitled The Nature of Hypnosis. Its remit was 'to provide a considered statement about hypnosis and important issues concerning its application and practice in a range of contexts, notably for clinical purposes, forensic investigation, academic research, entertainment and training.' The report provides a concise (c. 20 pages) summary of the current scientific research on hypnosis. It opens with the following introductory remark:

> Hypnosis is a valid subject for scientific study and research and a proven therapeutic medium. (BPS, 2001)

The report notes that the precise nature and status of hypnotic trance is still an area of scientific controversy about which research has established little with certainty. However, it also observes that there is good evidence to show that 'expectation' and 'enhanced motivation' are psychological factors which contribute to hypnotic suggestibility. To this the working party add,

> [...] although they may become very absorbed in the suggested ideas and images, subjects typically retain awareness of their environment and respond appropriately to it. Afterwards, they are usually able to recall most, if not all, of what they attended to during the session. (BPS, 2001)

They proceed to address the question as to whether subjects can be made to follow suggestions which are objectionable to them.

> Hypnotic procedures are not in themselves able to cause people to commit acts against their will. However, the demands of the context in which the procedures take place may exert pressure on the subject to comply with the hypnotist's instructions. (BPS, 2001)

In other words, in hypnosis people can be manipulated into doing things against their will in just the same way that they can when not in hypnosis, by persuasion, coercion, deceit, etc. These factors have nothing, however, to do with hypnotic state itself.

The report raises a number of questions about the use of hypnosis to recover memories, an area which has been the focus of recent research. In relation to scientific concerns over the "forensic" use of hypnosis, the working party note that several US states have gone so far as to actually ban witnesses who have previously been interviewed using hypnosis from testifying in court. The concern is that the inappropriate use of hypnosis prior to a trial might implant false memories and thereby corrupt and invalidate the testimony of witnesses.

There is no such ban in the UK, though in 1987 the Home Office issued draft guidelines on the use of forensic hypnotism which urged special caution when using hypnosis to recover memories as a source of legal evidence, and recommend that witnesses who are to testify in court should not be hypnotised. The working party add,

> Subsequently, in 1988, the Home Office issued a circular stating more definitively that, because of the risks attached to its use, hypnosis should be discouraged as a tool in police investigations. (BPS, 2001)

With regard to the therapeutic uses of hypnosis, the BPS arrive at much more positive conclusions.

> Enough studies have now accumulated to suggest that the inclusion of hypnotic procedures may be beneficial in the management and treatment of a wide range of conditions and problems encountered in the practice of medicine, psychiatry and psychotherapy. (BPS, 2001)

The working party then provide an overview of some of the most important contemporary research on the efficacy of clinical hypnotherapy, which are summarised as follows (omitting their detailed references).

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> There is convincing evidence that hypnotic procedures are effective in the management and relief of both acute and chronic pain and in assisting in the alleviation of pain, discomfort and distress due to medical and dental procedures and childbirth.
>
> Hypnosis and the practice of self-hypnosis may significantly reduce general anxiety, tension and stress in a manner similar to other relaxation and self-regulation procedures. Likewise, hypnotic treatment may assist in insomnia in the same way as other relaxation methods.
>
> There is encouraging evidence demonstrating the beneficial effects of hypnotherapeutic procedures in alleviating the symptoms of a range of complaints that fall under the heading 'psychosomatic illness.' These include tension headaches and migraine; asthma; gastro-intestinal complaints such as irritable bowel syndrome; warts; and possibly other skin complaints such as eczema, psoriasis and urticaria [hives].
>
> [...] There is evidence from several studies that its [hypnosis'] inclusion in a weight reduction programme may significantly enhance outcome. (BPS, 2001)

In relation to the safety of hypnotherapy, the BPS rightly conclude that though there are safety concerns with the use of hypnotism, similar concerns relate to the use of psychological therapy in general.

> Hypnosis is generally a benign procedure and consideration of potential risks resemble those for other similar psychological methods. (BPS, 2001)

They acknowledge the traditional contraindications to hypnotherapy, such as its use in the treatment of physical pain where physical diagnosis has not been sought, or in cases of psychosis. However, they also point out that depression, formerly classed as a contraindication, is now seen as treatable by many modern hypnotherapists. Nevertheless they caution against the use of psychodynamic techniques as being potentially contraindicated for use in treating certain cases of depression.

> Contrary to earlier accounts, hypnosis may be used adjunctively in the psychological treatment of some depressed patients. However, care should be taken to avoid subjecting the depressed patient to undue distress by, for example, the use of hypno-analytical procedures that may exacerbate suicidal ideation. (BPS, 2001)

There are, incidentally, also reasons to believe that techniques used in non-hypnotic psychodynamic therapy are contraindicated for some cases of depression. The concern is that where depression is accompanied, as is often the case, by morbid rumination upon unpleasant events in the client's past, the use of psychodynamic therapy which focuses attention on such issues may simply exacerbate the problems. This is a serious safety concern where the client is suicidal, as anything which exacerbates their depressed mood could –in the worst case scenario- trigger a suicide attempt.

Following on from this caution the working party note the two main safety issues now considered to arise in relation to certain hypnotic processes: "re-traumatisation" and "false memory syndrome." The risk of re-traumatisation of clients is mainly a consequence of the phenomenon of uncontrolled hypnotic "abreaction."

> During hypnotherapeutic procedures such as regression methods, a patient may become very emotional and may abreact. This has occasionally been reported to occur spontaneously in therapy, without the suggestion of reliving any memory. Therapists should, therefore, be knowledgeable and skilled in assisting patients who are in a state of extreme emotion. (BPS, 2001)

Likewise, it is emphasised that the "false memory" issue requires considerable caution on the part of therapists using hypno-analytic approaches.

> There is considerable potential for harm when hypnosis is used on the assumption that it facilitates the recollection of events when no conscious memories of these events exist in the first place. [...] What is incontrovertible is that using hypnosis in this way carries a real risk of producing substantial pseudo-memories. Sometimes, these may have such a bizarre quality (e.g. 'memories' of alien abduction) that they would be dismissed by any reasonable person, but some can be so plausible as to beguile the ther-

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> apist and client alike into accepting them as accurate. This problem has received a high profile in the so-called 'Recovered Memories' debate. (BPS, 2001)

These are both issues which most modern, ethical hypnotherapists would be apprised of and exercise caution with regard to. It is significant that they both issues are primarily related to psychodynamic methods, especially regression therapy. Modern, solution-focused and cognitive-behavioural approaches to therapy do not present the same kind of risk.

Scientific American

In 2001, the popular scientific periodical, Scientific American published a detailed article by Prof. Michael R. Nash, a world-authority on hypnosis research. The article summarised some of the key scientific findings of modern psychology with regard to hypnotism. It begins by making a bold assertion about the scientific status of hypnosis:

> […] the study of hypnotic phenomena is now ***squarely in the domain of normal cognitive science***, with papers on hypnosis published in some of the most selective scientific and medical journals.

The article then proceeds to discuss some of the areas in which modern research evidence has validated the efficacy of hypnotherapy.

> […] hypnosis is finding medical uses in controlling chronic pain, countering anxiety and even –in combination with conventional operating-room procedures– helping patients to recover more quickly from outpatient surgery.

The article cites the important NIH panel report mentioned above, which discusses the evidence in favour of hypnotic pain management, and adds,

> Voluminous clinical studies also indicate that hypnosis can reduce the acute pain experienced by patients undergoing burn-wound debridement, children enduring bone marrow aspirations and women in labor. A meta-analysis published in a special issue of the *International Journal of Clinical and Experimental Hypnosis,* for example, found that hypnotic suggestions relieved the pain of 75 percent of 933 subjects participating in 27 different experiments. The pain relieving effect of hypnosis is often substantial, and in a few cases the degree of relief matches or exceeds that provided by morphine.

The report adds that there is 'strong but not yet definitive evidence' that hypnosis can be effective in treating a wide range of other issues.

> Listed in rough order of tractability by hypnosis, these include a subgroup of asthmas; some dermatological disorders, including warts; irritable bowel syndrome; haemophilia; and nausea associated with chemotherapy.

Moreover, a large number of research studies support the fact that hypnosis can enhance the effects of other forms of therapy.

> Hypnosis can boost the effectiveness of psychotherapy for some conditions. Another meta-analysis that examined the outcomes of people in 18 separate studies found that patients who received cognitive behavioural therapy [CBT] plus hypnosis for disorders such as obesity, insomnia, anxiety and hypertension showed greater improvement than 70 percent of those who received psychotherapy alone. After publishing these findings the *American Psychological Association* validated hypnosis as an adjunct procedure for the treatment of obesity.

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The implications of this study are phenomenal as it appears to demonstrate, by means a substantial body of evidence, that a majority of people, with some of the most common presenting problems encountered in clinical practice, will benefit more from hypno-psychotherapy than from traditional CBT, the current treatment of choice in the medical establishment.

The article then proceeds to discuss how recent research studies have apparently discovered some of the mechanisms by which hypnosis acts within the neurology of the brain. Some research has tentatively indicated a correlation between a person's ability to become absorbed in reading, daydreaming, or listening to music. This observation may be supported by research on the neuropsychology of hypnosis.

In 2004 James E. Horton of the University of Virginia's College at Wise and Helen J. Crawford of Virginia Polytechnic Institute and State University showed with MRI images that the rostrum part of the corpus collosum was 32 percent larger for highly hypnotizable subjects than for those subjects who were not susceptible to hypnosis. This brain region plays a role in allocating attention and in the inhibition of unwanted stimuli.

In other words, brain scans suggest that good hypnotic subjects have a more developed capacity for mental absorption. Another neurological study seems to support the fact that hypnotic phenomena are more akin to hallucination than deliberate imagination.

> […] an elegant study using positron emission tomography (PET), which indirectly measures metabolism, has shown that different regions of the brain are activated when a subject is asked to imagine a sound than when he or she is hallucinating under hypnosis. […] The tests showed that a region of the brain called the right anterior cingulate cortex was just as active while the volunteers were hallucinating as it was while they were actually hearing the stimulus.

The article notes the fact that on the Stanford Hypnotic Susceptibility Scale (SHSS) 95% of people will respond to at least one suggestion test item. In other words, using the same, scripted series of suggestion tests, 95% of people will exhibit at least one hypnotic response. Moreover, we can speculate that the other 5% might respond simply by substituting a different type of script.

In order to further investigate the effects of hypnosis, therefore, Scientific American took the unusual step of referring six of its staff to be hypnotised and assessed for hypnotic responsiveness by Professor Nash. The journalists were tested using the Stanford Hypnotic Susceptibility Scale. All six responded to at least three suggestion tests from the scale, and one of them scored an 8 on the scale, indicating a particularly high level of hypnotisability.

Commenting on the group's personal experiences of the experiment, Carol Ezzell Webb, a staff writer from Scientific American, reports:

> In general, the experience was much less eerie than expected. The feeling was akin to falling into a light doze after you've awakened in the morning but while you're still in bed. All of the volunteers found that they felt less hypnotised during some parts of the session than during others, as if they had come near the "surface" for a few moments and then slipped under again.

Although the experiences of hypnosis can vary, this account is fairly representative of a typical subjective response.

The American Psychological Association

In 2005, the Society for Psychological Hypnosis, Division 30 of the American Psychological Association, published the following formal definition of hypnosis,

> Hypnosis typically involves an introduction to the procedure during which the subject is told that suggestions for imaginative experiences will be presented. The hypnotic induction is an extended initial suggestion for using one's imagination, and may contain further elaborations of the introduction. A hypnotic procedure is used to encourage and evaluate responses to suggestions. When using hypnosis, one person (the subject) is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behavior. Persons can also learn self-

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> hypnosis, which is the act of administering hypnotic procedures on one's own. If the subject responds to hypnotic suggestions, it is generally inferred that hypnosis has been induced. Many believe that hypnotic responses and experiences are characteristic of a hypnotic state. While some think that it is not necessary to use the word "hypnosis" as part of the hypnotic induction, others view it as essential.
>
> Details of hypnotic procedures and suggestions will differ depending on the goals of the practitioner and the purposes of the clinical or research endeavour. Procedures traditionally involve suggestions to relax, though relaxation is not necessary for hypnosis and a wide variety of suggestions can be used including those to become more alert. Suggestions that permit the extent of hypnosis to be assessed by comparing responses to standardised scales can be used in both clinical and research settings. While the majority of individuals are responsive to at least some suggestions, scores on standardised scales range from high to negligible. Traditionally, scores are grouped into low, medium, and high categories. As is the case with other positively-scaled measures of psychological constructs such as attention and awareness, the salience of evidence for having achieved hypnosis increases with the individual's score.

Note that this definition clearly emphasises the role of suggestibility over depth of relaxation.

Conclusions & Comments

This article is a summary of some key texts in the history of science and not to be taken as a statement of fact about clinical hypnotherapy or the science of hypnotism (‘neuro-hypnology’). In particular we disagree with some of the implications regarding the supposed ‘dangers’ of hypnosis, and the view that its use should be confined to medical professionals. The only possible dangers lie in the wilful abuse or incompetence of unethical or unprofessional practitioners, a ‘hazard’ that has nothing to do with hypnotic the hypnotic state itself and occurs in any form of therapeutic relationship.

The notion that the use of hypnosis should be confined to medical professionals (BMA, 1892), or even those following a medical code of ethics and acting under the supervision of a doctor (BMA, 1955), is very much an anachronism. This concern is no longer relevant as it harks back to a period before the development of respectable hypnotherapy organisations with their own professional registers, training requirements, and codes of ethics and practice. Of course, in cases where certain physical conditions are present the hypnotherapist may find it necessary or appropriate to consult with the client’s doctor before proceeding with therapy. However, it would be absurd to confine the practice of hypnosis to doctors and dentists as it is essentially a form of psychotherapeutic communication and not a medical procedure.

Likewise, the condemnation of ‘public exhibitions’ (BMA, 1892) or use of hypnosis for ‘entertainment purposes’ (AMA, 1958) -presumably indirect references to stage hypnosis- are unsupported by any reasoned argument and probably owe more to prejudice and misconception than to valid concerns.

Overall, the information contained in these reports may prove of use to hypnotherapists in their relations with medical professionals. For example, some of the quotations above might be used effectively in presentations to general practitioners or health organisations. The key facts established are the recognition and approval of hypnotherapy as an effective technique in the treatment of both psychological and organic conditions and in the management of pain. This approval gives hypnotherapists a possible advantage over other CAM practitioners in their relations to the medical establishment. It is information that we believe all hypnotherapy students should be made aware of during their initial training.

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