

The Medical & Scientific Approval of Hypnotherapy

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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 neuro-psychological 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. Having heard vague mention of this ‘approval’ from various sources I began a search for further details and specific references which clarify the medical establishment’s views on hypnotherapy. Earlier this year (1999) I set about conducting some brief research on the internet and in the *British Library* and medical history library of the *Wellcome Institute*, I also received further clarification from various sources at the BMA. The information which follows is taken from my analysis of key documents in the history of the hypnotherapy profession which were identified by that initial research.

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 *υπνος* 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 altered 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., psychoneuroses]. (*Ibid., my italics*)

The report is brief -I 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 hypnotized 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.

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)

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 recognized 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 direction, 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* (2000) 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 (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 recognized 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 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 (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 Behavioral & 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)

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 I summarise as follows (omitting their detailed references).

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; gastrointestinal 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 hypnoanalytical 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 hypnoanalytic 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 therapist 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.

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 neuro-psychology 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 hypnotized 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-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 endeavor. 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 standardized scales can be used in both clinical and research settings. While the majority of individuals are responsive to at least some suggestions, scores on standardized 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 I would comment that I personally 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 I believe all hypnotherapy students should be made aware of during their initial training.

References

- AMA(1958). 'Council on Mental Health: Medical use of Hypnosis', JAMA, Sep 13, 1958: 186-189.
- BMA(1955). 'Medical use of Hypnotism: Report of a Subcommittee appointed by the Psychological Medicine Group Committee of the British Medical Association', Supplement to the BMJ April 23, 1955: 190-193, Appendix X.
- BMA(1892). 'Statement of 1892 by a Committee appointed by the Council of the B.M.A.', Supplement to the BMJ April 23, 1955: 190-193, Appendix X, Sub-Appendix A.
- BPS. (2001). *The Nature of Hypnosis*. Leicester: BPS.
- Consumer Association (1997). 'Complementary Medicine: what works for you', Health Which?, June 1997: 84-87.
- Nash, M.R. & Benham, G. (2005) 'The Truth and the Hype of Hypnosis', in *Scientific American: Mind*, July 2005.
- NIH (1995). Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia. NIH Technol Statement Online 1995 Oct 16-18, 1-34.
- Vickers & Zollman (1999). 'Hypnosis and relaxation therapies,' BMJ, 319: 1346-1349.